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EXECUTIVE DEPARTMENT

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Incorporation by Reference
APPROVAL FORM

Date: September 23, 2019
COMAR: 10.37.01.02

Julie Deppe
Regulations Coordinator
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Julie:

The document entitled Accounting and Budget Manual for Fiscal and Operating Management (August 1987), Supplement 25, is approved for incorporation by reference.

Please note the following special instructions: Place the entire manual onto one disc, incorporating all of the supplements

Attach a copy of this approval form when submitting an emergency or proposed regulation to the AELR Committee and when submitting a proposed regulation to DSD for publication in the Maryland Register. If submitting through ELF, include as part of the attachment.

Any future changes to the incorporated documents do not automatically become part of the regulation. If there are subsequent changes to the incorporated documents, and the agency wishes those changes to become a part of its regulations, the agency must amend the regulation incorporating the documents.

Please call us if you have any questions.

Sincerely,
Gail S. Klakring
Administrator

HEALTH SERVICES COST REVIEW COMMISSION **INSTRUCTION SHEET**

COMAR 10.37.01.02

DATE PROPOSED IN MD. R. November 22, 2019

TITLE: Uniform Accounting and Reporting System for Hospitals and Related Institutions, Supplement 25 (February 10, 2020)

TO: STATE DEPOSITORIES

SUBJECT: COMAR 10.37.01.02 - Accounting and Budget Manual for Fiscal and Operating Management (August, 1987) - Proposed Permanent Regulations

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The Commission's Staff has updated the HSCRC "Accounting and Budget Manual" to reflect all changes through September 1, 2019. The changes are as follows:

MANUAL REVISION INVENTORY	OLD PAGES	NEW PAGES
Section 200		
Chart of Account	113	113
Section 400		
Reporting Requirements	1	1
	5	5
Section 500		
Reporting Instructions	369, 370	369, 370
SECTION 700		
Appendix D		
Table of Contents	NA	NA
Physical Therapy & Occupational Therapy	55	56 (page # changed only)
Respiratory Therapy & Pulmonary Function Testing	63	64 (page # changed only)
Leukopheresis	78	84 (page # changed only)
Labor and Delivery	79	85 (page # changed only)
Interventional Radiology/Cardiovascular	84	90 (page # changed only)
Clinic Services	89	95 (page # changed only)
Ambulance Services – Rebundled	107	113 (page # changed only)
Speech Therapy	108	114 (page # changed only)
Audiology	114	120 (page # changed only)
Laboratory Services	121	127 (page # changed only)
Emergency Services	188	194-199
CT Scanner	194	200 (page # changed only)
MRI	200	206 (page # changed only)

INQUIRIES TO: Julie Deppe, Regulations Coordinator, Maryland Health Care Commission, (410) 764-3563

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To: Julie Deppe, Program Manager, MHCC

From: William H. Hoff, Chief, Audit & Compliance

Date: September 16, 2019

RE: Revision #40 to the HSCRC Accounting & Budget Manual for Fiscal and Operating Management

The Commission's Staff has updated the HSCRC "Accounting and Budget Manual" to reflect all changes through July 1, 2019. The changes are as follows:

MANUAL REVISION INVENTORY	OLD PAGES	NEW PAGES
Section 200		
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Title 10 MARYLAND DEPARTMENT OF HEALTH

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 01 Uniform Accounting and Reporting System for Hospitals and Related Institutions

Authority: Health-General Article, §§19-207**[,** 19-211, 19-212, 19-215—19-217, 19-218, 19-220, 19-224, and 19-303,**]** *and 19-215,* Annotated Code of Maryland

.02 Accounting System; Hospitals.

A. The Accounting System.

(1) (text unchanged)

(2) The "Accounting and Reporting System for Hospitals", also known as the Accounting and Budget Manual for Fiscal and Operating Management (August, 1987), is incorporated by reference, including the following supplements:

(a)─(v) (text unchanged)

(w) Supplement 23 (July 28, 2015); **[**and**]**

(x) Supplement 24 (April 12, 2018)*; and*

(y) Supplement 25 (February 10, 2020).

(3)─(5) (text unchanged)

B.─D. (text unchanged)

ACCOUNTING PRINCIPLES AND CONCEPTS

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ACCOUNTING PRINCIPLES AND CONCEPTS

This Manual is intended to establish a foundation for uniform accounting and reporting for hospitals. It thus becomes necessary to set forth certain basic accounting principles and concepts to be followed throughout the Manual. This section deals with the most significant of these principles and concepts.

The accounting principles and concepts described in this chapter reflect the current state of the art in hospital accounting. The accounting principles and concepts have been drawn from existing systems wherever possible. The options that are currently available under Generally Accepted Accounting Principles (GAAP) have in several instances been limited or restricted. These modifications have been made to allow for more detailed and precise accounting practices so that a uniform accounting and reporting system for hospitals could be established.

Any accounting principles and concepts not specifically discussed in this Manual should be accounted for according to GAAP as interpreted in the opinions of the American Institute of Certified Public Accountants (AICPA) and in the statements by the Financial Accounting Standards Board (FASB).

A fundamental accounting concept is that of the accounting entity or unit. For accounting purposes, the hospital is presumed to be an entity capable of buying, selling and taking other economic actions which are to be accounted for separately from the personal affairs of those responsible for the hospital's administration. The hospital itself is the primary unit for which the accounting records are maintained. However, most departments of the hospital usually assume sufficient importance to require separate treatment as subordinate entities or units of accountability for planning and control purposes.

Another basic accounting concept is that of continuity of activity, or the going concern. The assumption being that the hospital will continue to function indefinitely. It then becomes necessary to divide the life of the hospital into accounting periods, to determine revenues earned and expenses incurred during each period and to measure the amounts of assets and obligations at the end of each period.

ACCOUNTING PERIOD .05

The basic accounting period is one year. This period shall consist of 12 consecutive calendar months.

A hospital beginning operations must select an initial accounting period beginning on the first day of operation, through the last month preceding the hospital's selected fiscal year. For example, a hospital beginning operations August 15, 1978, selecting a fiscal year beginning January 1, would have an initial fiscal period running from August 15, 1978 through December 31, 1978. It would then move to the standard January 1 to December 31 fiscal year.

OBJECTIVE EVIDENCE .06

Information produced by the accounting process should be based, to the extent possible, upon objectively determined facts. Transactions should be supported by properly executed documents such as charge slips, purchase orders, suppliers' invoices, cancelled checks, etc. Such documents serve as objective evidence of transactions and should be retained as a source of verification of the data in the accounting records.

Certain determinations that enter into the accounting records are based on estimates. The estimates should be based on past experiences modified by expected future considerations. Examples would include recognition of estimated provisions for depreciation and bad debts.

Books, papers, records, or other data relevant to matters of hospital ownership, organization, and operation must be maintained. The data must be maintained in an ongoing recordkeeping system which allows for the data to be readily verified by qualified auditors.

CONSERVATISM .07

Conservatism is a quality of judgment to be exercised in evaluating the uncertainties and risks present in the hospital entity to assure that reasonable provisions are made for potential losses in the realization of recorded assets and in the settlement of actual and contingent liabilities. However, conservatism is not a justification for deliberate understatement.

CONSISTENCY .08

Consistency refers to continued uniformity, during a period and from one period to another, in methods of accounting, mainly in valuation bases and methods of accrual, as reflected in the financial statements of an accounting entity, e.g., change from F.I.F.O. inventory method to L.I.F.O. method. Consistency is very important to the development and analysis of trends on a year to year basis and as a means of forecasting. However, consistency does not require continued adherence to a method or procedure that is incorrect or no longer useful, nor does it preclude a justifiable and desirable change in accounting and reporting methods or procedures unless otherwise specified in this manual.

FULL DISCLOSURE .09

The concept of full disclosure requires that all significant data be clearly and completely reflected in accounting reports. If, for example, a hospital were to change its method of accounting for certain transactions, within the limitations of this manual, and if the change had a material effect on the reported financial position or operating results, the nature of the change in method and its effect must be disclosed when reporting costs to any agency.

MATERIALITY .10

Materiality is an elusive concept with the dividing line between material and immaterial amounts subject to various interpretations. It is clear, however, that an amount is material if its exclusion from the financial statements would cause misleading or incorrect conclusions to be drawn by users of the statements.

BASIS OF VALUATION .11

Historical cost is the basis used in accounting for the valuation of all assets and in recording all expenses (except fair market value in the case of donations and imputed value in the case of non paid workers). Historical cost, simply defined, is the amount of cash or cash equivalents given in exchange for properties or services at the time of acquisition. It is the basis for the valuation of assets and for the recording of most expenses. Cost ordinarily has been the basis of accounting for assets and expenses because it is a permanent and objective measurement that reflects the accountability of management for the utilization of hospital funds.

Hospitals, however, frequently acquire property, equipment, services and supplies by donation. The property, equipment, service and/or supply is considered donated when acquired without the hospital making any payment for it in the form of cash, property or services.

The property, equipment, service and/or supply should be valued at the fair market value which is the price that the asset would cost by bona fide bargaining between well-informed buyers and sellers at the date of donation (regardless of date of receipt). Failure to give accounting recognition to donated properties and services results in an understatement of hospital assets, revenues and expenses.

Many hospitals receive the services of members of an organization of non paid workers that has arrangements with the hospital for the performance of services. The services are in positions customarily held by full-time employees, and are performed on a regularly scheduled basis. The fair value of donated services must be recorded when there is the equivalent of an employer-employee relationship and an objective basis for valuing such services. The value of services donated by organizations must be evidenced by a contractual relationship which provides the basis for valuation. The amounts recorded are not to exceed those paid others for similar work.

The value of services of a type for which hospitals generally do not remunerate individuals' performances, are not included as operating costs (e.g., donated services of individuals such as volunteers and trustees).

ACCOUNTING PRINCIPLES .21–.50

ACCRUAL ACCOUNTING .21

In order to provide the necessary completeness, accuracy and meaningfulness in accounting data, accrual basis of accounting is required. Accrual accounting is the recognizing and recording of the effects of transactions and other events on the assets and liabilities of the hospital entity in the time periods to which they relate rather than only when cash is received or paid. For example, the writing off to expense each year of 1/3 of the cost of a three year insurance policy.

MATCHING OF REVENUE AND EXPENSES .22

Determination of the net income of an accounting period requires measurements of revenue, revenue deductions, and expenses associated with the period. Hospital revenue must be recorded in the period in which it is earned; that is, in the time period during which the services are rendered to patients and a legal claim arises for the value of the services.

Once the revenue determination is made, a measurement must be made of the amount of expense incurred in rendering the services on which the revenue determination was based. Unless there is such a matching of revenue and expense, the reported net income of a period is meaningless.

The requirement that revenue deductions must also be matched properly against the gross revenues of the accounting period is sometimes overlooked. During the accounting period, patients' accounts receivable will be debited and revenue accounts will be credited, at the hospital's full established rates, for all services rendered to patients. Some of these accounts receivable will remain unpaid at the end of the accounting period. A majority of these accounts will be collected in cash from the patients or from their third-party payors, but the remainder eventually will be written off as deductions from revenue.

It is important that these revenue deductions be given accounting recognition in the same period that the related revenues were recorded, even though certain of these revenue deductions cannot be precisely determined.

Revenue and expenses are to be matched not only for the hospital as a whole, but also for each cost center. The cost center is an accounting device for accumulating items of cost or revenue that have common characteristics. A cost center may or may not be a department within the hospital. A cost center, such as depreciation, is an example where the cost center would not be a department of the hospital. The costs of the functions and activities included in each cost center description are to be included in the cost center. Revenue relative to such functions and activities must be included in the matching revenue center. For example, expenses related to the Laboratory functions (activities) are to be included in Laboratory Services cost center (Account 7210) and related revenue are to be included in Laboratory Services revenue center (Account 4210).

DEDUCTIONS FROM OPERATING REVENUE .23

In many instances, the hospital receives less than its full established charges for the services it renders. It is essential that accounting information reflect both the gross revenue and revenue "adjustments" resulting from inability to collect established charges for services provided. These revenue "adjustments" are called Deductions from Revenue and are of the following primary categories:

1. Provision for Bad Debts—These deductions represent estimated amount of current revenues that will not be realized as a result of credit losses.
2. Contractual Adjustments—These adjustments represent the differences between full established charges for individual services and the contractual rates received or to be received from third-party payors for services rendered.
3. Charity Service—These deductions represent the difference between full established charges and amounts received or to be received from indigent patients, voluntary agencies, or governmental units on behalf of specific indigent patients.
4. Policy Discounts—These deductions represent adjustments for items such as courtesy allowances and employee discounts from the hospital's full established charges for services.

5. Administrative Adjustments—These adjustments represent amounts of patient service revenue posted but not billed to patients because the cost of billing and collection would exceed the amounts received.

6. Prospective Rate Adjustments—These adjustments represent, essentially, revenue lost or gained due to variances from approved rates (price variance) and variances in approved volumes (volume variance). Revenue lost due to negative variances in rates and underachieving in approved volumes will be recouped, wholly or in part, by the hospital through increases in prospective rates. Similarly, revenue gained due to positive variances in rates and overachieving in approved volumes will be paid back, wholly or in part, by the hospital through reductions in prospective rates.

The above items must be recorded and reported as deductions from gross operating revenue on an accrual basis rather than as expenses.

FUND ACCOUNTING .24

Many hospitals receive, from donors and other third-parties, income, gifts, bequests and grants that are restricted as to use. When funds with donor-imposed restrictions are received, they must be accounted for separately. This would not preclude the pooling of assets for investment purposes.

For Balance Sheet reporting, donor-restricted funds must be recorded separately in the appropriate restricted fund classifications. For income statement purposes, expenses relating to donor-restricted activities must be recorded in the Unrestricted Fund, and the earned share relative to such current year donor-restricted activities must be recorded as "Other Operating Revenue" unless otherwise restricted by covenant agreement. Hospitals receiving no restricted income, gifts, bequests, or grants need not use separate fund accounting.

Restricted funds generally fall into three categories: Plant Replacement and Expansion Fund, Specific Purpose Fund, and Endowment Fund. The accounts within each restricted fund are self-balancing, as each fund constitutes a separate subordinate accounting entry. The following sections outline the conditions and events which require separate accountability and the required accounting treatment for transactions within the established funds.

Unrestricted Fund .241

The Unrestricted Fund is used to account for funds derived from the day-to-day activities of the hospital and unrestricted contributions. Funds which originate from unrestricted gifts or previously accumulated income may be designated by the governing board for special uses. If the governing board designates assets in this manner, it should be recognized that the board also has the authority to rescind its action. For this reason, such funds must be accounted for in the Unrestricted Fund as "Board-Designated Assets". All other funds within the Unrestricted Fund must be accounted for as Operating Funds. A separate structure of accounts in the Unrestricted Fund has been provided for Operating Funds and Board Designated Assets.
The term "restricted" should not be used in connection with board or other internal hospital appropriations or designations of assets.

Plant Replacement and Expansion Fund .242

Resources restricted by donors and other third-parties for the acquisition or construction of plant assets or the reduction of related debt must be accounted for in the Plant Replacement and Expansion Fund.

When expenditures for plant assets are made by the Unrestricted Fund for the Plant Replacement and Expansion Fund, a transfer must be made from the Plant Replacement and Expansion Fund to match such expenditures if such funds are available. The entries to record such expenditures and the required transfer in both funds are as follows:

Unrestricted Fund

June 30	Account	Dr.	Cr.
Construction in Progress	1260	$1,000	
Other Accounts Payable	2029		$1,000
Due from Plant Replacement and Expansion Fund	1073	$1,000	
Transfer from Restricted Funds for Capital Outlay	2294		$1,000

Plant Replacement and Expansion Fund

Transfer to Unrestricted Fund for Capital Outlay	2695	$1,000	
Due to Operating Fund	2581		$1,000

To record construction expenses incurred and related inter-fund transfer entries.

Due to/due from accounts are to be used only as an interim measure and should be reduced within a reasonable period of time by a transfer of assets (generally cash or investments) between the respective funds.

Plant Replacement and Expansion Fund			
July 3	Account	Dr.	Cr.
Due to Operating Fund	2851	$1,000	
Cash	1510		$1,000
Unrestricted Fund			
Cash	1010	$1,000	
Due from Plant Replacement and Expansion Fund	1073		$1,000
To record transfer of cash from Plant Replacement and Expansion Fund to the Operating Fund.			

Unrestricted Fund			
July 5	Account	Dr.	Cr.
Other Accounts Payable	2029	$1,000	
Cash	1010		$1,000
To record payment of the liability.			

If cash is disbursed for plant assets directly from the Plant Replacement and Expansion Fund, the plant assets must nonetheless be recorded in the Unrestricted Fund, with the accompanying credit made to Fund Balance. In the Plant Replacement and Expansion Fund, Fund Balance would be debited, and a cash account credited. No entries would be made to the inter-fund payable or receivable accounts, nor would any cash be transferred between funds.

The preferred method of accounting for the expenditure of restricted Plant Replacement and Expansion funds is specified above. However, because of restrictions placed on construction funds by certain funding authorities, such expenditures and related liabilities are required to be recorded in the Plant Replacement and Expansion Fund. If expenditures for plant assets are recorded in the Plant Replacement and Expansion Fund, the plant assets must be transferred to the appropriate asset account in the Unrestricted Fund, with the accompanying credit made to the Unrestricted Fund Balance. In the Plant Replacement and Expansion Fund, Fund Balance would be debited, and the temporary account(s) credited. No entry would be made to the inter-fund payable or receivable accounts. (Accounts have not been provided in this manual for recording such expenditures and related liabilities. Hospitals may establish such accounts as necessary.)

Income earned and any net realized gains on investments must be reflected as an addition to the fund balance if so specified by the donor. If available for general operating purposes, they must be included in non-operating revenue in the Unrestricted Fund:

Specific Purpose Fund .243

Funds received which are restricted for a specific operating purpose must be accounted for in the Specific Purpose Fund. These resources must be recorded as other operating revenue in the period in which expenditures are made for the purpose specified by the donor.

Income earned and any net realized gains on investment must be recorded as an addition to Fund Balance if required to conform to the donor's instructions or as non-operating revenue of the Unrestricted Fund if such revenue is available for general purposes.

Endowment Fund .244

Funds classified as endowment include:

- pure endowment (principal is to remain intact in perpetuity).
- term endowments (principal is available for use upon the
-passage of time or the occurrence of an event).

When term endowments become available to the governing board for unrestricted purposes, they must be recorded as non-operating revenue; if these funds are restricted, they must be transferred to the appropriate restricted fund.

Income earned on endowment fund investment must be accounted for in accordance with donor's instructions if restricted, or as non-operating revenue in the Unrestricted Fund if not restricted.

Inter-fund Transactions .245

As is shown in the Chart of Accounts, the only liability accounts included in the restricted funds (i.e., all funds other than the Unrestricted Fund) are liabilities to other funds (with the exception of the Endowment Fund, which allows for the inclusion of certain liabilities on Endowment Fund assets and the Plant Replacement and Expansion Fund for certain covenant agreements as explained in Section 100.242).

Thus, virtually all liabilities incurred by the hospital are to be recorded in the Unrestricted Fund. When these liabilities apply to restricted fund activities, a receivable from the applicable restricted fund activities must be recorded within the Unrestricted Fund. A payable to the Unrestricted Fund (or transfer of funds if paid immediately) as well as a reduction of the restricted fund balance is recorded within the applicable restricted fund.

Except for expenses incurred in conformity with covenant agreements, all expenses relating to restricted fund activities must be recorded in the Unrestricted Fund in the cost center category to which they apply. This is true whether the actual expenditures of cash are made from the Unrestricted Fund or a restricted fund. Separate cost centers must be established within each of these categories to record restricted activities for which separate accounting are required by the terms of the grant or gift. Sufficient account numbers have been allowed so that specific restricted fund activities may be segregated. Transfers from these restricted funds to match those expenses must be made in one of the following accounts:

Transfers from Restricted Funds for Research Expenses (Account 5020)

Transfers from Restricted Funds for Education Expenses (Account 5280)

Transfers from Restricted Funds for Other Operating Expenses (Account 5880)

EXAMPLE

In the following example, assume that $200 of consulting costs were incurred (this consulting was performed by a non-related organization) for restricted research activities, recorded as an expense and a liability in the Unrestricted Fund, and subsequently paid.

UNRESTRICTED FUND

June 1	Account	Dr.	Cr.
Research	8010	$ 200	
Accounts Payable	2020		$ 200
Due from Specific Purpose Fund	1074	$ 200	
Transfers from Restricted Funds for Research Expenses	5020		$ 200

SPECIFIC PURPOSE FUND

June 1			
Transfers to Operating Fund for Operating Purpose	2797	$ 200	
Due to Operating Fund	2781		$ 200

To record the expense and related liability for costs incurred in restricted research activities in the Operating Fund and record an inter-fund liability and reduction in fund balance in the specific purpose fund.

UNRESTRICTED FUND

June 10	Account	Dr.	Cr.
Cash	1010	$ 200	
Due from Specific Purpose Fund	1074		$ 200

SPECIFIC PURPOSE FUND

June 10			
Due to Operating Fund	2781	$ 200	
Cash	1710		$ 200

To record the transfer of cash to the Operating Fund

UNRESTRICTED FUND

June 15	Account	Dr.	Cr.
Accounts Payable	2020	$ 200	
Cash	1010		$ 200
To record the payment of the liability			

LONG-TERM SECURITY INVESTMENTS .25

Long-Term Security Investments are to be valued at hospital cost if purchased or, if acquired by donation, at the fair market value at the date of the gift. If there is evidence of a permanent decline in value, an appropriate reduction in carrying value must be made by charging the necessary expense account(s). The market value of long-term security investments at year-end must be disclosed.

POOLED INVESTMENTS .26

Investments of various funds may be pooled unless prohibited by law or the terms of a donation or grant. Gains/losses and investment income on pooled investments must be distributed to participating funds on a basis utilizing market value at least annually.
To illustrate the market value method of distributing gains/losses and income on pooled investments, assume the following facts:

1. A hospital decides to create a pool of investments from funds provided from the following sources:

	*Market Value at Inception of Pool	
	Amount	% to Total Pool
Unrestricted Funds	$ 1,000,000	20%
Endowment Funds (Single endowment)	$ 3,000,000	60%
Plant Replacement and Expansion (PR&E) Funds	$ 1,000,000	20%
	$ 5,000,000	100%

*This serves as the initial distribution basis.

2. Gains/losses on the endowment funds must be added to or deducted from the principal; however, the investment income is available for unrestricted purposes under the terms of the gift.

3. Gains/losses and investment income for the plant replacement and expansion funds must be added to or deducted from fund balance pursuant to the wishes of the donor.

4. There were no gains/losses on the sale of investments for the first year the pool was in existence. The income generated by the pool for that year was $400,000.

5. Any gains on investments sales and investment income are not reinvested in the investment pool. The cash is remitted to funds that are entitled to the gains and/or income.

The distribution of the income for the first year would be based on each participating fund's percentage (%) of the pool based on its contribution at market value at the initiation of the pool. Therefore, the distribution would be as follows:

	Distributed To	Income Distributed
Unrestricted Funds	(Total income of $400,000 × 20%)	$ 80,000
Endowment Funds	(Total income of $400,000 × 60%)	240,000
PR&E Funds	(Total income of $400,000 × 20%)	80,000
		$400,000

The accounting entries necessary to account for the distribution of income from the pooled investments would be as follows:

Unrestricted Fund

	Account	Dr.	Cr.
Cash	1010	$ 320,000	
Unrestricted Income from Endowment Funds (non-operating revenue)	9040		$ 240,000
Income, Gains and Losses from Unrestricted Investments	9040		$ 80,000
To record the income from pooled investments for the year.			

PR&E Fund

	Account	Dr.	Cr.
Cash	1510	$ 80,000	
Fund Balance	2690		$ 80,000
To record the income from pooled investments for the year.			

In the second year the following facts are assumed:

1. On the first day of the year the hospital decided to add $1,000,000 of unrestricted funds to the pooled investments. On that date; but prior to making the aforementioned addition, the pooled investments had the same cost, $5,000,000, as at inception but a market value of $6,000,000. There were no other additions to the pool during the year.

2. There were net gains on the sale of investments of $100,000 for the year and the investment income was $500,000 for the same period.

Based on the above facts the distribution percentage (%) for the income and gains on pooled investments for each of the participating funds would be based on the market value of the investment pool as of the date of the last addition and would be calculated as follows:

	Revised Distribution Basis	
	Units	% to Total Units
Unrestricted Fund:		
Market value $6,000,000 × 20% (distribution % prior to addition)	$1,200,000	
Addition to pool at fair value as of that date	1,000,000	
	$2,200,000	31.4%

	Revised Distribution Basis	
	Units	% to Total Units
Endowment Fund:		
Market value $6,000,000 × 60% (distribution % prior to addition—no new additions)	$ 3,600,000	51.4%
PR&E Fund:		
Market value $6,000,000 × 20% (distribution % prior to addition—no new additions)	1,200,000	17.2%
	$7,000,000	100.0%

The income and gains from pooled investments for the second year would be based on the newly computed distribution and would be as follows:

	Current Distribution %	Gains to be Distributed	Income to be Distributed
Unrestricted Funds	31.4%	$ 31,400	$ 157,000
Endowment Funds	51.4%	51,400	257,000
PR&E Funds	17.2%	17,200	86,000
	100.0%	100,000	500,000

The accounting entries necessary to reflect the above distribution would be as follows:

Unrestricted Fund

	Account	Dr.	Cr.
Cash	1010	$ 445,400	
Unrestricted Income from Endowment Funds (non-operating revenue)	9050		$ 257,000
Income, Gains and Losses from Unrestricted Investments	9040		188,400
To record the income and gains on pooled investments attributable to these funds for the year.			

Endowment Fund

	Account	Dr.	Cr.
Cash	1810	$ 51,400	
Fund Balance (Gains on sales of investments)	2890		$ 51,400
To record the gains on pooled investments attributable to this fund for the year.			

PR&E Fund

	Account	Dr.	Cr.
Cash	1510	$103,200	
Fund Balance	2690		$103,200
To record the gains and income on pooled investments attributable to this fund for the year.			

As the above example illustrates, each time an addition is made to the investment a new distribution basis may be calculated but at least annually. This is also true for any reductions to the pool. All gains/losses and investment income from the beginning of the accounting period up to the date of the addition must be determined and distributed on the basis of account balances prior to the addition. Any gains/losses and investment income subsequent to an addition would be distributed on the new basis until another addition or reduction is made.

INVENTORIES .27

Inventories reflect the cost of unused hospital supplies. Any generally accepted cost method (e.g., FIFO, LIFO, Average, etc.) may be used as long as it is consistent with that of the preceding accounting period.

Inventory accounting record systems are required, consistent with the method of the inventory valuation employed. Perpetual inventory records are recommended but are not required. Physical valuations must be made at least once a year and the accounting records, if applicable, adjusted to such valuations.

Inventory usage records are required to be maintained for all inventories that are distributed and used by more than one cost center in the hospital. It is recommended that the formal requisition system be used for this purpose.

ACCOUNTING FOR PROPERTY, PLANT AND EQUIPMENT .28

Classification of Fixed Asset Expenditures .281

Property, Plant and Equipment and related liabilities must be recorded in the Unrestricted Fund, since segregation in a separate fund would imply the existence of restrictions on the use of the asset. Cost of construction on progress and related liabilities must be recorded in the Unrestricted Fund as incurred except for assets and liabilities related to certain debt agreements. See Section 100.333, Accounting for Debt Proceeds.

Basis of Valuation .282

Property, Plant and Equipment must be reported on the basis of cost. Cost shall be defined as historical cost or fair market value at the date of gift of donated property in accordance with GAAP.

Accounting Control .283

To maintain accounting control over capital assets of the hospital, a plant asset ledger should be maintained as part of the general accounting records. Some items of equipment should be treated as individual units within the plant ledger when their individuality and unit cost justify such treatment. Other items of equipment, if they are similar and are used in a single cost center, may be grouped together and treated as a single unit within the ledger.

All equipment purchased for capital intensive cost centers must be segregated in the plant ledger record by cost center so that the cost of equipment and the related depreciation for each cost center is available.

Capitalization Policy .284

If a depreciable asset has at the time of its acquisition an estimated useful life of three or more years and a historical cost of at least $500, its cost must be capitalized, and written off ratably over the estimated useful life of the asset.

If a depreciable asset has a historical cost of less than $500, or if the asset has a useful life of less than three years, its costs are recorded in the year it is acquired, subject to the provisions of writing off the costs of minor movable equipment. The hospital may, if it desires, establish a capitalization policy with lower minimum criteria but under no circumstances may the above criteria be exceeded. Alterations and improvements which extend the life or increase the productivity or efficiency of an asset, as opposed to repairs and maintenance which either restore the asset to or maintain it at its normal or expected service life must be capitalized and depreciated over their expected useful lives not to exceed the lives of the asset to which they are fixed. Normal repair and maintenance costs are to be reported as expense in the current accounting period.

Minor Equipment .285

Minor equipment includes such items as waste baskets, bed pans, silverware, mops, buckets, etc. The general characteristics of this equipment are: (a) in general, no fixed location, and subject to use by various departments within a hospital; (b) comparatively small in size and unit cost; (c) subject to inventory control; (d) fairly large quantity in use; and (e) generally, a useful life of less than three years.

There are two ways in which the cost of minor equipment may be recorded:

a. The original investment in this equipment may be capitalized and written off over three years. All subsequent purchases would be written off over three years.

b. All purchases of minor equipment may be capitalized and depreciated over their estimated useful lives.

Once a hospital has applied one of the methods, that method must be used consistently thereafter.

Interest Expense During Period of Construction .286

Frequently hospitals borrow funds to construct new facilities or modernize and expand existing facilities. Interest costs incurred during the period of construction must be capitalized as a part of the cost of the construction. The period of construction is considered to extend to the date the constructed asset is put into use. When proceeds from a construction loan are invested and income is derived from such investments during the construction period, the amount of interest expense to be capitalized must be reduced by the amount of such income.

Depreciation Policies .287

Depreciation on plant assets used in the hospital's operations must be recorded as an operating expense in the Unrestricted Fund. The straight line method of depreciation must be used for all assets acquired after July, 1970.

The estimated useful life of a depreciable asset is its normal operating or service life in terms of utility to the hospital. Some factors to be considered in determining useful life include normal wear and tear, obsolescence due to normal economic and technological advances, climatic or other local conditions and the hospital's policy for repair and replacement. In selecting a proper useful life for computing depreciation, hospitals must utilize the most recent useful life guidelines published by the American Hospital Association. However, with the rapidly changing technology in hospitals, these recommendations may not be all inclusive; in which case, the expertise of the manufacturer or other reliable sources may be considered.

For reporting purposes, each hospital must establish, and follow consistently, from year to year, a policy relative to the amount of depreciation to be taken in the years of acquisition and disposal of depreciable assets. Examples of acceptable policies are:

1. Computing first year depreciation based upon the portion of time the asset was in use during the year. That is, if a depreciable asset was received and in use in the hospital for eight months in the year of acquisition, two-thirds of a full year's depreciation expense would be recognized in that first year.

2. Recording one-half of the yearly depreciation expense in the years of acquisition and disposal, regardless of date of acquisition.

3. Recording a full year's depreciation expense if the asset was acquired in the first half of the year. If the asset was acquired in the last half of the year, no depreciation expense would be recognized.

It should be noted that depreciation expense must not be recorded until assets are put into use in hospital operations. Thus, no depreciation would be recorded relative to a new hospital building until that building was actually put into use.

TIMING DIFFERENCES .29

Timing differences result when accounting policies and practices used in an organization's accounting differ from those used for reporting operations to governmental units collecting taxes or to outside agencies making payments based upon the reported operations. These differences must be recorded on the Hospital's records when they arise. The references relative to their acceptable accounting treatment are as follows:

- Income tax allocation—Accounting Principles Board Opinions Nos. 11, 23 and 24.

The following condensed income statement illustrates a timing difference attributable to different methods of calculating depreciation expense for financial accounting versus tax or third-party reimbursement purposes.

Assumptions:

1. Depreciation for accounting purposes is calculated on the straight-line method and amounts to $10 for the current year.

2. Depreciation for tax and third-party reimbursement purposes is calculated on a declining balance method and amounts to $20 for the current year.

3. The tax rate is 40%.

4. The third-party utilization is 50%.

5. The only deduction from revenue is the contractual allowance.

		Accounting Records	Tax/Third-Party Cost Report
Revenue		$ 180	$ 180
Deductions from Revenue	(B)	30	25
Net Revenue		$ 150	$ 155
Expenses (excluding depreciation)		110	110
Depreciation		10	20
Total Expenses before Taxes		120	130
Income before Taxes		30	25
Taxes	(A)	12	10
Net Income		$ 18	$ 15

(A) The income tax expense is comprised of three components:

1. $10 currently payable, (2) $4 payable in future periods representing the tax effect of the difference between depreciation expense for accounting and tax purposes (40% × $10 = $4), and (3) $2 to be applied against tax liabilities in future periods, representing the tax effect relative to reimbursement caused by the differences between depreciation for accounting purposes and cost report purposes, computed as follows: 40% (tax effect) = 50% (third party utilization) × $10 (difference between depreciation for accounting and cost report purposes) = $2 or stated another way, it is the difference between the deductions from revenue per the accounting records ($30) and the Tax/Cost Report Records ($25) times the tax rate of 40%. The journal entry to record these items is:

	Account	Dr.	Cr.
Provision for Income Taxes—Federal—Current	9411	$10	
Provision for Income Taxes—Federal—Deferred	9412	2	
Income Taxes Payable	2090		$10
Deferred Income Taxes Payable	2120		2

(B) The deduction from revenue (contractual adjustments) is calculated as follows:

	Accounting Records	Tax/Cost Report
Medicare Revenue ($180 × 50%)	$90	$90
Reimbursable Costs:		
$120 × 50%	60	
$130 × 50%		65
Contractual Adjustment		
	$30	$25

Of the $30 contractual adjustment for accounting purposes, $25 is the current portion and $5 is the deferred portion. The journal entry to record this expense is:

	Account	Dr.	Cr.
Contractual Adjustment-Medicare	5910	$30	
Allowance for Contractual Adjustment-Medicare	1042		$25
Deferred Revenue-Medicare	2131		5

ACCOUNTING FOR PLEDGES .30

All pledges, less a provision for amounts estimated to be uncollectible, must be included in the hospital's accounting records. If unrestricted, they must be recorded as non-operating revenue in the period the pledge is made. If part of the pledge is to be applied during some future period, that part must be recorded in the period the pledge is received as deferred revenue. If restricted, they must be recorded in addition to the appropriate restricted fund balance. See Hospital Audit Guide.

SELF INSURANCE .31

Self Insurance by a hospital for potential losses due to unemployment, workmen's compensation and malpractice claims, asserted or otherwise, places all or part of the risk of such losses on the hospital rather than insuring against all or part of such losses with an independent insurer. Accruing for self-insured losses is governed by the Financial Accounting Standards Board's Statement No. 5 on Accounting for Contingencies.

RELATED ORGANIZATIONS .32

Auxiliaries, guilds, fund raising groups and other related organizations frequently assist hospitals. If such organizations are independent and are characterized by their own charter, bylaws, tax-exempt status and governing board or a sufficient combination of these characteristics to demonstrate their independent existence from the hospital, the financial reporting of these organizations should be separate from reports of the hospital. If such organizations are under the control of (or common control with) hospitals and handle hospital resources, their financial reports must be combined with those of the hospital.

A hospital itself may be subsidiary to or under the control of a larger organization such as university, governmental entity or parent corporation. It is typical in such situations for hospitals to receive services from these related organizations. Examples of services received are administration, purchasing, general accounting and menu planning. In addition, related organizations lease property, plant and equipment to hospitals as well as paying for various other items such as insurance. The related organization then usually charges for the service either directly or through a management fee. The direct charges must be recorded in the appropriate cost centers as billed, and the management fee must be distributed to the functional cost centers in amounts relative to the services received for which the fee is paid. When this management fee is recorded in the related functional cost centers, the natural classification of expense account .76, Management and Contracted Services, must be used.

DEBT FINANCING FOR PLANT REPLACEMENT AND EXPANSION PURPOSES .33

Debt financing for plant replacement and expansion programs may take many forms. Under the terms of most debt financing agreements the debtor is required to perform or is prohibited from performing certain acts. In many instances debt financing gives rise to special accounting treatment because of discounts and premiums on bond issues, financing charges, formal restrictions on debt proceeds, and sinking and other required funds.

Discounts and Premiums on Bond Issues

.331

Discounts and Premiums arising from the issue of bonds must be amortized over the life of the related issue(s). Bond discounts must be recorded as a reduction of the related debt (Bonds Payable—Net of Unamortized Discount). Bond premium must be recorded as Other Deferred Credits, (Account 2140).

Financing Charges .332

Costs of obtaining debt financing other than discounts (e.g., legal fees, underwriting fees, special accounting costs) must be recorded as deferred costs and amortized over the life of the related debt.

Accounting for Debt Proceeds .333

Debt agreements for financing plant replacement and expansion programs may or may not require formal segregation of debt proceeds prior to their use. Proceeds which are not required to be formally segregated prior to their use must be recorded as other non-current assets in the Unrestricted Fund.

For the purposes of this manual, all funds received under covenant agreements which require formal segregation and/or separate accountability shall be recorded in the Plant Replacement and Expansion Fund until such time as the project is completed. Upon completion, the asset and related debt must be transferred to the Unrestricted Fund. See Section 100.242 for further discussion.

Sinking and Other Required Funds .334

These funds are usually established to comply with loan provisions whereby specific deposits are to be used to insure that adequate funds are available to meet future payments of:

1. Interest and principal (retirement of indebtedness funds); or

2. Property insurance, related taxes, repairs and maintenance costs, equipment replacement (escrow funds).

Funds of this nature may also be required to be held by trustees outside the hospital. Income generated from the investment of such funds may be immediately available to the hospital or such income may be held by the trustee for some future designated purpose.

For the purpose of this manual all sinking and other required funds will be accounted for in the following manner:

1. All fund assets, whether trustee or otherwise, must be recorded in the Unrestricted Fund as a long term investment.

2. All income generated from the investment of such funds must be recorded as non-operating revenue in the Unrestricted Fund, except as required in Section 100.286. Income generated from funds under covenant agreement may be accounted for as an addition to the appropriate restricted fund balance

Early Debt Retirement .335

Many bond contracts provide for the calling of any portion or all of the issue at the option of the company at a stated price, usually above par, for the purpose of enabling the corporation to reduce its indebtedness before maturity as occasion arises, or to take advantage of opportunities to borrow on more favorable terms. Bonds are often retired piecemeal through sinking fund operations.

Costs incidental to the recall of bonds before their date of maturity are considered debt cancellation costs. Such costs include bond recall penalties, unamortized bond discounts and expenses, legal and accounting fees, etc. These costs must be reduced by any unamortized bond premiums and recorded in the Unrestricted Fund in accordance with generally accepted accounting practices.

SPECIALIZED ACCOUNTING AREAS .51–.99

DIRECT RECORDINNG OF COSTS .51

The direct recording of costs is the process of identifying and assigning costs directly to the functional cost center generating those costs.

Buildings and Fixtures .511

The cost of all depreciation or rent/lease of buildings and fixtures is to be charged to the Depreciation and Amortization Cost Center (Account 8810) and to Leases and Rental Cost Center (Account 8820), respectively, and not accounted as direct expense of specific cost centers.

Movable Equipment .512

The cost of depreciation and rent/lease on movable equipment is to be charged to the Depreciation and Amortization Cost Center (Account 8810) and to the Leases and Rental Cost Center (Account 8820), respectively.

Salary and Payroll Related Employee Benefits .513

The salary cost must be assigned directly to the functional cost center to which the employee is assigned (see Natural Classification Accounts, Section 200.037). For example, the salary cost of direct nursing service must be directly assigned to the patient care cost centers receiving the service. This assignment must be based on each employee's actual nursing hours performed within each patient care cost center multiplied by that employee's hourly salary rate while performing the direct nursing services.

It may not be based on the average hours worked or any other such basis. For example, a nurse is assigned to work in various hospital cost centers (pediatric acute, medical-surgical intensive care, and coronary care) during a given payroll period. The hospital must specifically identify that portion of the particular nurses' salary attributable to each cost center. (See Nursing Float Personnel cost center, Account 8992).

Payroll related employee benefits must be reported in the cost center that the applicable employee's compensation is recorded. This can be accomplished by direct assignment each pay period or by accumulating employee benefit costs in account 8993, Employee Benefits, and assigning the expenses to the appropriate cost centers at year-end. This assignment can be performed on an actual basis or upon the following basis:

- FICA—actual expense by cost center
- Pension and Retirement and Health Insurance (non-union)—gross salaries of participating individuals by cost center
- Union Health and Welfare—gross salaries of participating union members by cost center
- All other payroll related benefits—gross salaries by cost centers

For non-payroll related employee benefits, see Section 100.514.

Employee Benefits (Non-Payroll Related) .514

The cost of non-payroll related employee benefits must be allocated to the functional cost centers based upon numbers of full time equivalent employees. Refer to Appendix A-Glossary for the methodology for computing a full time equivalent employee.

Non-Payroll Related employee benefits are those which can be identified as being equally available for the benefit of the entire hospital employee population even though all employees do not avail themselves to these benefits. Examples are provisions of recreation areas, employee health services, day care centers, cafeteria, etc.

Medical Supplies .515

The invoice/inventory cost of all disposable medical and surgical supplies used in daily hospital service centers, ambulatory service centers and certain ancillary service centers (Labor and Delivery Services Account 7010 and Operating Room, Account 7040, Ambulatory Surgery, Account 7050, Speech-Language Pathology, Account 7050, Audiology, account 7580 and Intervention Cardiovascular 7510 Physical Therapy, Account 7310 are to be accounted for as a cost of the Medical Supplies Sold cost center (Account 7110). The related revenue must be reflected in the Medical Supplies Sold revenue center (Account 4110).

The disposable medical and surgical supplies consist of billable supplies and non-billable supplies. The billable disposable supplies are accounted for in sub-accounts 4111 and 7111 for revenue and expenses respectively. The non-billable disposable supplies are accounted for in sub-accounts 4112 and 7112 revenue and expenses respectively.

The overhead associated with the issuing of all medical and surgical supplies must be accounted for in the Central Services and Supply cost center (Account 8460). The cost of reusable (Non-disposable) medical and surgical supplies used in daily hospital service centers, must be accounted for in the Central Services and Supply cost center (Account 8460).

Drugs .516

All pharmaceutical supplies and materials (including IV solutions, admixtures, etc.) used in daily hospital service centers, ambulatory service centers and ancillary service centers excluding Drugs Incident to Radiology are to be accounted for as a cost of the Drugs Sold cost center (Account 7150). The related revenue is to be reflected in the Drugs Sold revenue center (Account 4150).

Drugs Incident to Radiology, i.e. contrast media, etc. is to be accounted for as a cost of the using cost center.

The pharmaceutical supplies and materials consist of billable supplies and materials and non-billable supplies and materials. The billable pharmaceuticals are accounted for in sub-accounts 4151 and 7151 for revenue and expenses respectively. The non-billable pharmaceuticals are accounted for in sub-accounts 4152 and 7152 for revenue and expenses respectively.

The overhead associated with the issuing of pharmaceutical supplies and materials (including IV solutions, admixtures, etc.) must be accounted for in the pharmacy cost center (Account 8460).

Plant Maintenance .517

All direct costs incurred in the maintenance, repair and service of buildings, grounds, parking facilities and equipment, (with the exception of that equipment used in the performance of the principal function in following capital intensive cost centers: medical/surgical intensive care, coronary care, pediatric intensive care, neo-natal intensive care, operating room, laboratory services, cardiac catheterization laboratory, radiology-diagnostic, CT scanner, radiology-therapeutic, nuclear medicine, renal dialysis and MRI scanner) are included in the Plant Operations and Maintenance cost center (Account 8410

Data Processing .518

All the direct costs incurred in operating an electronic data processing center shall be recorded in the Data Processing cost center (Account 8994) and transferred to the using cost center on the basis of CPU (Central Processing Unit) time or some other basis. For reporting purposes this account carries a zero balance.

Central Patient Transportation .519

Central Patient Transportation costs of transporting patients to and from Ancillary Services are considered a part of the Ancillary Services function of the hospital. Therefore, all such costs, wherever they are incurred, must be transferred to the appropriate Ancillary Services Cost Centers for reporting purposes. A central Patient Transportation Cost Center (Account 8891) is provided for those institutions wishing to identify the expense of transporting patients within the facility. If used it should contain all the direct costs of transporting patients between services in and about the hospital. However, no costs shall be reported in this account. (See Section 200, Account 8991).

The expenses incurred in transporting patients to the Daily Hospital Services areas at the time of admission are to be assigned to the Inpatient Admitting Cost Center (Account 8524). The expenses incurred in transporting patients who have been discharged are to be assigned to the Daily Hospital services functional cost center from which the patient was discharged.

HOSPITAL RESEARCH AND EDUCATION COSTS .52

All direct costs incurred in conducting hospital research and formal education activities (as opposed to in-service education) must be recorded in Unrestricted Fund cost center accounts 8010–8199 (Research Expenses) or 8210–8299 (Education Expenses).

Grant Accountability .521

When a separate accounting is required by law, grant contract, or donations restricted for research and educational activities separate cost centers must be maintained. Transfers from restricted funds to match the expenditures for these activities must also be segregated into separate accounts in the series 5020–5199 (Research) or 5280–5300 (Education). Thus, accountability is maintained for all restricted research and educational activities.

Overhead Allocation .522

No allocation of indirect overhead is to be made on the books prior to cost reporting unless such allocation is required by grant contract. When a grant contract calls for the payment of direct costs plus an overhead factor, the overhead factor should be included in billing, but no allocation should be made in the hospital's accounting records.

The following example illustrates the accounting treatment of restricted grant activity.

Assume that a hospital received a specific research grant on December 1, which called for payment of direct costs incurred, plus an overhead allocation of 10 percent of such costs. At December 31, (the hospital's year end) $150 of direct costs had been incurred. The following entries would be made in the hospital's accounting records at December 31:

Unrestricted Fund

	Account	Dr.	Cr.
Research	8010	$ 150	
Cash	1010		$ 150
Due from Specific Purpose Fund	1074	$ 165	
Transfer from Restricted Funds for Research Expenses	5020		$ 165

To record specific research direct costs and to set up receivable and other operating revenue from restricted fund for direct costs, plus overhead allocation.

Specific Purpose Fund

Fund Balance—Transfers to Operating Fund for Operating Purposes	2797	$ 165	
Due to Operating Fund	2781		$ 165

To record liability to unrestricted fund for direct research costs and overhead allocation.

If direct overhead must, by grant contract, be recorded in the Unrestricted Fund cost centers used for the recording of the direct costs of the grant activity, the natural expense classification .89 (other expenses) must be used. A separate cost center entitled "Overhead Applied" should be established in the Unrestricted Fund and credited with the amount of such overhead allocation. For accounting purposes the balance in the "Overhead Applied" cost center must be offset against the grant activity cost center, so costs remaining in the grant activity cost center are direct costs only.

Affiliated School Contracts .523

Education costs incurred relative to affiliated school contracts must be reflected in the Education series of accounts (8220–8299) in the Unrestricted Fund. Salaries, wages and stipends paid to students on approved programs (including interns and residents must be reflected in this series of accounts. Salaries, wages and stipends paid to interns and residents must be reflected in the appropriate natural classification of the Postgraduate Medical Education cost center (Account 8240). Fees paid to physicians involved primarily in approved education programs must also be recorded in the Education series of accounts, in the appropriate cost center.

IN-SERVICE EDUCATION—NURSING .53

Nursing in-service education activities are defined as educational activities conducted by the hospital for hospital nursing personnel. The cost of time spent by nursing personnel as students in such classes and activities must remain in the cost center in which their normal salary and wage costs are charged (i.e., the cost center in which they work). However, the cost (defined as salary, wages, and payroll related fringe benefits) of time spent in such classes and activities by those instructing and administering the programs must be included in the Nursing Administration Cost Center (Account 8750). For those hospitals that want to account for these costs separately and In-service Education Nursing sub-account (Account 8751 has been provided.

If instructors do not work full-time in the in-service program, the cost (as defined above) of the portion of time they spend working in the in-service education program must be included in the Nursing Administration cost center. This may be accomplished by direct distribution of these costs (by natural classification of expense category) each payroll period based upon actual hours worked.

the costs of nursing in-service education supplies (such as cassettes, books, medical supplies, etc.) and outside lecturers must also be reflected in the Nursing Administration cost center. Nursing in-service education does not include orientation of new employees. Such orientation costs must be charged to the cost center in which the new employees are, or will be assigned.

IN-SERVICE EDUCATION—NON-NURSING .54

All expenses associated with non-nursing in-service education activities must be included in the financial cost center to which the participating employees' salaries and wages are assigned, as such in-service educational activities will rarely apply to more than one functional activity.

PHYSICIAN REMUNERATION .55

Due to the numerous types of financial and work arrangements between hospitals and hospital-based physicians, comparability of costs between hospitals may be significantly impaired. This section deals with the methods that are currently used in recording costs and revenues related to the services of hospital-based physicians. The Commission recognizes that certain hospital-based physician costs are not recorded by the hospital as hospital expenses. However, the Commission contends that costs of hospital-based physicians, regardless of billing arrangement, are hospital costs and as such are to be reported to the Commission as hospital costs. The legality of the Commission contention is currently under review by the Court of Appeals and until a decision is reached, hospitals only have to report as hospital costs for their hospital-based physicians who are compensated under method 1 (Agency Arrangement), method 2 (Compensation Arrangement) and method 3 (Contracted Arrangement) described below.

Financial Arrangements .551

1. Agency Arrangement—The hospital bills patients for the physician's professional services, but records these billings as liabilities and the subsequent payment to the physician as a reduction of that liability. The hospital reflects no operating revenue or expense relative to the professional component.

2. Compensation Arrangement—The hospital bills patients for the physician's contractual professional services, including this amount as hospital revenue. All cost center expenses are paid by the hospital. The hospital remits a fee or pays a salary to the physician which is included in hospital expenses.

The compensation arrangement can be either fixed or variable. Under fixed compensation arrangement the physician is paid a specific dollar amount (salary) unrelated to volume of services rendered. Under the variable compensation arrangement the physician's compensation will be a percentage of departmental gross charges or net collections. The actual compensation received by the physician will vary in proportion to the number of procedures performed and to the total charges made by the hospital.

3. Contracted Arrangement—Under this arrangement, the physician may pay any or all expenses of the cost center. The hospital bills patients for the departmental services and remits a fee to the physician. This fee would typically be designated to cover the expenses incurred by the physician recorded as Professional Fees (Natural Classification of Expense .31) regardless of the expenses incurred by the physician.

4. Rental Arrangement—The physician bills the patients for certain of the Part A and Part B component (as defined by Medicare) and incurs all substantial direct expenses. The physician remits a fee to cover certain hospital expenses. This fee is recorded as operating revenue in the appropriate revenue center.

5. Independent/Separate Arrangement—The functions are provided by an independent physician or group of physicians. Neither revenues nor expenses are incurred by the hospital. The hospital refers patients and/or specimens to the physician or group, which is usually located on separate premises. No costs are incurred and no revenue is received under this arrangement.

Note: Compensation paid to interns and residents is not to be included in the revenue producing cost centers, but must be charged to the Post Graduate Medical Education cost center, Account 8240.

Work Arrangement .552

The services provided by hospital-based physicians may be categorized into three general components:

1. Provider Component—provider component activities benefit patients as a group and normally are not identifiable to an individual patient. For purposes of reporting to the Commission, the provider

component can be allocated to the following activities:

a. Research—Working on research projects (see Section 200, account number 8010).

b. Chief of the Medical Staff—this function includes the position of Chief of the Medical Staff. Compensation paid to other departmental chief should not be included under this function (see Section 200, account number 8720).

c. Medical Care Review and PSRO—this function includes peer review, quality assurance, and PSRO (see Section 200, account number 8720).

d. Other Administration and Supervision—this function includes supervision of departmental personnel, administration of the department, in-service education of departmental personnel and stand-by time. Generally, this function includes all provider component activities not included in a, b, and c above.

e. The services do not include physician availability services, except for reasonable availability services furnished in emergency rooms.

2. Physicians Part B Services—The Physicians Part B Services (i.e., Professional component) is an identifiable service that meets the following requirements:

a) The service is personally furnished for an individual patient by a physician;

b) The service contributes directly to the diagnosis or treatment of an individual patient;

c) The service ordinarily requires performance by a physician;

d) In the case of anesthesiology services, the following additional conditions obtain:

1) For each patient, the physician—

i) Performs a pre-anesthetic examination and evaluation;

ii) Prescribes the anesthesia plan;

iii) Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergency;

iv) Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;

v) Monitors the course of anesthesia administration at frequent intervals;

vi) Remains physically present and available for immediate diagnosis and treatment of emergencies; and

vii) Provides indicated post anesthesia care.

2) The physician directs no more than four anesthesia procedures concurrently, and does not perform any other services while he or she is directing the concurrent procedures.

e. In the case of radiology services, the service is an identifiable, direct, and discrete diagnostic or therapeutic service to an individual patient, such as interpretation of x-ray plates, angiograms, myelograms, pyelograms, or ultrasound procedures, and;

f. In the case of pathology service, the services are:

1) Anatomical pathology services;

i) Consultative pathology services that meet the requirements in paragraph (b) of this section; or

ii) Services performed by a physician in personal administration of test devices, isotopes, or other materials to an individual patient.

2) Consultative pathology services. For purposes of this section, consultative pathology services must:

i) Be requested by the patient's attending physician;

ii) Relate to a test result that lies outside the clinically significant normal or expected range in view of the condition of the patients;

iii) Result in a written report included in the patient's medical record; and

iv) Require the exercise of medical judgment by the consultant physician.

3. Education Component—the education component is the time spent teaching and supervising student activity in an organized and approved educational program (see Section 200, account number 8210–8229). This function does not include in-service education and training of departmental personnel which is included as administration and supervision under Identified Physician Costs.

The distinction of a provider Component, Physicians Part B Services and Educational Component is consistent with the total time allocations for those functions as defined by the Medicare Professional Component Form P.C.-7 as revised in June of 1977 for Parts I, II and III of that form, respectively. A reconciliation of the detail of the Provider Component activities between the Commission and Medicare definitions will have to be made from the hospital's records.

When physicians are involved in more than one of the above functional activities, their remuneration, if any, must be recorded in the cost center for which services are paid.

For example, if a physician is paid and spends 40 percent of his time in direct care of patients, 10 percent in teaching activities, 15 percent in research, 5 percent in medical care review activities, and 30 percent in administration and supervision of the department, the reclassification of his remuneration would be as follows:

10 percent Education Costs (To Account 8210-8229)

15 percent Research Projects (To Account 8010-8199)

5 percent Medical Care Review (To Account 8880)

30 percent Cost Center Supervision (Remains in Patient Care cost center)

40 percent identified Physicians Part B Services (This amount must be reported in the Physicians Part B Services cost center, Account 8730.)

Computations:

If the above physician is assigned to the Coronary Care cost center and is paid $50,000 annually—including employee benefits, the following reclassifications would be required for reporting purposes:

10 percent Education Costs (To Account 8210-8299)

15 percent Research Projects (To Account 8010-8199)

5 percent Medical Care Review (To Account 8010-8199)

30 percent Cost Center Supervision (Remains in Patient Care cost center)

40 percent Professional Component (This amount must be reported in the Medical Staff Services cost center, Account 8370.)

Computation: If the above physician is assigned to the Coronary Care cost center and is paid $50,000 annually—including employee benefits, the following reclassifications would be required for reporting purposes:

Professional Component	40% of $50,000 = $20,000 - to Account 8730
Education	10% of $50,000 = $ 5,000 - To Account 8210-8299
Research	15% of $50,000 = $ 7,500 - To Account 8010-8199
Medical Care Review	5% of $50,000 = $ 2,500 - To Account 8880
Cost Center Supervision	30% of $50,000 = $15,000 - Remains in Patient Care cost center

The reclassification of the Professional component from the assigned cost centers to the medical Staff Services cost center, Account 8730 is necessary in order to obtain comparable direct costs between hospitals which employ physicians and hospitals which do not. The reclassification of the other components is to obtain functional comparability.

ALLOCATIONS TO OTHER INSTITUTIONAL PROGRAMS (OIPs),

AUXILIARY ENTRPRISES (AEs) AND UNREGULATED SERVICES (URs).56

Hospitals having OIPs, AEs and URs may have general services functions that support hospital and OIPs, AEs and URs functions.

The methods used to allocate these "common" general services costs will be at the discretion of the hospital. If general service costs are maintained separately for OIPs, AEs and URs these costs should be recorded directly. For example, if housekeeping labor is recorded separately for the hospital and a nursing school, but all supplies are charged to the hospital, the nursing school labor and hospital labor should be recorded directly and supplies should be transferred via the reporting schedules contained in the forms for Budgeting, Section 600 of this manual.

CAPITAL FACILITIES .57

In the area of making provisions for funding the replacement of Capital facilities, the Commission will use as guidelines:

- The fair market value of fixed assets utilized, including assets not owned by institutions
- The current recorded expenses relating to these assets, such as depreciation, leasing costs, financing costs, rentals, etc., including the fair rental value of assets whose use is donated
- The current and projected annual cash requirements for capital facilities, including leases, rents, and debt service requirements, as well as planned needs for the outright purchase of assets.

In order for institutions to provide this information to the Commission for the purpose of establishing this rate component, the following records must be maintained.

- Records which identify major capital facilities (including donated assets) and depreciation thereon to the functional cost centers employing them. Buildings, improvements to land and grounds, building equipment, general purpose fixtures, etc., should be carried on an institution-wide account as should minor facilities, when departmentalization would not be practicable.
- Records which similarly identify rentals, leasing expenses, etc., by functional cost center. Included in this category should be the fair rental value of assets whose use is donated.
- Estimates of the fair market value of the above assets. For those assets owned, an inventory of the current values maintained for insurance purposes would be acceptable. For leased assets with a purchase price, it may be necessary to obtain appraisals of some significant facilities if no alternative value is available.
- Capital budgets for the reporting year and for at least the following three years, including planned method of financing.
- Three-year budgets and debt amortization schedules.

Uncompensated Care .58

Uncompensated care is defined by the Commission to include Charity Care and Bad Debts. Charity Care Services are those Commission regulated services rendered for which payment is not anticipated. Bad Debts Services are those Commission regulated services rendered for which payment is anticipated and credit is extended to the patient. (Bad Debt expense is estimated and recognized by providing an allowance for such amounts estimated to be written off.)

Charity Care: Hospitals should have a written charity care policy. Charity care patients should be identified at the time of admission or service date or as soon thereafter as possible. Charity care, as reported to the Commission, shall consist only of the difference between the hospital's approved rates and the amount, if any, received form such patients in payment.

Bad Debts: Bad Debts, as reported to the Commission, may include only the following:

1. Bad debt write-offs, made after following the provisions of the hospitals collection and write-off policy, less gross Bad Debt recoveries. (Outside collection agency, attorney expenses or any other expenses associated with the collection of patient accounts may not be written off as Bad Debts but must be reported as collection expenses in the Patient Accounting cost center.)

Hospital charges written-off for the following reasons are not bad debts and may not be included in uncompensated care reported to the Commission:

a. Contractual allowances and adjustments associated with Commission approved differentials—i.e., prompt payment, SAAC, and the differential granted to Medicare and Medicaid.

b. Administrative, Courtesy and Policy Discounts and Adjustments - These include, but are not limited to, reductions from established rates for courtesy discounts, employee discounts, administrative decision discounts, discounts to patients not meeting charity policy guidelines, undocumented charges and, payments for services denied by third party payers.

c. Charges for medically unnecessary hospital services.

d. Charges written off that are not the result of a patient's inability to pay or where the hospital has not expended a reasonable collection effort.

CHART OF ACCOUNTS

PREFACE .01

A Chart of Accounts is a listing of account titles, with numerical symbols, used in the compilation of financial data concerning the assets, liabilities, capital, revenues, and expenses of an enterprise.

An outline of the required Chart of Accounts for hospitals is presented in this section along with an explanation of the numerical coding system, and a description of the nature and content of each account required to be used and reported. It is recognized, however, that it is impossible to develop a Chart of Accounts that will fulfill all of the requirements of all hospitals. Many hospitals will not require the detailed information provided for the Chart of Accounts; others may require even more detailed classification. The Chart of Accounts is designed (at the zero level) to provide the basis for a minimum standard of uniform accounting and reporting which will meet the needs of management, regulators, planners, and others.

Hospitals are required to use for reporting purposes all balance sheet accounts which have capitalized titles and which have numerical codes with a fourth digit of zero, when such balance sheet items exist. These accounts are referred to as zero level accounts.

Hospitals are required to use for reporting purposes all revenue and expense accounts which have capitalized titles and which have numerical codes with a fourth digit of zero when such a function as defined in this manual exists even though the activity is not separately organized within the hospital. The only circumstances under which the hospital need not report an existing zero level account is when the patient service provided in a daily hospital services cost center is not provided in a discrete unit, or when the zero level account has sub-accounts which must be reported individually, e.g., 3411/6411, 3412/6412, 4911/7911, 4912/7912.

Since the zero level accounts presented in this manual are required, all zero level accounts presented herein, except as noted above, must be reported by the hospital wherever the related item or function exists in that hospital. A hospital will not be granted an exemption to the establishment of an account solely because of reporting difficulty.

FUNCTIONAL AND RESPONSIBILITY CONCEPTS .02

In developing this Chart of Accounts, it was necessary to choose between functional and responsibility concepts of accounting. Both of these concepts result in the accumulation of the same amount of total costs. However, because organizational structures vary among hospitals, responsibility accounting would not allow for comparability. On the other hand, functions (Housekeeping, Dietary, Intensive Care, etc.) carried out by any hospital would be similar, thus a functional accounting system allows for comparability. For this reason, this Chart of Accounts is based upon functional accounting concepts.

NUMERICAL CODING SYSTEM .03

The numerical coding system in the Chart of Accounts is based on the use of a six digit numbering system. Account numbers include four digits to the left of a decimal point which identify primary account classifications and two digits to the right, which identify secondary account classifications.

The numerical coding system also provides for daily hospital and ancillary service revenue accounts only, that positions seven and eight can be used for designating the program in which the patient is being served as defined by the second and third digits of the routine patient care cost center numbers.

The first digit of an account designates the financial statement classification of the account.

1 - Assets
2 - Liabilities, Equity, and Capital or Fund Balances
3 - Daily Hospital and Ambulatory Services Revenue
4 - Ancillary Services Revenue
5 - Other Operating Revenue and Deductions from Revenue
6 - Daily Hospital and Ambulatory Services Expenses
7 - Ancillary Services Expenses
8 - Research Expenses; Education Expenses; General Services Expenses; Medical Care Administration Expenses; Other Operating Expenses
9 - Non-Operating Revenue and Expenses

The second, third, and fourth digits of the daily hospital services, ambulatory services and the ancillary service centers are the same for revenue and expense.

Balance Sheet Accounts .031

The balance sheet coding uses only the first four digits appearing to the left of the decimal point. The two digits to the right of the decimal point are available for the optional use of the hospital.

Daily Hospital and Ambulatory Services .032

The daily hospital and ambulatory services revenue allows the use of six digits—four to the left of the decimal and two to the right of the decimal. The digits to the left of the decimal represent the functional area serving the patient; the first digit to the right of the decimal represents the classification of service category of the patient service which the patient received and the second digit represents the primary payor for services rendered (Medicare—Part A, Blue Cross, Self Pay, etc.).

Ancillary Services Revenue .033

The ancillary services revenue allows the use of eight digits—four to the left of the decimal point and four to the right. The digits to the left of the decimal represents the ancillary service area rendering service; the first digit to the right of the decimal represents the classification of service category of the patient service which the patient received and the second digit represents the primary payor for services rendered (Medicare—Part A, Blue Cross, Self Pay, etc.). The third and fourth digits to the right of the decimal point may be used to designate the program in which the patient is being served as defined by the second and third digits of the daily hospital and ambulatory services cost centers.

Operating Expense .034

The expense coding uses six digits—four to the left of the decimal and two to the right. The digits to the left of the decimal represent the cost center incurring the expense. The digits to the right of the decimal represent the natural classification of expense. See Section 200.037 for explanations of digits representing the natural classification of expense.

Non-Operating Revenue and Expense .035

Non-Operating revenue and expense consist of amounts not directly related to patient care, related patient services or the revenue and expense of related goods. The non-operating revenue and expense coding uses the four digits appearing to the left of the decimal point. The digits to the right of the decimal are available for the optional use of the hospital.

FIGURE I—NUMERICAL CODING SYSTEM—BALANCE SHEET ACCOUNTS

FIRST DIGIT	SECOND DIGIT	THIRD DIGIT	FOURTH DIGIT	DECIMAL POINT	FIFTH AND SIXTH DIGITS
0 Not Used	0 Unrestricted Fund	0 Not used	0 Mandated Reporting Level	.	Classification According to Hospital Needs
1 Asset	1 Unrestricted Fund	1	1	.	
2 Liability and Equity	2 Unrestricted Fund	2	2	.	
	3 Unrestricted Fund	3	3	.	
	4 Unrestricted Fund	4	4	.	
	5 Plant Replacement and Expansion Fund	5 Primary Sub-Classification	5 Optional Accounts	.	
	6 Plant Replacement and Expansion Fund	6	6	.	
	7 Specific Purpose Fund	7	7	.	
	8 Endowment Fund	8	8	.	
	9 Not Used	9	9	.	

FIGURE II—NUMERICAL CODING SYSTEM—REVENUE ACCOUNTS

FIRST DIGIT	SECOND AND THIRD DIGITS	FOURTH DIGIT	DECIMAL POINT	FIFTH DIGIT	SIXTH DIGIT	SEVENTH AND EIGHTH DIGITS
0 Not Used	0	0 Mandated Reporting Level	.	0 Inpatient-Acute Care	0 Medicare-Part A	0
1 Not Used	1	1	.	1 Inpatient-Intensive Care	1 Medicare-Part B	1
2 Not Used	2	2	.	2 Inpatient-Skilled Nursing Care	2 Medicaid	2
3 Daily Hospital and Ambulatory Services	3	3	.	3 Inpatient-Other	3 Other Government	3
4 Ancillary Services	4	4	.	4 Outpatient-Emergency	4 Workmen's Compensation	4
5 Other Operating Revenue	5 Classification by Function	5 Optional Accounts	.	5 Outpatient-Clinic	5 Blue Cross	5 Program Serving Patient
6 Not Used	6	6	.	6 Outpatient Referred (Including Ambulatory Surgery)	6 Commercial Insurance	6
7 Not Used	7	7	.	7 Home Health Care	7 Charity/ Uncompen-Care	7
8 Not Used	8	8	.	8 Day Care	8 Self Pay	8
9 Non-Operating Revenue	9	9	.	9 Non-Patient	9 Other	9

Natural Classification of Revenue .036

The coding system for revenue provides for the use of 6 digits: four digits to the left of the decimal point and 2 digits to the right of the decimal point. In addition, for daily hospital service, ambulatory service and ancillary service revenue accounts only, positions seven and eight (third and fourth digits to the right of the decimal point) may be used for designating the program in which the patient is being served.

First digit - indicates the primary account classification of the revenue account.

0–2	Not Used
3	Daily Hospital and Ambulatory Service Revenue
4	Ancillary Service Revenue
5	Other Operating Revenue and Deductions from Revenue
6–8	Not Used
9	Non-Operating Revenue

Second through fourth digits (010–999) - indicates the primary sub-classification of accounts.

Decimal Point

Fifth digit - indicates the classification of service category of the patient service which the patient received.

.0	Inpatient - Acute Care
.1	Inpatient - Intensive Care
.2	Inpatient - Skilled Nursing Care
.3	Inpatient - Other
.4	Outpatient - Emergency
.5	Outpatient - Clinic
.6	Outpatient - Referred (Including Ambulatory Surgery)
.7	Home Health Care
.8	Day Care
.9	Non-Patient

Sixth digit 1/ - indicates primary payor (admission status unless changed at later date) for patient as follows:

0	-	Medicare - Part A
1	-	Medicare - Part B
2	-	Medicaid
3	-	Other Government
4	-	Workmen's Compensation
5	-	Blue Cross
6	-	Commercial Insurance
7	-	Charity/Uncompensated Care
8	-	Self Pay
9	-	Other

Seventh and Eighth digits - Reserved to designate program.

Examples of the coding of daily hospital and ancillary service revenue are as follows:

1. A room and board charge made to a Pediatric Acute patient whose bill will be assumed by Blue Cross.

Daily Hospital Service Revenue	3
Pediatric Acute	170
Decimal Point	.
Inpatient Acute Care	0
Blue Cross	5
Pediatric Acute Care	17*
or 3170.0517	

2. A laboratory charge (cytology) made to the same patient.

Ancillary Service Revenue	4
Laboratory Services	210
Decimal Point	.
Inpatient Acute Care	0
Blue Cross	5
Pediatric Acute Care	17*
or 4210.0517	

1/ Use of sixth digit is unnecessary if logs are maintained.

* Optional digits indicating program in which the patient is being served.

FIGURE 3—NUMERICAL CODING SYSTEM—EXPENSE ACCOUNTS

FIRST DIGIT	SECOND AND THIRD DIGITS	FOURTH DIGIT (SEE NOTE BELOW)	DECIMAL POINT	FIFTH DIGIT	SIXTH DIGIT
0 Not Used	0	0 Mandated Reporting Level	.	0 Salaries and Wages	0-9 Job Categories
1 Not Used	1	1	.	1 Salaries and Wages	0-9 Job Categories
2 Not Used	2	2	.	2 Employee Benefits	0-9 Type of Benefit
3 Not Used	3	3	.	3 Professional Fees	0-9 Type of Fee
4 Not Used	4	4	.	4 Medical and Surgical Supplies	0-9 Type of Supplies
5 Not Used	5 Classification by function	5 Optional Accounts	.	5 Non-Medical and Non-Surgical Supplies	0-9 Type of Supplies
6 Daily Hospital and Ambulatory Services	6	6	.	6 Utilities	0-9 Type of Utility
7 Ancillary Services	7	7	.	7 Purchased Services	0-9 Type of Service
8 Other Operating Expense	8	8	.	8 Other Direct Expenses	0-9 Classification by Type
9 Non-Operating Expense	9	9	.	9 Depreciation/ Rent/Transfers	0-9 Classification by Type

Natural Classification of Expense .037

The coding system for expenses provides for the use of six digits: four digits to the left of the decimal point and two digits to the right of the decimal point. If two digits to the right of the decimal point are not sufficient for the individual hospital requirements, additional digits to the right of the decimal point may be added to obtain the desired detail.

First digit - indicates the primary account classification of expense account.

6	Daily Hospital and Ambulatory Service Expense
7	Ancillary Service Expense
8	Other Operating Expense
9	Non-Operating Expense

Second through Fourth digits (010–999) - indicates the primary sub-classification of accounts.

Decimal Point - the two required digits (fifth and sixth digits as specified below) identify secondary account classifications.

The major categories are as follows:

.00 - .19	Salaries and Wages
.20 - .29	Employee Benefits
.30 - .39	Professional Fees
.40 - .49	Medical and Surgical Supplies
.50 - .59	Non-Medical and Non-Surgical Supplies
.60 - .69	Utilities
.70 - .79	Purchased Services
.80 - .89	Other Direct Expense
.90 - .99	Depreciation/Rent/Transfers

.00, .10 Salaries and Wages .0371

If hospital management is to have maximum control over labor costs, close control of the number of man-hours paid is essential. Man-hours are a more stable measure of labor utilization than dollars, because man-hours are not affected by inflation. Also, when man-hours are compared to units of service, they can provide management with information that is useful both for internal control and external comparisons.

Full-time equivalent (FTE) employees must be reported by natural classification of salaries and wages. This requires that the hospital maintain a record of man-hours for all personnel whose compensation is included on the payroll including exempt personnel. The hospital must also maintain a record of man-hours for non-paid workers. These man-hour records must include separate records of worked man-hours worked, overtime worked, call-back hours worked, restricted on-call hours, hours spent in in-service education, and so forth. Non-worked man-hours will include paid vacations, holidays, paid sick leave, military leave, educational leave, bereavement or funeral leave, jury duty, paid lunchtime and so forth.

Overtime hours are hours for which an overtime pay rate is used. The actual overtime hours are not treated differently from regular worked hours: it is the rate that changes. This is preferable to the common but undesirable practice of adding additional hours to the records when calculating the payroll so that the regular pay rate can be used instead of the overtime rate.

On-call and/or standby pay is compensation to an employee for being available to work. During that period when the employee is on call or on standby, he might not actually perform work. The Fair Labor Standards Act differentiates between restricted and unrestricted on-call situations. All restricted on-call hours are compensable and contribute to the total hours used for determining overtime pay. Unrestricted on-call hours do not contribute to total hours, but unrestricted on-call compensation does contribute to the salary base used for calculating overtime premiums only. Thus all restricted on-call hours must be accounted for, but only those hours worked need be accounted for when employees are on unrestricted on-call duty.

In those instances where the hospital has a policy to pay for a minimum number of hours whenever an employee is called back to work and the employee works less than the minimum number of hours, the worked time recorded will include only the number of hours actually worked. For example, a four hour minimum is guaranteed; the employee works two hours and returns home. The hospital will record only two hours as worked time.

Salaries and wages are defined as (1) all remuneration, payable in cash, for services performed by an employee for the hospital, and (2) the fair market value of donated services when there is the equivalent of an employer-employee relationship. The value of donated services may be evidenced by a contractual relationship which may provide the basis for valuation. If persons donating the services are not paid (or are paid less than fair market value of their services), the lay-equivalent salaries (or the difference between lay-equivalent salaries and salaries paid) must be reported as expense with the credit to non-operating revenue. Do not include services rendered by persons such as candy-stripers unless the hospital would actually hire someone to perform such services. Reimbursement of independent contractors such as private duty nurses must be excluded.

See Section 300 for a list of job titles and the natural classification to which assigned.

.01 Management and Supervision

Employees included in this classification are primarily involved in the direction, supervision, and coordination of hospital activities. Usually included here are job titles such as Administrator, Manager, Department Head, Supervisor, Director and Foreman.

.02 Technician and Specialist

Employees included in this classification usually perform activities of a creative or complex nature. Includes such job titles as Coordinator, Technologist, Technician, Therapist, Instructor and Accountant. These employees are often licensed or registered. Some of these positions are exempt from Federal wage and hour laws as administrative or professional. Lead positions of Chief, Head, etc. must be classified as Management and Supervision (.01) if they provide direct supervision to 5 or more other employees.

.03 Registered Nurses

This classification includes only registered Nurses employed in the performance of direct nursing care to patients. Registered Nurses performing supervisory functions must be classified as Management (.01). Those functioning as instructors and coordinators must be classified as Technical (.02). Lead nurses must be classified as Management and Supervision (.01) if they provide direct supervision of 5 or more other employees.

.04 Licensed Vocational (Practical) Nurses

This classification includes Licensed Vocational (Practical) Nurses employed in the performance of direct nursing care to patients. Those Licensed Vocational (Practical) Nurses not providing direct patient care should be classified as Technical (.02). Employees in this classification are usually subject to Federal wage and hour laws.

.05 Aides, Orderlies and Attendants

Included in this classification are non-technical personnel employee for providing direct nursing care to patients. Included are job titles such as aide, orderly and nurse assistant. These employees are subject to Federal wage and hour laws.

.06 Physicians

Include in this classification all salaries to physicians and dentists. This employee must possess a Doctor of Medicine, Doctor of Osteopathy or Doctor of Dentistry degree and be licensed to practice medicine or dentistry. Include physicians as Management and supervision (.01) if they provide direct supervision to 5 or more employees.

.07 Intern, Resident and Fellow

Employees included in this classification are employed for consulting, diagnosing, prescribing and providing treatment for patients. Included are such job titles as intern, resident, and fellow. Also included would be stipends paid to interns and residents, which would be recorded only in the Post Graduate Medical Education Teaching Program (Account 8240).

.08 Non-Physician Medical Practitioners

Include in this classification individuals other than a licensed physician who, after adequate training and registration by the Maryland State Board of Medical Examiners, may perform certain duties that would otherwise be performed by persons licensed to practice medicine. Reference Hospital Guidelines for Utilizing Physician's Assistants published by the Maryland Hospital Education Institute.

.11 Environment, Hotel, and Food Service Employees

This classification includes personnel employed in providing basic services related to food and accommodations. They perform routine work of a non-technical nature and are subject to Federal wage and hour laws. Examples of job titles are maintenance man, housekeeping aide, cooks' helper, flatwork finisher, guard, food service worker, wall washer, and wash person.

.12 Clerical and Other Administrative Employees

Included in this classification are non-technical personnel employed in the performance of record keeping, communication and other administrative functions. Examples of job titles are accounting clerk, admitting clerk, messenger, keypunch operator, secretary, telephone operator, clerk-typist, cashier and receptionist. These employees are subject to Federal wage and hour laws.

.19 Other Employee Classifications

This classification includes personnel not included in the job classes described above.

.20 Employee Benefits .0372

The following employee benefits are to be included as direct costs of all cost centers whose employees received such benefits.

.21 FICA

.22 SUI and FUI (UIC)

These classifications are charged to the employer's portion of the Social Security tax, State Unemployment Insurance, and Federal Unemployment Insurance.

.23 Group Health Insurance
.24 Group Life Insurance
.25 Pension and Retirement
.26 Workmen's Compensation Insurance
.27 Union Health and Welfare
.28 Other Payroll Related Employee Benefits
.29 Employee Benefits (Non-Payroll Related)

Classifications .23 - .28 are to be charged with the cost of employee benefits specified by the respective account titles, classification .29 is to include non-payroll related employee benefits such as personal education, recreation, cultural activities, day care and cafeteria subsidy.

.30 Professional Fees .0373

Fees and other amounts paid for professional services of people who are not on the hospital payroll are included in the following classifications. These classifications contain almost exclusively labor related expense.

.31 Medical Physicians

Include in this classification all fees paid to physicians. See Section 100.55 (Physician Remuneration).

.32 Medical - Therapists and Other Non-Physicians

This classification is charged with amounts paid to medical personnel, other than physicians, not on the payroll such as registered physical therapists and registry nurses.

.33 Consulting and Management Fees

This classification is charged with amounts paid to consultants and management firms when such consultants and firms are not a related organization. Amounts paid to related organizations are charged to natural classification "Management and Contracted Services" (.76).

.34 Legal Fees
.35 Audit Fees
.39 Other Fees

These classifications are to be charged with the amount of legal fees, audit fees, and other fees not included elsewhere.

.40 Medical and Surgical Supplies .0374

The following classifications are used to record the costs of various types of medical and surgical supplies used by a hospital. The fair market value of donated supplies is charged to these classifications if the commodity otherwise would be purchased by the hospital. An offsetting credit is made to "Donated Commodities" (Account 5760).

.41 Prostheses

The cost of replacements for parts of the body and substitutes or aids to permanently impaired functions of the body is charged to this classification. This includes such items as artificial limbs and eyes, dentures, bone plates, permanent braces, eye-glasses, implanted pacemakers, corrective footwear, etc. Also included are components used in the assembling and fitting of such items.

.42 Surgical Supplies - General

The cost of sutures, surgical needles, surgical packs and sheets and all other surgical supplies not described elsewhere is charged to this classification.

.43 Anesthetic Materials

This classification should be charged with the cost of gaseous and volatile agents used in inhalation anesthesia such as cyclopropane, fluothane, halothane, nitrous oxide, ether, and chloroform.

.44 Oxygen and Other Medical Gases

The cost of gases, other than anesthesia gases, used in treatment of patients, such as oxygen and carbon dioxide mixtures should be charged to this classification. Oxygen used to drive equipment such as fog generators and atomizers should be also charged here.

.45 I.V. Solutions
.46 Pharmaceuticals
.47 Radioactive Materials
.48 Radiology Films
.49 Other Medical Care Materials and Supplies

These classifications (.45–.49) should be charged with the cost of I.V. solutions, pharmaceutical supplies, radioactive materials, radiology films, and other medical care materials and supplies, respectively.

.50 Non-Medical and Non-Surgical Supplies .0375

.51 Food - Meats, Fish and Poultry
.52 Food - Other

Food purchased for dietary, kitchen or the cafeteria should be charged to these classifications.

.53 Tableware and Kitchen Utensils
.54 Linen and Bedding
.55 Cleaning Supplies
.56 Office and Administrative Supplies
.57 Employee Wearing Apparel

These classifications should be charged with the cost of tableware and kitchen utensils, linen and bedding, cleaning supplies, office and administrative supplies, and employee wearing apparel.

.58 Instruments and Minor Equipment

The cost of minor equipment as previously defined in Section 100.285 is charged to this classification.

.59 Other Non-Medical and Non-Surgical Supplies

This classification should be charged with the cost of non-medical and non-surgical supplies not included elsewhere. Included here is the cost of miscellaneous supplies for the personal care of patients.

.60 Utilities .0376

.61 Electricity
.62 Fuel
.63 Water
.64 Disposal Service
.65 Telephone/Telegraph
.66 Purchased Steam
.69 Utilities - Other

All utilities except Telephone/Telegraph (.65) are to be charged to the Plant Operations and Maintenance cost center (Account 8410). Telephone/Telegraph is charged to the Hospital Administration cost center (Account 8610).

.70 Purchased Services .0377

.71 Medical
.72 Maintenance and Repairs
.73 Medical School Contracts
.74 Laundry and Linen
.75 Data Processing
.76 Management and Contracted Services
.77 Collection Agency
.78 Transcription Services
.79 Other Purchased Services

These classifications should be used to record the costs of purchased services. For instance, if the laboratory function is purchased outside the hospital, the expense may be charged to classification .71 - Medical in Laboratory Services (Account 7210). Medical School Contracts natural classification would only appear in the Education cost centers. The Management and Contracted Services Account (.76) is to include only fees paid to related organizations. Include expenses incurred for temporary help services in classification .79, Other Purchased Services.

.80 Other Direct Expenses .0378

.81 Insurance
.82 Interest
.83 Licenses and Taxes (Other than on Income)
.84 Dues, Books and Subscriptions
.85 Outside Training Sessions (Including Travel)
.86 Travel - Other
.87 Postage
.88 Printing and Duplicating
.89 Other Expenses

Other direct expenses such as those indicated above are included in these classifications. Amortization of intangibles such as pre-opening costs is included in Other Expenses (.89).

.90 Depreciation/Rent .0379

.91 Depreciation and Amortization-Buildings and Building Improvements

.92 Depreciation-Fixed Equipment
.93 Depreciation-Movable Equipment
.94 Depreciation and Amortization-Land Improvements and Other
.95 Lease/Rentals-Buildings, Improvements, and Fixed Equipment
.96 Lease/Rentals-Movable Equipment
.97 Lease/Rentals-Other

Interdepartmental Transfer of Direct Expense

In order to maintain the integrity of the Natural Classifications, all transfers of direct expenses to cost centers must be debited and credited to the appropriate Natural Classification within the cost center expense accounts. The effect of this entry is the same as if the initial charge was incorrect and the correct cost center is then charged.

Examples of the coding for expenses are as follows:

1. A registered nurse provides nursing care to a Pediatric Acute patient. The salary expense applicable to the registered nurse would be recorded as follows:

Daily Hospital Service Expense	6
Pediatric Acute	170
Decimal Point	.
Salaries and Wages	0
Registered Nurses	3
or 6170.03	

2. A Food Service Worker prepares fish for serving to a patient in a daily hospital service cost center. The salary expense applicable to the food service worker would be recorded as follows:

Other Operating Expense	8
Dietary Services	310
Decimal Point	.
Salaries and Wages	1
Environmental, Hotel, and Food Service Employee	1
or 8310.11	

The recording of the food (fish) prepared for the patient would be recorded as follows:

Other Operating Expense	8
Dietary Services	310
Decimal Point	.
Non-Medical and Non-Surgical Supplies	5
Food - Meats, Fish, and Poultry	1
or 8310.51	

BALANCE SHEET ACCOUNTS .04

Unrestricted Funds		Restricted Funds			
Operating	Board Designated	Plant Replacement & Expansion Fund	Specific Purpose Fund	Endowment Fund	Account Title
			CURRENT ASSETS	.041	
1010	1110	1510	1710	1810	CASH
1011	1111	1511	1711	1811	General Checking Accounts
1012					Payroll Checking Accounts
1013	1113	1513	1713	1813	Other Checking Accounts
1014					Imprest Cash Accounts
1015	1115	1515	1715	1815	Savings Accounts
1016	1116	1516	1716	1816	Certificates of Deposit
1019	1119	1519	1719	1819	Other Cash Accounts
1020	1120	1520	1720	1820	INVESTMENTS
1021	1121	1521	1721	1821	U.S. Government Securities
1022	1122	1522	1722	1822	Other Current Investments
1023	1123	1523	1723	1823	Share of Pooled Investments
					Real Property
					Accumulated Depreciation on Real Property
				1826	Mortgages
1029	1129	1529	1729	1829	Other Investments

Unrestricted Funds		Restricted Funds			
Operating	Board Designated	Plant Replacement & Expansion Fund	Specific Purpose Fund	Endowment Fund	Account Title
			CURRENT ASSETS (Continued)		
1030					ACCOUNTS AND NOTES RECEIVABLE
1031					Inpatient Receivables-In-house
1032					Inpatient Receivables-Discharged and Unbilled
1033					Inpatient Receivables-Medicare
1034					Inpatient Receivables-Medicaid
1035					Inpatient Receivables-Other
1036					Outpatient Receivables-Unbilled
1037					Outpatient Receivables-Medicare
1038					Outpatient Receivables-Medicaid
1039					Outpatient Receivables-Other
1040					ALLOWANCE FOR UNCOLLECTIBLE RECEIVA-
1041					Allowance for Bad Debts
1042					Allowance for Contractual Adjustments-Medicare
1043					Allowance for Contractual Adjustments-Medicaid
1044					Allowance for Contractual Adjustments-Blue Cross
1047					Allowance for Contractual Adjustments-Other
1049					Allowance for Other Adjustments

Unrestricted Funds		Restricted Funds			
Operating	Board Designated	Plant Replacement & Expansion Fund	Specific Purpose Fund	Endowment Fund	Account Title
			CURRENT ASSETS (Continued)		
					RECEIVABLES FROM THIRD PARTY PAYORS
1050					
1051					PIP Clearing Account
1052					Other Receivables-Third Party Cost Report Settlement-Medicare
1053					Other Receivables-Third Party Cost Report Settlement-Medicaid
1059					Other Receivables-Third Party Cost Report Settlement-Other
1060	1160	1560	1760	1860	PLEDGES AND OTHER RECEIVABLES
1061	1161	1561	1761	1861	Pledges Receivable
1062	1162	1562	1762	1862	Allowance for Uncollectible Pledges
1063	1163	1563	1763	1863	Grants and Legacies Receivable
1064		1564	1764	1864	Interest Receivable
1065					Accounts and Notes Receivable-Staff, Employees, etc.
1066					Inter-company Advances, Current
1069	1169	1569	1769	1869	Other Receivables

Unrestricted Funds		Restricted Funds			
Operating	Board Designated	Plant Replacement & Expansion Fund	Specific Purpose Fund	Endowment Fund	Account Title
			CURRENT ASSETS (Continued)		
1070	1170	1570	1770	1870	DUE FROM OTHER FUNDS
		1571	1771	1871	Due from Operating Fund
1072		1572	1772	1872	Due from Board Designated Assets
1073	1173		1773	1873	Due from Plant Replacement and Expansion Fund
1074	1174	1574		1874	Due from Specific Purpose Fund
1075	1175	1575	1775		Due from Endowment Fund
1080					INVENTORY
1081					Inventory-General Stores
1082					Inventory-Pharmacy
1083					Inventory-Central Services and Supplies
1084					Inventory-Dietary
1085					Inventory-Plant Operation and Maintenance
1089					Inventory-Other
1090	1190				PREPAID EXPENSES AND OTHER CURRENT ASSETS
1091					Prepaid Insurance
1092					Prepaid Interest
1093					Prepaid Rent
1094					Prepaid Pension Plan Expense
1095					Prepaid Taxes
1096					Prepaid Service Contracts
1097					Other Prepaid Expenses
1098					Deposits
1099	1199				Other Current Assets

Unrestricted Funds		Restricted Funds			
Operating	Board Designated	Plant Replacement & Expansion Fund	Specific Purpose Fund	Endowment Fund	Account Title
		PROPERTY, PLANT AND EQUIPMENT . .042			
1200					LAND
1210					LAND IMPROVEMENTS
1211					Parking Lots
1219					Other Land Improvements
1220					BUILDINGS
1221					Hospital
1224					Clinic
1225					Student Housing Facility
1226					Employee Housing Facility
1227					Non-Paid Workers Housing Facility
1228					Skilled Nursing Facility
1229					Parking Structure
1230					FIXED EQUIPMENT
1231					Hospital
1234					Clinic
1235					Student Housing Facility
1236					Employee Housing Facility
1237					Non-Paid Workers Housing Facility
1238					Skilled Nursing Facility
1239					Parking Structure

Unrestricted Funds		Restricted Funds			
Operating	Board Designated	Plant Replacement & Expansion Fund	Specific Purpose Fund	Endowment Fund	Account Title
		PROPERTY, PLANT AND EQUIPMENT (Continued)			
1240					LEASEHOLD IMPROVEMENTS
1250					EQUIPMENT
1251					Major Movable Equipment
1259					Minor Movable Equipment
1260					CONSTRUCTION IN PROGRESS
1261					Buildings
1262					Fixed Equipment
1263					Major Movable Equipment
1264					Fees
1265					Insurance
1266					Interest
1270					ACCUMULATED DEPRECIATION-LAND
1271					Parking Lots
1279					Other Land Improvements
1280					ACCUMULATED DEPRECIATION-BUILDINGS
1281					Hospital
1284					Clinic
1285					Student Housing Facility
1286					Employee Housing Facility
1287					Non-Paid Workers Housing Facility
1288					Skilled Nursing Facility
1289					Parking Structure

Unrestricted Funds		Restricted Funds			
Operating	Board Designated	Plant Replacement & Expansion Fund	Specific Purpose Fund	Endowment Fund	Account Title
			PROPERTY, PLANT AND EQUIPMENT (Continued)		
1290					ACCUMULATED DEPRECIATION-FIXED EQUIPMENT
1291					Hospital
1294					Clinic
1295					Student Housing Facility
1296					Employee Housing Facility
1297					Non-Paid Workers Housing Facility
1298					Skilled Nursing Facility
1299					Parking Structure
1310					ACCUMULATED DEPRECIATION-LEASEHOLD IMPROVEMENTS
1320					ACCUMULATED DEPRECIATION-EQUIPMENT
1321					Major Movable Equipment
1329					Minor Movable Equipment
			OTHER TANGIBLE ASSETS .043		
1330				1830	INVESTMENT IN NON-OPERATING PROPERTY, PLANT AND EQUIPMENT
1340				1840	ACCUMULATED DEPRECIATION-INVESTMENT IN NON-OPERATING PROPERTY, PLANT AND EQUIPMENT
1350		1550	1750	1850	OTHER TANGIBLE ASSETS
1351					Inter-company Advances Non-Current

Unrestricted Funds		Restricted Funds			
Operating	Board Designated	Plant Replacement & Expansion Fund	Specific Purpose Fund	Endowment Fund	Account Title
			INTANGILE ASSETS		.044
1360					GOODWILL
1370					UNAMORTIZED BORROWING COST
1380					PREOPENING AND OTHER ORGANIZATION COSTS
1381					Pre-opening Costs
1389					Other Organization Costs
1390					OTHER INTANGIBLE ASSETS
			CURRENT LIABILITIES		.045
2010					NOTES AND LOANS PAYABLE
2011					Notes and Loans Payable-Vendors
2012					Notes and Loans Payable-Banks
2013					Current Portion of Long Term Debt
2019					Other Notes and Loans Payable
2020					ACCOUNTS PAYABLE
2021					Trade Payables
2029					Other Accounts Payable

Unrestricted Funds		Restricted Funds			
Operating	Board Designated	Plant Replacement & Expansion Fund	Specific Purpose Fund	Endowment Fund	Account Title
			CURRENT LIABILITIES (Continued)		
2030					ACCRUED COMPENSATION AND RELATED LIABILITIES
2031					Accrued Payroll
2032					Accrued Vacation, Holiday and Sick Pay
2033					Other Accrued Salaries and Wages Payable
2034					Non-Paid Worker Services Payable
2035					Federal Income Taxes With-held
2036					Social Security Taxes With-held and Accrued
2037					State Income Taxes Withheld
2038					Local Income Taxes Withheld
2039					Unemployment Taxes Payable
2041					Accrued Hospitalization Insurance Premiums
2042					Union Dues Payable
2049					Other Payroll Taxes and Deductions Payable
2050					OTHER ACCRUED EXPENSES
2051					Interest Payable
2052					Rent Payable
2053					Property Taxes Payable
2054					Fees Payable-Medical Specialists
2055					Fees Payable-Other
2059					Other Accrued Expenses Payable

Unrestricted Funds		Restricted Funds			
Operating	Board Designated	Plant Replacement & Expansion Fund	Specific Purpose Fund	Endowment Fund	Account Title
			CURRENT LIABILITIES (Continued)		
					ADVANCES FROM THIRD PARTY
2060					PAYORS
2061					Advances-Medicare
2062					Advances-Medicaid
2063					Advances-Blue Cross
2069					Advances-Other
2070					PAYABLE TO THIRD PARTY PAYORS
2071					Reimbursement Settlement Due-Medicare
2072					Reimbursement Settlement Due-Medicaid
2073					Reimbursement Settlement Due-Blue Cross
2079					Reimbursement Settlement Due-Other
2080	2480	2580	2780	2880	DUE TO OTHER FUNDS
		2581	2781	2881	Due to Operating Fund
2082		2582	2782	2882	Due to Board Designated Assets
2083	2483		2783	2883	Due to Plant Replacement and Expansion Fund
2084	2484	2584		2884	Due to Specific Purpose Fund
2085	2485	2585	2785		Due to Endowment Fund

Unrestricted Funds		Restricted Funds			
Operating	Board Designated	Plant Replacement & Expansion Fund	Specific Purpose Fund	Endowment Fund	Account Title
			CURRENT LIABILITIES (Continued)		
2090					INCOME TAXES PAYABLE
2091					Federal Income Tax Payable
2092					State Income Tax Payable
2093					Local Income Taxes Payable
2110					OTHER CURRENT LIABILITIES
2111					Deferred Income-Patients Deposits
2112					Deferred Income-Tuition and Fees
2113					Deferred Income-Other
2114					Dividends Pavable
2115					Current Maturities of Long Term Debt
2116					Inter-company Indebtedness, Current
2117					Construction Retention Pavable
2118					Construction Contracts Pavable
2119					Other Current Liabilities
			DEFERRED CREDITS AND OTHER LIABILITIES .046		
2120					DEFERRED INCOME TAXES
2121					Deferred Taxes Pavable-Federal
2122					Deferred Taxes Pavable-State
2123					Deferred Taxes Pavable-Local
2130					DEFERRED THIRD PARTY REVENUE
2131					Deferred Revenue-Medicare
2132					Deferred Revenue-Medicaid
2133					●●●

Unrestricted Funds		Restricted Funds			
Operating	Board Designated	Plant Replacement & Expansion Fund	Specific Purpose Fund	Endowment Fund	Account Title
		DEFERRED CREDITS AND OTHER LIABILITIES (Continued)			
2140					OTHER DEFERRED CREDITS
			LONG TERM DEBT		.047
2210				2810	MORTGAGES PAYABLE
2220					CONSTRUCTION LOANS
2230					NOTES UNDER REVOLVING CREDIT
2240					CAPITALIZED LEASE OBLIGATIONS
2250					BONDS PAYABLE
2260					INTERCOMPANY INDEBTEDNESS, NON-CURRENT
2270				2870	OTHER NON-CURRENT LIABILITIES
			FUND BALANCES		.048
2290		2690	2790	2890	FUND BALANCE
		2691	2791		Restricted Project Funds
2292		2692			Depreciation Funds
		2693	2793	2893	Donor Restricted Funds
2294					Transfers from Restricted Funds for Capital Outlay
		2695	2795	2895	Transfers to Unrestricted Funds for Capital Outlay
2296		2696	2796	2896	Value of Donated Property, Plant and Equipment
		2697	2797	2897	Transfers to Operating Fund for Operating Purposes

Unrestricted Funds		Restricted Funds			
Operating	Board Designated	Plant Replacement & Expansion Fund	Specific Purpose Fund	Endowment Fund	Account Title
			EQUITY AND CAPITAL		049
2350					STOCKHOLDERS' EQUITY
2351					Preferred Stock
2352					Common Stock
2353					Retained Earnings
2354					Treasurv Stock
2355					Additional Paid in Capital
2350					CAPITAL-PARTNERSHIP OR SOLE PROPRIETOR
2351					Capital
2352					Partner's Draw

INCOME STATEMENT ACCOUNTS .05

Account Number

Revenue	Expense	Account Title
		DAILY HOSPITAL SERVICES
		ACUTE CARE .051
3010	6010	MEDICAL/SURGICAL ACUTE
3170	6170	PEDIATRIC ACUTE
3250	6250	OBSTETRICS ACUTE
3640	6640	CHRONIC CARE
		DEFINITIVE OBSERVATION
3280	6280	DEFINITIVE OBSERVATION
		INTENSIVE CARE
3310	6310	MEDICAL/SURGICAL INTENSIVE CARE
3330	6330	CORONARY CARE
3331	6331	Myocardial Infarction
3332	6332	Pulmonary Care
3333	6333	Heart Transplant
3339	6339	Other Coronary Care
3350	6350	PEDIATRIC INTENSIVE CARE
3370	6370	NEO-NATAL INTENSIVE CARE
3380	6380	BURN CARE
3410	6410	OTHER INTENSIVE CARE
3411	6411	Shock Trauma
3412	6412	Oncology
		PSYCHIATRIC CARE
3210	6210	Psychiatric Acute-General Hospitals
3220	6220	Psychiatric Adult-Specialty Hospitals
3230	6230	Psychiatric Child/Adolescent-Specialty Hospitals
3240	6240	Psycho-Geriatric-Specialty Hospitals
3390	6390	Psychiatric Intensive Care-Specialty Hospitals
3260	6260	Adolescent Dual Diagnosed - Specialty Hospitals
		NURSERY
3210	6510	NEWBORN NURSERY
3511	6511	Normal Newborns
3520	6520	PREMATURE NURSERY
3620	6620	Rehabilitation
		Rehabilitation

Daily Hospital Services (continued)

Account Number			
Rever	Expense		
		AMBULATORY SERVICES	.052
3710	6710	EMERGENCY SERVICES	
3711	6711	Emergency Room	
3719	6719	Other Emergency Services	
3720	6720	CLINIC SERVICES	
3721	6721	Allergy Clinic	
3722	6722	Cancer Clinic	
3723	6723	Cardiology Clinic	
3724	6724	Dental Clinic	
3725	6725	Dermatology Clinic	
3726	6726	Diabetic Clinic	
3727	6727	Drug Abuse Clinic	
3728	6728	Ear, Nose and Throat Center	
3729	6729	Eye Clinic	
3731	6731	General Medicine Clinic	
3732	6732	Obstetrical/Gynecology Clinic	
3733	6733	Orthopedic Clinic	
3734	6734	Pediatric Clinic	
3735	6735	Physical Medicine Clinic	
3736	6736	Psychiatric Clinic	
3737	6737	Surgery Clinic	
3738	6738	Urology Clinic	
3739	6738	Venereal Disease Clinic	
3889	6889	Other Clinic Services	
3950	6750	Observation Service	
3940	6940	PSYCHIATRIC DAY AND NIGHT CARE SERVICES	
3960	6960	FREE STANDING EMERGENCY SERVICE	
4060	7060	SAME DAY SURGERY	
		ANCILLARY SERVICES	.053
4010	7010	LABOR AND DELIVERY SERVICES	
4040	7040	OPERATING ROOM	
4041	7041	General Surgery	
4042	7042	Open Heart Surgery	
4043	7043	Neurosurgery	
4044	7044	Orthopedic Surgery	
4045	7045	Kidney Transplant	
4046	7046	Other Organ Transplants	
4949	7049	Recovery Room	
4050	7050	AMBULATORY SURGERY SERVICES	
4060	7060	Ambulatory Surgery	
4070	7070	OPERATING ROOM - CLINIC	

Hospital Services (continued)

Account Number		
Revenu	Expense	Account Title
4080	7080	ANESTHESIOLOGY
4110	7110	MEDICAL SUPPLIES SOLD
4111	7111	Medical Supplies-Billable
4112	7112	Medical Supplies-Non-Billable
4150	7150	DRUGS SOLD
4151	7151	Drugs Billable
4152	7152	Drugs Non-Billable
4210	7210	LABORATORY SERVICES
4211	7211	Chemistry
4212	7212	Hematology
4213	7213	Immunology (Serology)
4214	7214	Microbiology (Bacteriology)
4215	7215	Procurement and Dispatch
4216	7216	Urine and Feces
4219	7219	Other Clinical Laboratories
4231	7231	Cytology
4232	7232	Histology
4233	7233	Autopsy
4239	7239	Other Pathological Laboratories
4250	7250	BLOOD
4251	7251	Blood-Whole
4252	7252	Blood-Other Components
4254	7254	Blood Storing and Processing
4290	7290	ELECTROCARDIOGRAPHY
4310	7310	INTERVENTIONAL RADIOLOGY/CARDIOVASCULAR
4320	7320	RADIOLOGY-DIAGNOSTIC
4321	7321	Angiocardiography
4322	7322	Ultrasonography
4339	7339	Radiology-Diagnostic-Other
4340	7340	CT SCANNER
4350	7350	MRI SCANNER
4355	7355	LITHOTRIPSY

Account Number			
Revenue	Expense	Account Title	
		ANCILLARY SERVICES (Continued)	
4360	7360	RADIOLOGY-THERAPEUTIC	
4380	7380	NUCLEAR MEDICINE	
4381	7381	Nuclear Medicine-Diagnostic	
4382	7382	Nuclear Medicine-Therapeutic	
4420	7420	RESPIRATORY THERAPY	
4440	7440	PULMONARY FUNCTION TESTING	
4460	7460	ELECTROENCEPHALOGRAPHY	
4510	7510	PHYSICAL THERAPY	
4511	7511	Electromyography	
4530	7530	OCCUPATIONAL THERAPY	
4550	7550	SPEECH-LANGUAGE PATHOLOGY	
4570	7570	RECREATIONAL THERAPY	
4580	7580	AUDIOLOGY	
4590	7590	OTHER PHYSICIAN MEDICINE	
4670	7670	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	
4671	7671	Individual Therapies	
4672	7672	Group Therapies	
4673	7673	Family Therapies	
4674	7674	Education	
4675	7675	Psychological Testing	
4676	7676	Electroconvulsive Therapy	
4677	7677	Activity Therapy	
4689	7689	Other Therapies	
4710	7710	RENAL DIALYSIS	
4711	7711	Hemodialysis	
4713	7713	Peritoneal Dialysis	
4515	7515	Patient Dialysis Training	
4717	7717	Home Dialysis Services	
4719	7719	Other Dialysis	
4730	7730	KIDNEY ACQUISITION	
4910	7910	OTHER ANCILLARY SERVICES	
4911	7911	Leukopheresis	
4912	7912	Hyperbaric Chamber	
4920	7920	Ambulance Services-Rebundled	
		ADMISSIONS SERVICES	.054
4990		ADMISSIONS CHARGE	
		OTHER OPERATING REVENUE	.055
5020		TRANSFERS FROM RESTRICTED FUNDS FOR RESEARCH EXPENSES	
5220		NURSING EDUCATION	
5221		Registered Nurses	
5222		Licensed Vocational (Practical) Nurses	

Account Number		
Revenue	Expense	Account Title
		OPERATING REVENUE (Continued)
5240		POST GRADUATE MEDICAL EDUCATION
5241		Approved Teaching Programs
5242		Non-Approved Teaching Programs
5260		OTHER HEALTH PROFESSION EDUCATION
5261		School of Medical Technology
5262		School of X-Ray Technology
5263		School of Respiratory Therapy
5264		Administrative Intern Program
5265		Medical Records Librarian Program
5270		COMMUNITY HEALTH EDUCATION
5280		TRANSFERS FROM RESTRICTED FUND FOR EDUCATION EXPENSE
5320		CAFETERIA SALES
5330		LAUNDRY AND LINEN SERVICES REVENUE
5350		SOCIAL SERVICES REVENUE
5360		HOUSING REVENUE
5361		Employee Housing
5363		Student Housing
5430		AMBULANCE SERVICES
5440		PARKING REVENUE
5450		HOUSEKEEPING SERVICES REVENUE
5610		TELEPHONE AND TELEGRAPH REVENUE
5620		DATA PROCESSING SERVICES REVENUE
5670		COMMUNITY HEALTH EDUCATION REVENUE
5690		PURCHASING SERVICES REVENUE
5710		SALE OF ABSTRACTS/MEDICAL RECORDS
5760		DONATED COMMODITIES
5770		DONATED BLOOD
5780		CASH DISCOUNTS ON PURCHASES
5790		SALE OF SCRAP AND WASTE
5810		REBATES AND REFUNDS
5820		VENDING MACHINE COMMISSIONS
5830		OTHER COMMISSIONS
5840		TELEVISION/RADIO RENTALS
5850		NON-PATIENT ROOM RENTALS
5860		MANAGEMENT SERVICES REVENUE
5870		OTHER OPERATING REVENUE
5880		TRANSFERS FROM RESTRICTED FUNDS FOR OTHER OPERATING EXPENSE

Account Number

Revenue	Expense	Account Title	
		DEDUCTIONS FROM REVENUE	.056
5900		PROVISION FOR BAD DEBTS	
5910		CONTRACTUAL ADJUSTMENTS-MEDICARE	
5911		Contractual Adjustments-Medicare-Part A	
5912		Contractual Adjustments-Medicare-Part B	
5920		CONTRACTUAL ADJUSTMENTS-MEDICAID	
5930		CONTRACTUAL ADJUSTMENTS-BLUE CROSS	
5940		CONTRACTUAL ADJUSTMENTS-OTHER	
5941		Contractual Adjustments-Voluntary	
5950		CHARITY/UNCOMPENSATED CARE	
5951		Charity/Uncompensated Care-Hill Burton	
5959		Charity/Uncompensated Care-Other	
5960		RESTRICTED DONATIONS AND GRANTS FOR INDIGENT CARE (Credit Balance Sheet)	
5970		ADMINISTRATIVE, COURTESY, AND POLICY DISCOUNTS AND ADJUSTMENTS	
5980		OTHER DEDUCTIONS FROM REVENUE	
5990		PROSPECTIVE RATE ADJUSTMENTS	
		OTHER OPERATING EXPENSES	.057
		RESEARCH EXPENSES	
	8010	RESEARCH	
		EDUCATION EXPENSES	
	8220	NURSING	
	8221	Registered Nurses	
	8222	Licensed Vocational (Practical Nurses)	
	8240	POST GRADUATE MEDICAL EDUCATION	
	8241	Approved Teaching Program	
	8242	Non-Approved Teaching Program	
	8260	OTHER HEALTH PROFESSION EDUCATION	
	8261	School of Medical Technology	
	8262	School of X-Ray Technology	
	8263	School of Respiratory Therapy	
	8264	Administrative Intern Program	
	8265	Medical Records Librarian Program	
	8270	COMMUNITY HEALTH EDUCATION	

Account Number		
Revenue	Expense	Account Title
		OTHER OPERATING EXPENSES (Continued)
		GENERAL SERVICES
	8310	DIETARY SERVICES
	8320	CAFETERIA
	8330	LAUNDRY AND LINEN
	8350	SOCIAL SERVICES
	8360	HOUSING
	8361	Employee Housing
	8362	Non-Paid Workers Housing
	8365	Student Housing
	8410	PLANT OPERATIONS AND MAINTENANCE
	8411	Plant Operations
	8412	Plant Maintenance
	8413	Grounds
	8414	Security
	8415	Energy
	8430	AMBULANCE SERVICES
	8440	PARKING
	8450	HOUSEKEEPING
	8460	CENTRAL SERVICES AND SUPPLY
	8470	PHARMACY
	8480	ORGAN ACQUISITION OVERHEAD
		FISCAL SERVICES
	8510	GENERAL ACCOUNTING
	8520	PATIENT ACCOUNTS
	8521	Patient Accounting
	8522	Credit and Collection
	8523	Cashiering
	8524	Inpatient Admitting
	8525	Emergency Room Registration
	8526	Clinic Registration
	8527	Referred Ambulatory Registration
	8528	Other Outpatient Registration

Account Number		
Revenue	Expense	Account Title
		OTHER OPERATING EXPENSES (Continued)
		ADMINISTRATIVE SERVICES
	8610	HOSPITAL ADMINISTRATION
	8611	Office of Hospital Administration
	8612	Governing Board
	8613	Public Relations
	8614	Spiritual Care
	8615	Communications
	8616	Personnel
	8617	Management Engineering
	8618	Health Sciences Library
	8619	Auxiliary Groups
	8621	Fund Raising
	8690	PURCHASING AND STORES
		MEDICAL CARE ADMINISTRATION
	8710	MEDICAL RECORDS
	8720	MEDICAL STAFF ADMINISTRATION
	8723	Medical Photography and Illustration
	8729	Medical Staff Administration-Other
	8730	MEDICAL STAFF SERVICES
	8740	PHYSICIAN SUPPORT SERVICES
	8750	NURSING ADMINISTRATION
	8751	In-service Education-Nursing
	8759	Nursing Administration-Other
		UNASSIGNED EXPENSE
	8810	DEPRECIATION AND AMORTIZATION
	8811	Land Improvements
	8812	Buildings and Improvements
	8813	Leasehold Improvements
	8814	Fixed Equipment
	8815	Intangibles
	8816	Movable Equipment
	8820	LEASES AND RENTALS
	8830	INSURANCE-HOSPITAL AND PROFESSIONAL MALPRACTICE
	8840	INSURANCE-OTHER
	8850	LICENSES AND TAXES (OTHER THAN INCOME TAXES)

Account Number		
Revenue	Expense	Account Title
		OTHER OPERATING EXPENSES (Continued)
	8860	INTEREST-SHORT TERM
	8870	INTEREST-LONG TERM
	8880	MEDICAL CARE REVIEW
	8881	PSRO
	8882	Medical Care Review
		HOLDING ACCOUNTS
	8991	Central Patient Transportation
	8992	Nursing Float Personnel
	8993	Employee Benefits
	8994	Data Processing
		NON-OPERATING REVENUE AND EXPENSE .058
9010		GAINS OR LOSSES ON SALE OF HOSPITAL PROPERTY
9020		UNRESTRICTED CONTRIBUTIONS
9030		DONATED SERVICES
9040		INCOME, GAINS AND LOSSES FROM UNRESTRICTED INVESTMENTS
9050		UNRESTRICTED INCOME FROM ENDOWMENT FUNDS
9060		UNRESTRICTED INCOME FROM OTHER RESTRICTED FUNDS
9070		TERM ENDOWMENT BECOMING UNRESTRICTED
9080		TRANSFERS FROM RESTRICTED FUNDS FOR NON-OPERATING EXPENSE
9110		DOCTOR'S PRIVATE OFFICE RENTAL REVENUE
9120		OFFICE AND OTHER RENTAL REVENUE
9130		RETAIL OPERATIONS REVENUE
9150		OTHER NON-OPERATING REVENUE
	9210	DOCTOR'S PRIVATE OFFICE RENTAL EXPENSE
	9220	OFFICE AND OTHER RENTAL EXPENSE
	9230	RETAIL OPERATIONS EXPENSE
	9250	OTHER NON-OPERATING EXPENSE
	9410	PROVISION FOR INCOME TAXES
	9411	Federal-Current
	9412	Federal-Deferred
	9413	State-Current
	9414	State-Deferred
	9415	Local-Current
	9416	Local-Deferred
	9500	EXTRAORDINARY ITEMS

Account Number			
Revenue	Expense		
		Unregulated Services Revenue and Expense	.059
3610	6610	Skilled Nursing Care	
3611	6611	Medicare Certified	
3612	6612	Medicare Non-Certified	
3970	6970	Free Standing Clinic Services	
3980	6980	Home Health Services	
4090	7090	Certified Nurse Anesthetist	
4220	7220	Laboratory—Non Patient	
4720	7720	Renal Dialysis-Outpatient	
9160	8760	Physicians Part B Services—Medicare and Other	

BALANCE SHEET .06

Unrestricted Fund Assets .061

Current Assets .0611

1010 CASH
- 1011 General Checking Accounts
- 1012 Payroll Checking Accounts
- 1013 Other Checking Accounts
- 1014 Imprest Cash Funds
- 1015 Savings Accounts
- 1016 Certificates of Deposit
- 1019 Other Cash Accounts

These cash accounts represent the amount of cash on deposit in banks and immediately available for use in financing Unrestricted Fund activities, amounts on hand for minor disbursements, and amounts invested in savings accounts and certificates of deposit.

1020 INVESTMENTS
- 1021 U.S. Government Securities
- 1022 Other Current Investments
- 1023 Share of Pooled Investments
- 1029 Other Investments

Current securities and investments, evidenced by certificates of ownership or indebtedness, must be reflected in these accounts.

1030 ACCOUNTS AND NOTES RECEIVABLES
- 1031 Inpatient Receivables-In-house
- 1032 Inpatient Receivables-Discharged and Unbilled
- 1033 Inpatient Receivables-Medicare
- 1034 Inpatient Receivables-Medicare
- 1035 Inpatient Receivables-Other
- 1036 Outpatient Receivables-Unbilled
- 1037 Outpatient Receivables-Medicare
- 1038 Outpatient Receivables-Medicaid
- 1039 Outpatient Receivables-Other

These accounts shall reflect the amounts due from hospital patients and their third party sponsors.

Separate accounts may be maintained for different levels of inpatient care (i.e., Acute and Intensive, Skilled Nursing, etc.) and outpatient care (i.e., Emergency Room, Clinic) and for different payors, if desired. This may be accomplished by the inclusion of digits to the right of the decimal.

Notes receivable and accounts receivable may also be segregated, but there is usually little to be gained from this practice, as the amount of notes receivable will usually be nominal.

1031 Inpatient Receivables-In-house

This account shall reflect all charges and credits (at the hospital's full established rates) for medical services rendered to patients still in hospital.

1032 Inpatient Receivables-Discharged and Unbilled

This account shall reflect all charges and credits, (at the hospital's full established rates) for medical services rendered to patients who have been discharged but not yet billed.

1033 Inpatient Receivables-Medicare-Discharged and Billed

This account should be used only if the hospital is not on the Periodic Interim Payment Program. The balance in this account reflects all unpaid charges billed to the Medicare intermediary. Direct billings to the Medicare inpatient (or to Medicaid) for deductibles, coinsurance, and other patient-chargeable items would also be included in this account if such billings were not included in Inpatient Receivables-Other (or Inpatient Receivables-Medicaid).

1034 Inpatient Receivables-Medicaid-Discharged and Billed

The balance in this account reflects all unpaid charges billed to Medicaid. Direct billings to the Medicaid inpatient (or to the Medicare intermediary) for deductibles, co-insurance, other patient-chargeable items and items under "Part B" Medicare coverage would also be included in this account if such billings were not included in Receivables-Other (or Inpatient Receivables-Medicare).

1035 Inpatient Receivables-Other-Discharged and Billed

Include in this account all unpaid billings for medical services and supplies provided to all non-Medicare inpatients. Direct billings to Medicare and Medicaid inpatients for deductibles, co-insurance, and other patient-chargeable items may also be included if they are not included elsewhere.

1036 Outpatient Receivables-Unbilled

This account reflects all unbilled charges and credits (at the hospital's full established rates) for medical services rendered to outpatients.

1037 Outpatient Receivables-Medicare

The balance in this account reflects all unpaid charges billed to the Medicare intermediary. Direct billings to the Medicare outpatient (or to Medicaid) for deductibles, co-insurance, and other patient-chargeable items would also be included in this account if such billings were not included in Outpatient Receivables-Other (or Outpatient Receivables-Medicaid).

1038 Outpatient Receivables-Medicaid

The balance in this account reflects all unpaid charges billed to Medicaid. Direct billings to the Medicaid outpatient (or to the Medicare intermediary) for deductibles, co-insurance, other patient-chargeable items, and "Part B" coverage, would also be included in this account if such billings are not included in Outpatient Receivables-Other (or Outpatient Receivables-Medicare).

1039 Outpatient Receivables-Other

Include in this account all unpaid billings for medical services and supplies provided to all non-Medicare, non-Medicaid outpatients. Direct billings to Medicare and Medicaid outpatients for deductibles, co-insurance, and other patient-chargeable items, may also be included if they are not included elsewhere.

1040 ALLOWANCE FOR UNCOLLECTIBLE RECEIVABLES AND THIRD-PARTY CONTRACTUALS

1041 Allowance for Bad Debts
1042 Allowance for Contractual Adjustments-Medicare
1043 Allowance for Contractual Adjustments-Medicaid
1044 Allowance for Contractual Adjustments-Blue Cross
1047 Allowance for Contractual Adjustments-Other
1049 Allowance for Other Adjustments

These are valuation (or contra-asset) accounts whose credit balances represent the estimated amount of uncollectible receivables from patients and third-party payors. For details on the computation of the related deductions from revenue, see the account descriptions of the Deductions from Revenue accounts.

1050 RECEIVABLES FROM THIRD PARTY PAYORS

1051 PIP Clearing Account

During the year, this Account reflects the differences between amounts billed to the Medicare intermediary for applicable services rendered, and periodic interim payments received from the Medicare intermediary. At year-end, this account must be closed out, with the balance going to the account entitled Contractual Adjustment-Medicare.

1052 Other Receivables-Third Party Cost Report Settlement-Medicare
1053 Other Receivables-Third Party Cost Report Settlement-Medicaid
1059 Other Receivables-Third Party Cost Report Settlement-Other

The balance of this account reflect the amount due from third party reimbursement programs based upon cost reports submitted and/or audited. Sub-accounts may be maintained for each year's settlement if more than one year's settlement is included in an account.

1060 PLEDGES AND OTHER RECEIVABLES

1061 Pledges Receivable
1062 Allowance for Uncollectible Pledges
1063 Grants and Legacies Receivable
1064 Interest Receivable
1065 Accounts and Notes Receivable-Staff, Employees, etc.
1066 Inter-company Advances-Current
1069 Other Receivables

These accounts reflect other amounts due to the Operating Fund for other than patient services.

1070 DUE FROM OTHER FUNDS
- 1072 Due from Board Designated Assets
- 1073 Due from Plant Replacement and Expansion Fund
- 1074 Due from Specific Purpose Fund
- 1075 Due from Endowment Fund

The balances in these accounts reflect the amounts due from designated assets or restricted funds to the Operating Fund. The balance of these accounts should not be construed as receivable in the sense that a claim external to the hospital exists. Instead, this balance should be viewed as representing assets of the Operating fund which are currently accounted for as restricted funds.

1080 INVENTORY
- 1081 Inventory-General Stores
- 1082 Inventory-Pharmacy
- 1083 Inventory-Central Services and Supplies
- 1084 Inventory-Dietary
- 1085 Inventory-Plant Operations and Maintenance
- 1089 Inventory-Other

These balances reflect the cost of unused hospital supplies. Any generally accepted cost method (e.g., FIFO, LIFO, etc.) may be used as long as it is consistent with that of the preceding accounting period. The extent of inventory control and detailed recordkeeping will depend upon the size and organizational complexity of the hospital. See Section 100.27, for a further discussion on inventory discounting.

1090 PREPAID EXPENSES AND OTHER CURRENT ASSETS
- 1091 Prepaid Insurance
- 1092 Prepaid Interest
- 1093 Prepaid Rent
- 1094 Prepaid Pension Plan Expense
- 1095 Prepaid Taxes
- 1096 Prepaid Service Contracts
- 1097 Other Prepaid Expenses
- 1098 Deposits
- 1099 Other Current Assets

These prepaid assets and other current assets accounts represent costs incurred which are properly chargeable to a future accounting period. Other current assets not included elsewhere are also contained in these accounts.

Board Designated Assets .0612

1110		CASH
	1111	General Checking Accounts
	1113	Other Checking Accounts
	1115	Savings Accounts
	1116	Certificates of Deposit
	1119	Other Cash Accounts
1120		INVESTMENTS
	1121	U.S. Government Securities
	1122	Other Current Investments
	1123	Share of Pooled Investments
	1129	Other Investments
1160		PLEDGES AND OTHER RECEIVABLES
	1161	Pledges Receivables
	1162	Allowance for Uncollectible Pledges
	1163	Grants and Legacies Receivable
	1169	Other Receivables
1170		DUE FROM OTHER FUNDS
	1173	Due from Plant Replacement and Expansion Fund
	1174	Due from Specific Purpose Fund
	1175	Due from Endowment Fund
1190		PREPAID EXPENSES AND OTHER CURRENT ASSETS
	1199	Other Current Assets

Included in these accounts are assets which have been designed (or appropriated) by the governing board for special use.

Property, Plant, and Equipment .0613

1200 LAND

The balance of this account reflects the cost of land used in hospital operations. Included here is the cost of off-site sewer and water lines, public utility charges for servicing the land, governmental assessments for street paving and sewers, the cost of permanent roadways and of grading of a non-depreciable nature, the cost of curbs and of sidewalks whose replacement is not the responsibility of the hospital, as well as other land expenditures of a non-depreciable nature. Unlike buildings and equipment, land does not deteriorate with use or with the passage of time; therefore, no depreciation is accumulated.

1210 LAND IMPROVEMENTS
- 1211 Parking Lots
- 1219 Other Land Improvements

All land expenditures of a depreciable nature that are used in hospital operations are charged to this account. This would include the cost of on-site sewer and water lines; paving of roadways, parking lots, curbs and sidewalks (if replacement is the responsibility of the hospital) as well as the cost of shrubbery, fences and walls.

1220 BUILDINGS
- 1221 Hospital
- 1224 Clinic
- 1225 Student Housing Facility
- 1226 Employee Housing Facility
- 1227 Non-Paid Workers Housing Facility
- 1228 Skilled Nursing Facility
- 1229 Parking Structure

The cost of all buildings and subsequent additions used in hospital operations shall be charged to this account. Included are all architectural, consulting and legal fees related to the acquisition or construction of buildings. Interest paid during construction financing is a cost of the building and is included in this account.

1230 FIXED EQUIPMENT
- 1231 Hospital
- 1234 Clinic
- 1235 Student Housing Facility
- 1236 Employee Housing Facility
- 1237 Non-Paid Workers Housing Facility
- 1238 Skilled Nursing Facility
- 1239 Parking Structure

The cost of all fixed equipment used in hospital operations shall be charged to this account. Fixed equipment has the following general characteristics:

1. Affixed to the building, not subject to transfer or removal.
2. A life of three or more years, but less than that of the building to which it is affixed.
3. Used in hospital operations.

Fixed equipment includes such items as boilers, generators, elevators, engines, pumps and refrigeration machinery, including the plumbing, wiring, etc. necessary for equipment operations.

1240 LEASEHOLD IMPROVEMENTS

All expenditures for the improvement of a leasehold used in hospital operations shall be charged to this account.

1250 EQUIPMENT
- 1251 Major Movable Equipment

Equipment to be charged to this account have the following general characteristics:

1. Ability to be moved, as distinguished from fixed equipment.
2. A more or less fixed location in the building.
3. A unit cost large enough to justify the expense incident to control by means of an equipment ledger.
4. Sufficient individuality and size to make control feasible by means of identification tags.
5. A minimum life of three years or more.
6. Used in hospital operations.

Major movable equipment includes such items as automobiles and trucks, desks, beds, chairs, accounting machines, sterilizers, operating tables, oxygen tents and X-ray apparatus.

1259 Minor Movable Equipment

Equipment to be charged to this account has the following general characteristics:

1. Location generally not fixed; subject to requisition or use by various cost centers of the hospital.
2. Relatively small in size and unit cost.
3. Subject to storeroom control.
4. Fairly large number in use.
5. A useful life of less than three years.
6. Used in hospital operations.

Minor equipment includes such items as wastebaskets, bed pans, basins, glassware, silverware, pots and pans, sheets, blankets, ladders, and surgical instruments.

1260 CONSTRUCTION-IN-PROGRESS
- 1261 Buildings
- 1262 Fixed Equipment
- 1263 Major Movable Equipment
- 1264 Fees
- 1265 Insurance
- 1266 Interest

Cost of construction that will be in progress for more than one month and will be used for hospital operations should be charged to these accounts. Upon completion of the construction program, these accounts should be credited and the appropriate asset account(s) debited.

1270 ACCUMULATED DEPRECIATION-LAND IMPROVEMENTS
- 1271 Parking Lots
- 1279 Other Land Improvements

1280 ACCUMULATED DEPRECIATION-BUILDINGS
- 1281 Hospital
- 1284 Clinic
- 1285 Student Housing Facility
- 1286 Employee Housing Facility
- 1287 Non-Paid Workers Housing Facility
- 1288 Skilled Nursing Facility
- 1289 Parking Structure

1290 ACCUMULATED DEPRECIATION-FIXED EQUIPMENT
- 1291 Hospital
- 1294 Clinic
- 1295 Student Housing Facility
- 1296 Employee Housing Facility
- 1297 Non-Paid Workers Housing Facility
- 1298 Skilled Nursing Facility
- 1299 Parking Structure

1310 ACCUMULATED DEPRECIATION-LEASEHOLD IMPROVEMENTS

1320 ACCUMULATED DEPRECIATION-EQUIPMENT
- 1321 Major Movable Equipment
- 1329 Minor Movable Equipment

The balances in these accounts reflect the depreciation accumulated on the above-mentioned assets used in hospital operations. Reference Section 100.287 for a discussion of the acceptable depreciation methods.

Other Tangible Assets .0614

1330 INVESTMENT IN NON-OPERATING PROPERTY, PLANT AND EQUIPMENT

1340 ACCUMULATED DEPRECIATION-INVESTMENTS IN NON-OPERATING PROPERTY, PLANT, AND EQUIPMENT

1350 OTHER TANGIBLE ASSETS
- 1351 Inter-company Advances, Non-Current
- 1352 Long Term Investments

Accounts 1330 and 1340 include the cost (or fair market value at date of donation) of property, plant, and equipment not used in hospital operations and accumulated depreciation thereon. Other tangible assets not included elsewhere are contained in Account 1350.

Intangible Assets .0615

1360 GOODWILL

1370 UNAMORTIZED BORROWING COSTS

1380 PREOPENING AND OTHER ORGANIZATIONAL COSTS
- 1381 Pre-opening Costs
- 1389 Other Organization Costs

1390 OTHER INTANGIBLE ASSETS

Accounts 1360–1390 are used to record intangible assets. If such intangibles are being amortized, the amortization may be directly credited to the asset account, or accumulated in a sub-account. Account 1360, Goodwill, contains the excess of the price paid for a business as a whole over the book value, or over the computed or agreed value of all intangible net assets purchased. Account 1370, Unamortized Borrowing Costs, includes such items as legal fees, underwriting fees, etc.

Restricted Fund Assets .062

Plant Replacement and Expansion Fund Assets .0621

1510 CASH
- 1511 General Checking Accounts
- 1513 Other Checking Accounts
- 1515 Savings Accounts
- 1516 Certificates of Deposit
- 1519 Other Cash Accounts

Cash donated for the replacement of plant assets is included in these accounts.

1520 INVESTMENTS
- 1521 U.S. Government Securities
- 1522 Other Current Investments
- 1523 Share of Pooled Investments
- 1529 Other Investments

The balance of these accounts reflects the cost of investments purchased with Plant Replacement and Expansion Fund cash and the fair market value (at the date of donation) of securities donated to the hospital for the purpose of plant renewal or replacement.

1550 OTHER TANGIBLE ASSETS

1560 PLEDGES AND OTHER RECEIVABLES
- 1561 Pledges Receivable
- 1562 Allowance for Uncollectible Pledges
- 1563 Grants and Legacies Receivable
- 1564 Interest Receivable
- 1569 Other Receivables

Other tangible assets and the receivable and allowance balances of this fund are reflected in these accounts.

1570 DUE FROM OTHER FUNDS
- 1571 Due from Operating Fund
- 1572 Due from Board Designated Assets
- 1574 Due from Specific Purpose Fund
- 1575 Due from Endowment Fund

The balances in these accounts represent the amount due to the Plant Replacement and Expansion Fund from the other funds. These accounts represent assets of the Plant Replacement and Expansion Fund which are currently accounted for in other funds.

Specific Purpose Fund Assets .0622

1710 CASH
- 1711 General Checking Accounts
- 1713 Other Checking Accounts
- 1715 Savings Accounts
- 1716 Certificates of Deposit
- 1719 Other Cash Accounts

Cash donated for specific purposes, such as research and education, is included in these accounts.

1720 INVESTMENTS
- 1721 U.S. Government Securities
- 1722 Other Current Investments
- 1723 Share of Pooled Investments
- 1729 Other Investments

The balance of these accounts reflect the cost of investments purchased with Specific Purpose Fund cash and the fair market value (at the date of donation) of securities donated to the hospital for specific purposes.

1750 OTHER TANGIBLE ASSETS

1760 PLEDGES AND OTHER RECEIVABLES
- 1761 Pledges Receivable
- 1762 Allowance for Uncollectible Pledges
- 1763 Grants and Legacies Receivable
- 1764 Interest Receivable
- 1769 Other Receivables

Other tangible assets and the receivable and allowance balances of this fund are reflected in these accounts.

1770		DUE FROM OTHER FUNDS
	1771	Due from Operating Fund
	1772	Due from Board Designated Assets
	1773	Due from Plant Replacement and Expansion Fund
	1775	Due from Endowment Fund

The balances in these accounts represent the amount due to the Specific Purpose Fund from the other funds. These accounts represent assets of the Specific Purpose Fund which currently are accounted for in other funds.

Endowment Fund Assets .0623

1810		CASH
	1811	General Checking Accounts
	1813	Other Checking Accounts
	1815	Savings Accounts
	1816	Certificates of Deposit
	1819	Other Cash Accounts

Cash restricted for endowment purposes is included in these accounts.

1820		INVESTMENTS
	1821	U.S. Government Securities
	1822	Other Investments
	1823	Share of Pooled Investments
	1824	Real Property
	1825	Accumulated Depreciation on Real Property
	1826	Mortgages
	1829	Other Investments

The balances of these accounts reflect the cost of investments purchased with Endowment Fund cash and the fair market values (at the date of donation) of non-cash donations to the hospital for Endowment purposes. Included would be such assets as Real Property and related accumulated Depreciation and Mortgages.

1830 INVESTMENT IN NON-OPERATING PROPERTY, PLANT AND EQUIPMENT

1840 ACCUMULATED DEPRECIATION-INVESTMENTS IN NON-OPERATING PROPERTY, PLANT AND EQUIPMENT

1850 OTHER TANGIBLE ASSETS

Accounts 1830 and 1840 include the cost (or fair market value at date of donation) of restricted property, plant, and equipment not used in hospital operations and accumulated depreciation thereon. Other tangible assets not included elsewhere

1860 PLEDGES AND OTHER RECEIVABLES
- 1861 Pledges Receivable
- 1862 Allowances for Uncollectible Pledges
- 1863 Grants and Legacies Receivable
- 1864 Interest Receivable
- 1869 Other Receivables

Other tangible assets and the receivable and allowance balances of this fund are reflected in these accounts. Included in Account 1869 would be rent, dividends and trust income receivable.

1870 DUE FROM OTHER FUNDS
- 1871 Due from Operating Fund
- 1872 Due from Board Designated Assets
- 1873 Due from Plant Replacement and Expansion Fund
- 1874 Due from Specific Purpose Fund

The balances in these accounts represent the amount due to the Endowment Fund from the other funds. These accounts represent assets of the Endowment Fund which currently are accounted for in other funds.

Unrestricted Fund Liabilities .063

Current Liabilities .0631

2010 NOTES AND LOANS PAYABLE
- 2011 Notes and Loans Payable-Vendors
- 2012 Notes and Loans Payable-Banks
- 2013 Current Portion of Long Term Debt
- 2019 Other Notes and Loans Payable

These accounts reflect liabilities of the hospital to vendors, bank, and others, evidenced by promissory notes due and payable within one year.

2020 ACCOUNTS PAYABLE
- 2021 Trade Payables
- 2029 Other Accounts Payable

The balance of these accounts must reflect the amounts due trade creditors and others for supplies and services purchased.

2030	ACCRUED COMPENSATION AND RELATED LIABILITIES
2031	Accrued Payroll
2032	Accrued Vacation, Holiday and Sick Pay
2033	Other Accrued Salaries and Wages Payable
2034	Non-Paid Workers Services Payable
2035	Federal Income Taxes Withheld
2036	Social Security Taxes Withheld and Accrued
2037	State Income Taxes Withheld
2038	Local Income Taxes Withheld
2039	Unemployment Taxes Payable
2041	Accrued Hospitalization Insurance Premiums
2042	Union Dues Payable
2049	Other Payroll Taxes and Deductions Payable

The balances of these accounts reflect the actual or estimated liabilities of the hospital for salaries and wages payable, as well as related amounts payable for payroll taxes withheld from salaries and wages, payroll taxes to be paid by the hospital, and other payroll deductions, such as hospitalization insurance premiums. Non-Paid Worker Services Payable (Account 2034) refers to amounts payable to Mother Houses, etc., for the services of non-paid workers.

2050	OTHER ACCRUED EXPENSES
2051	Interest Payable
2052	Rent Payable
2053	Property Taxes Payable
2054	Fees Payable-Medical Specialists
2055	Fees Payable-Other
2059	Other Accrued Expenses Payable

These accounts include the amounts of those current liabilities that have accumulated at the end of the month or accounting period because of expenses, incurred up to that time.

2060 ADVANCES FROM THIRD PARTY PAYORS
- 2061 Advances-Medicare
- 2062 Advances-Medicaid
- 2063 Advances-Blue Cross
- 2069 Advances-Other

Include in these accounts liabilities to third party payors for current financing and other types of advances due and payable within one year. Do not include liabilities to third party payors arising from reimbursement settlements. Such liabilities must be included in Account 2070—Payable to Third Party Payors.

2070 PAYABLE TO THIRD PARTY PAYORS
- 2071 Reimbursement Settlement Due-Medicare
- 2072 Reimbursement Settlement Due-Medicaid
- 2073 Reimbursement Settlement Due-Blue Cross
- 2079 Reimbursement Settlement Due-Other

These accounts reflect reimbursement due to third party payors. Separate sub-accounts may be maintained within each account for each year's settlement included.

2080 DUE TO OTHER FUNDS
- 2082 Due to Board Designated Assets
- 2083 Due to Plant Replacement and Expansion Fund
- 2084 Due to Specific Purpose Fund
- 2085 Due to Endowment Fund

These accounts reflect the amounts due to other funds by the Operating Fund. Under no circumstances should these accounts be construed as payables in the sense that an obligation external to the hospital exists.

2090 INCOME TAXES PAYABLE
- 2091 Federal Income Taxes Payable
- 2092 State Income Taxes Payable
- 2093 Local Income Taxes Payable

Include in these accounts the amount of current income taxes payable.

2110 OTHER CURRENT LIABILITIES
- 2111 Deferred Income-Patient Deposits
- 2112 Deferred Income-Tuition and Fees
- 2113 Deferred Income-Other

Deferred income is defined as income received or accrued which is applicable to services to be rendered within the next accounting period and/or the current year's effect of deferred income items classified as non-current liabilities. Deferred income applicable to accounting periods extending beyond the next accounting period should be included in Accounts 2120–2140 (Deferred Credits and Other Liabilities) or in Account 2270 (Other Non-Current Liabilities).

2114	Dividends Payable
2115	Current Maturities of Long Term Debt
2116	Inter-company Indebtedness, Current
2117	Construction Retention Payable
2118	Construction Contracts Payable
2119	Other Current Liabilities

Include in these accounts the amount of Operating Fund Current liabilities for which special accounts have not been provided elsewhere, including bank overdrafts.

Deferred Credits and Other Liabilities .0632

2120 DEFERRED INCOME TAXES

2121	Deferred Taxes Payable-Federal
2122	Deferred Taxes Payable-State
2123	Deferred Taxes Payable-Local

2130 DEFERRED THIRD PARTY REVENUE

2131	Deferred Revenue-Medicare
2132	Deferred Revenue-Medicaid
2133	Deferred Revenue-Blue Cross
2139	Deferred Revenue-Other

These accounts reflect the effects of any timing differences between books and tax or third party reimbursement accounting. See the Timing Differences discussion in the Accounting Principles and Concepts chapter for details (Section 100.29).

2140 OTHER DEFERRED CREDITS

This account should reflect all deferred credits not specifically identified elsewhere.

Long Term Debt .0633

2210 MORTGAGES PAYABLE

2220 CONSTRUCTION LOANS

2230 NOTES UNDER REVOLVING CREDIT

2240 CAPITALIZED LEASE OBLIGATIONS

2250 BONDS PAYABLE

2260 INTERCOMPANY INDEBTEDNESS, NON-CURRENT

2270 OTHER NON-CURRENT LIABILITIES

These accounts reflect those liabilities that have maturity dates extending more than one year beyond the current year-end.

Board Designated Liabilities .0634

2480 DUE TO OTHER FUNDS
- 2483 Due to Plant Replacement and Expansion Fund
- 2484 Due to Specific Purpose Fund
- 2485 Due to Endowment Fund

These accounts reflect the amounts due to other funds by Board Designated Assets.

Restricted Fund Liabilities .064

Plant Replacement and Expansion Fund Liabilities .0641

2580 DUE TO OTHER FUNDS
- 2581 Due to Operating Fund
- 2582 Due to Board Designated Assets
- 2584 Due to Specific Purpose Fund
- 2585 Due to Endowment Fund

These accounts reflect the amounts due to other funds by the Plant Replacement and Expansion Fund.

Specific Purpose Fund Liabilities .0642

2780 DUE TO OTHER FUNDS
- 2781 Due to Operating Fund
- 2782 Due to Board Designated Assets
- 2783 Due to Plant Replacement and Expansion Fund
- 2785 Due to Endowment Fund

These accounts reflect the amounts due to other funds by the Specific Purpose Fund.

Endowment Fund Liabilities .0643

2810 MORTGAGES PAYABLE

2870 OTHER NON-CURRENT LIABILITIES

These accounts reflect liabilities on Endowment Fund assets that existed at the time the assets were received by the hospital or were incurred subsequent to receipt of these assets, based upon the endowment agreement.

2880 DUE TO OTHER FUNDS
- 2881 Due to Operating Fund
- 2882 Due to Board Designated Assets
- 2883 Due to Plant Replacement and Expansion Fund
- 2884 Due to Specific Purpose Fund

These accounts reflect the amounts due to other funds by the Endowment Fund.

Fund Balances .065

Non-Profit .0651

Unrestricted Fund Balances

2290 FUND BALANCE
- 2292 Depreciation Funds
- 2294 Transfers from Restricted Funds for Capital Outlay
- 2294 Value of Donated Property, Plant and Equipment

Unrestricted Fund balances represent the differences between the total of Unrestricted Fund Assets and Unrestricted Fund Liabilities, i.e., the net of the Unrestricted Fund. Separate sub accounts may be maintained for the above when applicable.

The Transfers from Restricted Funds for Capital Outlay account should be credited for the cost of capital items purchased directly by the Unrestricted Fund with funds from the Plant Replacement and Expansion Fund. The fair market value of donated property, plant, and equipment (at the date of donation) should be credited to the Donated Property, Plant and Equipment account. At the end of the year these accounts should be closed out to the Fund Balance account.

Depreciation Funds (Account 2292) represents amounts restricted by third party payors for replacement of specified assets.

Plant Replacement and Expansion and Fund Balance

2690		FUND BALANCE
	2691	Restricted Project Fund
	2692	Depreciation Funds
	2693	Donor Restricted Funds
	2695	Transfers to Unrestricted Fund for Capital Outlay
	2696	Value of Donated Property, Plant and Equipment
	2697	Transfers to Operating Fund for Operating Purposes

The credit balances of these accounts represent the net amount of this restricted fund's assets available for its designated purpose. These accounts must be credited for all income earned on restricted fund assets, as well as gains and losses on the disposal of such assets. If however, such items are to be treated as Unrestricted Fund income (considering legal requirements and donor intent), the Restricted Fund Balance account should be charged, and the Due to Unrestricted Fund account credited, for such income.

Depreciation Funds (Account 2692) represents amounts restricted by third party payors for replacement of specified assets.

Accounts 2695 and 2697 are debit balance accounts and during the year the balance of the accounts would reflect the amounts transferred to the Unrestricted Fund for Capital Outlay and operating purposes. At the end of the year the balances of these sub-accounts should be closed out to the Fund Balance account. Account 2696 reflects the fair market value, at the date of donation, of donor restricted property, plant and equipment.

Specific Purpose Fund Balance

2790		FUND BALANCE
	2791	Restricted Project Funds
	2793	Donor Restricted Funds
	2795	Transfers to Unrestricted Fund for Capital Outlay
	2796	Value of Donated Property, Plant and Equipment
	2797	Transfers to Operating Fund for Operating Purposes

The credit balances of these accounts represent the net amount of this restricted fund's assets available for its designated purpose. These accounts must be credited for all income earned on restricted fund assets, as well as gains on the disposal of such assets. If, however, such items are to be treated as Unrestricted Fund income (considering legal requirements and donor intent), the Restricted Fund Balance account should be charged, and the Due to Operating Fund account credited, for such income.

Accounts 2795 and 2707 are debit balance accounts and during the year the balance of the accounts would reflect the amounts transferred to the Unrestricted Fund for capital outlay and operating purposes. At the end of the year the balances of these sub-accounts should be closed out to the Fund Balance account.

Account 2796 reflects the fair market value at the time of donation of donor restricted property, plant and equipment.

Endowment Fund Balance

2890		FUND BALANCE
	2893	Donor Restricted Funds
	2895	Transfers to Unrestricted Funds for Capital Outlay
	2896	Value of Donated Property, Plant and Equipment
	2897	Transfers to Operating Fund for Operating Purposes

The credit balances of these accounts represent the net amount of this restricted fund's assets available for its designated purpose. These accounts must be credited for all income earned on restricted fund assets, as well as gains on the disposal of such assets. If, however, such items are to be treated as Operating Fund Income (considering legal requirements and donor intent), the Restricted Fund Balance account should be charged, and the Due to Operating Fund account credited, for such income.

Accounts 2895 and 2897 are debit balance accounts and during the year the balance of the accounts would reflect the amounts transferred to the Unrestricted Fund for capital outlay and operating purposes. At the end of the year the balance of these sub-accounts should be closed out to the Fund Balance account.

Account 2896 reflects the fair market value at the time of donation of donor-restricted property, plant and equipment.

Investor-Owned Corporation .0652

2350		STOCKHOLDER'S EQUITY
	2351	Preferred Stock
	2352	Common Stock
	2353	Retained Earnings
	2354	Treasury Stock
	2355	Additional Paid-in Capital

The total of these equity accounts reflected the difference between the total assets and the total liabilities of the Investor-Owned Corporation.

Investor-Owned Partnership or Sole Proprietor .0653

2350		CAPITAL-PARTNERSHIP OR SOLE PROPRIETOR
	2351	Capital
	2352	Partner's Draw

The total of these accounts represents the net assets of the Partnership or Sole Proprietor.

CHART OF ACCOUNTS - INCOME STATEMENT .07

An Income Statement is an accounting statement which reflects the financial results of a hospital during an accounting period. The data for this statement are accumulated in the revenue and expense accounts.

Hospitals are required to use all revenue and expense accounts which have capitalized titles and which have numerical codes with a fourth digit of zero when such a function as defined in this manual exists even though the activity is not separately organized within the hospital. The only circumstances under which the hospital need not report an existing zero level account is when the patient service provided in a daily hospital services cost center is not provided in a discrete unit or when the zero level account has sub-accounts which must be reported individually, e.g., 3411/6411, 3412/6412, 4911/7911, 4912/7912. For example, if pediatric patients receive care in the Medical/Surgical Acute cost center, no reclassification of expense or revenue from the Medical/Surgical cost center to the pediatric cost center is required. No functional reporting of revenue and expense is required for daily hospital service cost centers.

Where a function required by the accounting system is not separately organized within the hospital, but combined with one or more functions required by the accounting system, an analysis will be required to determine the gross revenue and direct expenses applicable to each required function. For instance, smaller hospitals may be combining the functions of Electrocardiography (Accounts 4290/7290) and Electroencephalography (Accounts 4460/7460). In such cases, it is necessary to determine the total direct revenue and direct costs relative to the two different types of services rendered.

The gross revenue recorded in each required revenue account must be the actual gross revenue attributable to such identified function. The expense recorded in each required expense account must represent the direct expenses related to each identified function. The direct expenses related to such function may be determined based upon analysis. It should be noted that reclassification must be made for material amounts of misplaced costs.

Since the zero level accounts presented in this manual are required, all zero level accounts presented herein except as noted above, must be reported by the hospital where the related item or function exists in that hospital. A hospital will not be granted an exemption to the reporting of an account solely because of accounting difficulty.

Operating Revenue Accounts-General .071

Hospital revenue consists mainly of the value, at the hospital's full established rates, of all hospital services rendered to patients, regardless of amounts actually paid to the hospital by or on behalf of patients. The objective of patient service revenue accounting should be that of compiling a complete and accurate record, on the accrual basis, of gross revenue, accumulated by revenue centers and by various impatient and outpatient classifications, and a record of revenue deductions, classified by type. In many instances, the hospital receives less than its established rates for the services it renders. It is important to develop information that reflects both the potential total revenue and the revenue "adjustments" resulting from the inability to collect established rates for the services provided.

Patient service revenues must be accumulated in the accounts in such a manner as to clearly identify these revenues with the functional ambulatory services and ancillary services cost centers and the discrete daily hospital services cost centers of the hospital. Measurements of revenues of each revenue producing cost center are needed for comparison with the expenses of the center, so that operating performances can be evaluated, planned, and controlled.

In addition to patient service revenue, hospitals obtain revenue from sources and activities only indirectly related to patient care. These "other" operating revenues typically consist of tuition revenue, parking lot revenue, cafeteria sales, etc.

Regardless of the source of hospital revenue, it is important that it be accounted for on the accrual basis. This system of accounting requires that revenue be recognized and recorded in the accounts in the time period it is earned, irrespective of the timing of the cash flow between the hospital and other parties. No other system provides the necessary qualities of completeness, accuracy, and usefulness in accounting data and/or the proper basis for matching revenues with expenses.

The operating revenue accounts in the chart of accounts presented are classified into six categories.

1. DAILY HOSPITAL SERVICES

This group of accounts (3000–3690) is used to record the gross revenue, measured in terms of the hospital's full established rates, earned from daily hospital services rendered to inpatients. These revenues must be recorded at the hospital's full established rates regardless of the amounts actually collected.

Daily hospital services generally are those services included by the provider in a daily service charge-sometimes referred to as the "room and board" charge. Included in daily hospital services are the regular room, dietary and nursing services, medical and social services, and the use of certain equipment and facilities for which the hospital does not customarily make a separate charge. All medical and surgical supplies are excluded.

Daily hospital services are categorized into broad areas: (a) acute care, (b) definitive observation, (c) intensive care, (d) nursery, and (e) sub-acute.

a. Acute Care - This group of accounts (3000–3270) is used to record the gross revenues, measured in terms of the hospital's full established rates earned from daily hospital services provided to patients who are in an acute phase of illness but not to the degree which requires the concentrated and continuous

observation and care provided in the intensive care units of a hospital.

b. Definitive Observation - This group of accounts (3280–3290) is used to record the gross revenue measured in terms of the hospital's full established rates earned from daily hospital services provided to patients who are in a phase of illness more intensive than acute care but not sufficiently intensive to require admission to an intensive care unit of a hospital.

c. Intensive Care - This group of accounts (3000–3490) is used to record the gross revenues measured in terms of the hospital's full established rates earned from inpatient intensive care services provided in a hospital unit to patients which require extraordinary observation and care on a concentrated and continuous basis.

d. Nursery - This group of accounts (3500–3590) is used to record gross revenues measured in terms of the hospital's full established rates earned from nursery services provided to newborn infants which require routine and premature care.

e. Sub-Acute Care - This group of accounts (3600–3680) is used to record the gross revenues measured in terms of the hospital's full established rates earned from services provided to patients who require a level of nursing care less than acute, including residential care.

2. AMBULATORY SERVICES

This group of accounts (3710–3990) is used to record the gross revenues measured in terms of the hospital's full established rates earned from ambulatory services. The essential characteristic distinguishing ambulatory services is that patients arrive at a facility of the hospital for a purpose other than admission as an inpatient. For reporting purposes, ambulatory services, free standing clinic, free standing emergency services and home health services.

3. ANCILLARY SERVICES

This group of accounts (4000–4980) is used to record the gross revenues measured in terms of the hospital's full established rates earned from ancillary services. Ancillary services generally are those special services for which charges are customarily made in addition to routine charges and include such services as laboratory, diagnostic radiology, surgical services, etc. Ancillary services are billed as separate items when the patient receives these services.

4. ADMISSIONS SERVICES

This group of accounts (4990–4990) is used to record the gross revenues measured in terms of the hospital's full established rates earned from admissions services. The admissions center is composed of that portion of 3 general service center costs which are allocated via step-down to the daily hospital service centers. The general service centers are: Medical Staff Administration, Medical Records and Social Services.

5. OTHER OPERATING REVENUE

This group of accounts (5000–5890) is used to record all operating revenues other than those that are directly associated with patient care.

6. DEDUCTIONS FROM REVENUE

This group of accounts (5900–5990) is used to record reductions in gross revenue arising from bad debts, contractual adjustments, uncompensated care, administrative, courtesy, policy discounts, adjustments and others.

7. UNREGULATED SERVICES

This group of accounts is used to record all revenue associated with patient care services not regulated by the Health Services Cost Review Commission.

Operating Revenue Accounts-Description .072

Patient Revenue Account Descriptions .0721

The descriptions of the patient revenue accounts in the following section are extremely brief. This is due to the fact that detailed descriptions of the functions or types of activities to be included in each cost center are included in the cost center descriptions which follow. The revenue relative to these functions and activities must be recorded in the revenue account matching the cost center in which the costs are recorded. For example, charges for Pediatric Acute services are recorded in Pediatrics Acute (Account 3170) and the cost of the services are recorded in Pediatrics Acute (Account 6170). Thus a matching of revenues and expenses is achieved within each cost center.

DAILY HOSPITAL CARE SERVICES-ACUTE CARE REVENUE

		Reporting Schedule
3010	MEDICAL/SURGICAL ACUTE	Schedule RSA
3170	PEDIATRIC ACUTE	Schedule RSA

		Reporting Schedule
3210	PSYCHIATRIC ACUTE	Schedule RSA
3250	OBSTETRICS ACTUE	Schedule RSA

DAILY HOSPITAL SERVICES-DEFINITIVE OBSERVATION REVENUE

	3280	DEFINITIVE OBSERVATION	Schedule RSA

DAILY HOSPITAL SERVICES-INTENSIVE CARE REVENUE

			Reporting Schedule
3310		MEDICAL/SURGICAL INTENSIVE CARE	Schedule RSA
3330		CORONARY CARE	Schedule RSA
	3331	Myocardial Infarction	
	3332	Pulmonary Care	
	3333	Heart Transplant	
	3339	Other Coronary Care	
	3350	PEDIATRIC INTENSIVE CARE	Schedule RSA
3370		NEO-NATAL INTENSIVE CARE	Schedule RSA
3380		BURN CARE	Schedule RSA
3390		PSYCHIATRIC INTENSIVE CARE	Schedule RSA
3410		OTHER INTENSIVE CARE	
	3411	Shock Trauma	Schedule RSA
	3412	Oncology	Schedule RSA

DAILY HOSPITAL SERVICES-NURSERY REVENUE

3510	NEWBORN NURSERY	Schedule RSA
3511	NORMAL NEWBORNS	Schedule RSA
3520	PREMATURE NURSERY	Schedule RSA

DAILY HOSPITAL SERVICES-REHABILITATION REVENUE

3620	REHABILITATION	Schedule RSA

DAILY HOSPITAL SERVICES-SUB-ACUTE CARE REVENUE

3640	INTERMEDIATE CARE	Schedule RSA
3650	RESIDENTIAL CARE	None

AMBULATORY SERVICES

3710		EMERGENCY SERVICES	Schedule RSA
	3711	Emergency Room	
	3719	Other Emergency Services	
3720		CLINIC SERVICES	Schedule RSA
	3721	Allergy Clinic	
	3722	Cancer Clinic	
	3723	Cardiology Clinic	
	3724	Dental Clinic	
	3725	Dermatology Clinic	
	3726	Diabetic Clinic	
	3727	Drug Abuse Clinic	
	3728	Ear, Nose, and Throat Clinic	
	3729	Eye Clinic	
	3731	General Medicine Clinic	
	3732	Obstetrics/Gynecology Clinic	
	3733	Orthopedic Clinic	
	3734	Pediatric Clinic	
	3735	Physical Medicine	
	3736	Psychiatric Clinic	
	3737	Surgery Clinic	
	3738	Urology Clinic	
	3739	Venereal Disease clinic	
	3750	Observation Service	
	3880	Other Clinic Services	
3940		PSYCHIATRIC DAY AND NIGHT CARE SERVICES	Schedule RSB
3950		OBSERVATION	Schedule RSB
3960		FREE STANDING EMERGENCY SERVICE	Schedule RSB

ANCILLARY SERVICES REVENUE

4010		LABOR AND DELIVERY SERVICES	Schedule RSB
4040		OPERATING ROOM	Schedule RSB
	4041	General Surgery	
	4042	Open Heart Surgery	
	4043	Neurosurgery	
	4044	Orthopedic Surgery	
	4045	Kidney Transplant	
	4046	Other Organ Transplant	
	4047	Recovery Room	
	4049	Other Surgical Services	
4050		AMBULATORY SURGERY SERVICES	Schedule RSB
4060		SAME DAY SURGERY	Schedule RSB
4070		OPERATING ROOM – CLINIC	Schedule RSB
4080		ANESTHESIOLOGY	Schedule RSB
4090		CERTIFIED NURSE ANESTHETIST	Schedule RSB
4110		MEDICAL SUPPLIES SOLD	Schedule RSC
	4111	Medical Supplies-Billable	
	4112	Medical Supplies-Non-Billable	

4150		DRUGS SOLD	Schedule RSC
	4151	Drugs-Billable	
	4152	Drugs-Non-Billable	
4210		LABORATORY SERVICES	Schedule RSB
	4211	Chemistry	
	4212	Hematology	
	4213	Immunology (Serology)	
	4214	Microbiology (Bacteriology)	
	4215	Procurement and Dispatch	
	4216	Urine and Feces	
	4219	Other Clinical Laboratories	

	4231	Cytology	
	4232	Histology	
	4233	Autopsy	
	4234	Other Pathological Laboratories	
4250		BLOOD	Schedule RSB
	4251	Blood-Whole	
	4252	Blood-Plasma	
	4253	Blood-Other Components	
	4259	Blood Storing and Processing	
4290		ELECTROCARDIOGRAPHY	Schedule RSB
4310		INTERVENTIONAL RADIOLOGY/CARDIOVASCULAR	Schedule RSB
4320		RADIOLOGY-DIAGNOSTIC	Schedule RSB
	4321	Angiocardiography	
	4322	Ultrasonography	
	4339	Radiology-Diagnostic-Other	
4340		CT SCANNER	Schedule RSB
4350		MRI SCANNER	Schedule RSB
4355		LITHOTRIPSY	Schedule RSB
4360		RADIOLOGY-THERAPEUTIC	Schedule RSB
4380		NUCLEAR MEDICINE	Schedule RSB
	4381	Nuclear Medicine-Diagnostic	
	4382	Nuclear Medicine-Therapeutic	
4420		RESPIRATORY THERAPY	Schedule RSB
4440		PULMONARY FUNCTION TESTING	Schedule RSB
4460		ELECTROENCEPHALOGRAPHY	Schedule RSB
4510		PHYSICAL THERAPY	Schedule RSC
	4511	Electromyography	
4530		OCCUPATIONAL THERAPY	Schedule RSC
4550		SPEECH-LANGUAGE PATHOLOGY	Schedule RSC
4570		RECREATIONAL THERAPY	Schedule RSC
4580		AUDIOLOGY	Schedule RSC
4590		OTHER PHYSICAL MEDICINE	Schedule RSC
4670		PSYCHIATRIC/PSYCHOLOGICAL SERVICES	None
	4671	Individual Therapy	
	4672	Group Therapy	
	4673	Family Therapy	
	4674	Bio-Feedback	
	4675	Psychological Testing	
	4676	Electric Shock	
	4689	Other Psychiatric/Psychological Services	
4710		RENAL DIALYSIS	Schedule RSC
	4711	Hemodialysis	
	4713	Peritoneal Dialysis	
	4715	Patient Dialysis	
	4717	Home Dialysis	
	4719	Other Dialysis	
4730		KIDNEY ACQUISITION	Schedule RSC
4910		OTHER ANCILLARY SERVICES	

4911	Leukopheresis	Schedule RSC
4912	Hyperbaric Chamber	Schedule RSC

ADMISSIONS SERVICES REVENUE

4990	ADMISSIONS SERVICES	Schedule RSB

Other Operating Revenue Account Descriptions .0722

5020 TRANSFERS FROM RESTRICTED FUNDS FOR RESEARCH EXPENSES Schedule F1

This account reflects the amount of transfers from restricted funds to the operating fund to match expenses incurred in the current period by the Operating Fund for restricted fund research activities. Separate accounts are recommended for each specific restricted fund activity or group of activities for which separate accounting is required by law, grant or donation agreement.

5220		NURSING EDUCATION	Schedule F2
	5221	Registered Nurses	
	5222	Licensed Vocational (Practical) Nurses	
5240		POSTGRADUATE MEDICAL EDUCATION	Schedules P4A to P4G
	5241	Approved Teaching Program	
	5242	Non-Approved Teaching Program	
5260		OTHER HEALTH PROFESSION EDUCATION	Schedule F3
	5261	School of Medical Technology	
	5262	School of X-Ray Technology	
	5263	School of Respiratory Therapy	
	5264	Administrative Intern Program	
	5265	Medical Records Librarian	
5270		COMMUNITY HEALTH EDUCATION	Schedule F4

These accounts (5220–5270) are used to record the revenue from the schools of nursing, postgraduate medical education, paramedical education, and other educational activities.

5280 TRANSFERS FROM RESTRICTED FUNDS FOR EDUCATIONAL ACTIVITIES Schedules F2, F3, F4

This account reflects the amounts of transfers from restricted funds to the Operating Fund to match expenses incurred in the current period by the Operating Fund for restricted educational activities. Separate accounts must be maintained for each specific restricted fund activity or group of activities for which separate accounting is required by law or grant or donation agreement.

		Reporting Schedule
5320	CAFETERIA SALES	Schedule E7

This account is used for the revenues earned in the hospital cafeteria for meals served to employees and others. Also included is revenue from employees and others for meals, even if the hospital does not operate a formal cafeteria.

5330	LAUNDRY AND LINEN SERVICES REVENUE	Schedule C - Line C2

This account shall be credited for revenues earned by providing laundry services to other organizations (both related and unrelated) and to employees and students housed on property.

5330	SOCIAL SERVICES REVENUE	Schedule C - Line C3

This account shall be credited for revenues earned by providing social services to patients and others.

5360	HOUSING REVENUE	Schedule E9
5360	Employee Housing	
5363	Student Housing	

This account is used to record revenue from room (or cot) rentals provided for employees and students.

5430	AMBULANCE SERVICES REVENUE	Schedule E1

This account is credited for revenues for providing ambulance services to the ill and injured.

5440	PARKING REVENUE	Schedule E2

Amounts received from visitors, employees and others in payment of parking privileges shall be recorded in this account.

5450	HOUSEKEEPING SERVICES REVENUE	Schedule C - Line C6

This account shall be credited for revenues earned by providing housekeeping services to other organizations (both related and non-related).

		Reporting Schedule
5610	TELEPHONE AND TELEGRAPH REVENUE	Schedules C - Line C11, E6

Amounts received from patients, employees and others in payment of hospital telephone and telegraph services shall be credited to this account.

5620	DATA PROCESSING SERVICES REVENUE	Schedule E4

This account shall be credited for revenues earned by providing data processing services to other organizations (both related and non-related).

5690	PURCHASING SERVICES REVENUE	Schedule C - Line C4

This account shall be credited for revenues earned by providing purchasing services to other organizations (both related and non-related).

5710	SALE OF ABSTRACTS/MEDICAL RECORDS	Schedule G

This account is credited for medical records, transcripts and abstract fees.

		Reporting Schedule
5760	DONATED COMMODITIES	Schedule G

Donated medicines, linen, office supplies and other materials which would normally be purchased by a hospital shall be recorded at fair market value in this account. An offsetting debit should be made to the appropriate inventory account or cost center.

5770	DONATED BLOOD	Schedule G

Donated Blood is recorded at fair market value in this account. An offsetting debit is made to the blood inventory account or Blood cost center (Account 7250).

5780	CASH DISCOUNTS ON PURCHASES	Schedule G

The amounts of cash discounts taken by the hospital on purchases shall be recorded in this account. Trade discounts, however, shall be treated as reductions in the cost of items purchased.

5790	SALE OF SCRAP AND WASTE	Schedule G

This account shall be used to record the revenue from the sale of miscellaneous scrap and waste.

5810	REBATES AND REFUNDS	Applicable Schedule

This account shall be used to record revenue from rebates and refunds of expense.

5820	VENDING MACHINE COMMISSIONS	Schedule G

Commissions earned by the hospital from coin-operated telephones and vending machines shall be credited to this account.

5830	OTHER COMMISSIONS	Schedule G

Commissions earned by the hospital, other than commissions from coin-operated telephones and vending machines shall be recorded in this account.

		Reporting Schedule
5840	TELEVISION RENTALS	Schedule E5

This account shall be used to record the revenues from television and radio rentals, when the activity is hospital conducted.

5850	NON-PATIENT ROOM RENTALS	Schedule G

This account is used to record revenue from room or (cot) rentals charged to non-patients.

5860	MANAGEMENT SERVICES REVENUE	Schedule C - Line C11

This account shall be credited for revenue earned by providing management services to other organizations (both related and non-related).

5865	HSCRC REGULATED PHYSICIANS PART B SERVICES (REGULATED)	Schedule P2

This account shall be used to record revenue from regulated Physicians Part B Services.

5870	OTHER OPERATING REVENUE	Schedule G

This account shall be credited with Other Operating revenue not included elsewhere.

5886	PHYSICIANS PART B SERVICES (UNREGULATED)	Schedule UR5

This account shall be used to record revenue from unregulated Physicians Part B Services.

5880 TRANSFERS FROM RESTRICTED FUNDS FOR OTHER OPERATING EXPENSES — Var. Schedules

This account reflects the amounts of transfers from restricted funds to the Operating Fund to match expenses incurred in the current period by the Operating Fund for restricted fund activities other than the transfers from restricted funds recorded in Account 5020 (Transfers from Restricted Funds for Research Expenses) and Account 5280 (Transfers from Restricted Funds for Education Expenses).

Deductions from Revenue .0723

5900 PROVISION FOR BAD DEBTS

5909 Provision for Bad Debts Other — Schedule GT

Account 5909 shall be used to accumulate the hospital's periodic estimates of the amounts of accounts and notes receivables from all receivables that are likely to be credit losses.

Reporting Schedule

Because hospitals experience different bad debt patterns with various classes or types of patients, it is recommended that the computation of the estimate (provision) take into consideration these differences. Sub-accounts may be established in order to reflect the differences more accurately. The hospital may use any Provision for Bad Debt Sub-accounts which will enable a more accurate estimate of credit losses.

5910		CONTRACTUAL ADJUSTMENTS-MEDICARE	Schedule GT
	5911	Medicare-Part A	
	5912	Medicare-Part B	
5920		CONTRACTUAL ADJUSTMENTS-MEDICAID	Schedule GT
5930		CONTRACTUAL ADJUSTMENTS-BLUE CROSS	Schedule GT
5940		CONTRACTUAL ADJUSTMENTS-OTHER	Schedule GT

These accounts must be charged with the differential (if any) between the amount based on the hospital's full established rates, of contractual patients' charges for hospital services which are rendered during the reporting period and are covered by the contract, and the amount received and to be received from third-party agencies in payment of such charges, including adjustments made at year-end, based upon Cost Reports submitted. For example, if during the year, a hospital follows the practice of debiting the contractual adjustment account for the amount of the retention on interim payments, the following adjustments would be necessary at year-end to properly reflect each Contractual Adjustments account:

1) The amount of the retention in year-end program accounts receivable should be estimated and reflected in the accounting records by debiting the contractual adjustment account and crediting appropriate Allowance for Contractual Adjustments account (1040).

2) The Contractual Adjustments account should be adjusted to reflect cost reimbursement settlement, with the offsetting debit or credit going to the appropriate Receivables from Third Party Payors account (1050) or Payable to Third Party Payors account (2070).

Reporting Schedule

Prior period contractual revenue adjustments normally would also be reflected in these accounts rather than in the Fund Balance or Retained Earnings accounts. (Please refer to the AICPA Hospital Audit Guide for a more extensive discussion of accounting for prior contractual revenue adjustments.)

Should the hospital receive more than its established rates from an agency, the differential is credited to these accounts.

In any instance, of course, when the difference between a patient's bill and the payment received by the hospital from a third party agency is recoverable from the patient, the differential is retained in Accounts Receivable until it is paid or until it is deemed to be a bad debt and is written off.

5941 CONTRACTUAL ADJUSTMENTS - VOLUNTARY

Any difference between a patient's charge and the payment received by the hospital which is as the result of a contract between the hospital and a third-party payor, employee, or employee group whereby the hospital agrees to accept less than approved charges as payment for services rendered shall be charged to account 5941 - Contractual Adjustments - Voluntary. This account shall not include any monies which are as the result of contractual adjustments mandated by Commission approved rate orders. It should additionally be noted that such monies shall not be charged to accounts in such a way as to increase charges to any other patient or payor.

For example, if the Commission approved charge is $100 and the contractual allowance to the patient as the result of a voluntary agreement is $90 and the hospital receives $85, then $10 shall be charged to account 5941 and $5 shall be charged as a bad debt.

Also for example, if the approved charge for a service is $200 and the Medicaid-Commission approved discount would result in a normal payment of $188, but that the hospital and Medicaid have entered into an agreement which allows for a payment by Medicaid of $175, then $12 shall be charged to account 5920 and $13 shall be charged to account 5941

		Reporting Schedule
5945	HSCRC Uncompensated Care Fund	Schedule GT

This account is charged with the amount of patient charges paid into, or received from, the HSCRC Uncompensated Care Fund. This account is used to calculate the proper Net Patient Revenue of the reporting hospital

5950	CHARITY/UNCOMPENSATED CARE	Schedule GT
5951	Charity/Uncompensated Care-Hill-Burton	
5959	Charity/Uncompensated Care-Other	

This account is charged with the differential between the amount based on the hospital's full established rates, of charity/uncompensated care patients' bills for hospital services and the amount (if any) to be received from such patients in payment for such services. This differential should be credited directly to the appropriate Accounts Receivable account, rather than to a Contractual Adjustment account, as such charity/uncompensated care discounts are readily determinable. Charges billed and uncollected for medically unnecessary services are not recognized by the Commission, as charity or uncompensated care and should not be charged to these accounts. Amounts resulting from medically unnecessary services should be charged to Administrative, Courtesy and Policy Discounts and Adjustments, Account 5970

When the hospital receives lump-sum grants or subsidies (rather than specific payments for individual patient's bills) from government or voluntary agencies for the care of medically indigent patients, the amount of the lump-sum or grant or subsidy must be credited to "Restricted Donations and Grants for Indigent Care" (Account 5960).

Reporting Schedule

In order to distinguish properly between patients whose uncollectible bills should be considered as charity/uncompensated care write-off and patients whose uncollectible bills should be considered as bad debts, all patients should be classified at the time of admittance, or as soon after as it is possible, being charity/uncompensated (full or partial) paying patients. There may be some instances in which, because of complications unforeseen at the time of admission, the charges made to a patient turn out to be considerably greater than anticipated, and the patient is unable to pay the full amount. In such cases, the patient would be reclassified as a charity/uncompensated care patient, and the charges attributable to the unforeseen complications would be considered charity service. Uncollectible charges made to patients classified as paying patients - except for contractual adjustments, policy discounts and administrative adjustments - should be treated as credit losses, i.e., as bad debts.

5960 RESTRICTED DONATIONS AND GRANTS FOR INDIGENT CARE — Schedule GT

This account is credited with voluntary and governmental agency grants or subsidies for the care of medically indigent patients during the current accounting period.

5970 ADMINISTRATIVE, COURTESY AND POLICY DISCOUNTS AND ADJUSTMENTS — Schedule GT

This account shall be charged or credited for write-offs, of debit or credit balances in patients' accounts in which the cost of billing or refunding exceeds the amount of the account balance. In addition, reductions in the nature of courtesy allowances and employee discounts from the hospital's established rates for services rendered must be charged to this account and credited to the appropriate Accounts Receivable account.

Reporting Schedule

5980 OTHER DEDUCTIONS FROM REVENUE Schedule GT

Other deductions from revenue which are not included elsewhere should be credited to this account.

5990 PROSPECTIVE RATE ADJUSTMENTS Schedule GT

This account shall be charged or credited for adjustments due to revenue lost or gained due to variances from approved rates (price variance) and variances in approved volumes (volume variance). Revenue lost due to negative variances in rates and underachieving in approved volumes will be recouped, wholly or in part, by the hospital through increases in prospective rates. Similarly, revenue gained due to positive variances in rates and overachieving in approved volumes will be paid back, wholly, or in part by the hospital through reductions in prospective rates.

Patient Care and Other Operating Expense Accounts – General .073

Expenses are expired costs, that is, costs that have been used up in carrying on some activity during the accounting period and from which no future measurable benefit will be obtained.

Hospital expenses consist primarily of employee compensation, but substantial amounts of expense are in the form of supplies used, utilities, repairs, insurance, depreciation and other items. The objective of expense accounting is to accumulate on the accrual basis, complete and meaningful records of expenses. Within each cost center, the expenses are classified according to natural classification (see Natural Classification of Expenses, Section 200.037) by the use of the fifth and sixth digits in the numerical coding system.

Hospitals are required to use in the required reports all revenue and expense accounts which have capitalized titles and which have numerical codes with a fourth digit of zero when such a function as defined in this manual exists even though the activity is not separately organized within the hospital. The only circumstances under which the hospital need not report an existing zero level account is when the patient service provided in a Daily Hospital Services Cost Center is not provided in a discrete unit or when the zero level account has sub-accounts which must be reported individually, e.g., 3411/6411, 3412/6412, 4911, 7911, 4912/7912.

1. PATIENT SERVICE EXPENSE

   This group of accounts (6000–7999) is used to record the direct expenses incurred in providing nursing and other professional services (daily hospital services, ambulatory services and ancillary services) rendered to patients. For each nursing and other professional service revenue center account a corresponding cost center account is provided. The second, third and fourth digits of the account numbers of the related revenue and expense cost centers are the same. Comparisons of the revenue and direct expense of each nursing and other professional service centers are thereby facilitated.

2. OTHER OPERATING EXPENSE

   This group of accounts (8000–8999) is used to record the direct expenses incurred by the research, education, general, fiscal, general administrative, medical care administration cost centers and various unassigned cost centers. When cost finding procedures are performed, the expenses charged to these centers are allocated to the various patient service expense cost centers to determine the full cost of providing each revenue producing service.

Patient Care and Other Operating Expense Accounts-Description .074

The following pages contain detailed descriptions of the functions or types of activities to be included in each cost center, the name and definition of the applicable standard unit of measure and the data source of the standard unit of measure.

The Standard Unit of Measure must be maintained as defined and tabulated on an actual basis for all cost centers. The data source must be utilized as defined in each account description, for example, the laboratory units must be maintained by the laboratory cost center and may not be obtained from a hospital's billing system.

Standard Unit of Measure .0741

The Standard Unit of Measure is required to provide a uniform statistic for measuring costs. The Standard Unit of Measure for revenue-producing cost centers (Daily Hospital, Ambulatory, and Ancillary Services) attempts to measure the volume of services rendered to patients (productive output). For non-revenue producing cost centers, the Standard Unit of Measure attempts to measure the volume of support services rendered. The Standard Unit of Measure provides a method of determining unit cost and revenue to facilitate cost and revenue comparisons among peer group health facilities.

Standard Units of Measure should not be confused with allocation statistics used to allocate cost of non-revenue producing cost centers to each other and to the revenue-producing centers.

Table of Standard Units of Measure .0742

This table of Standard Units of Measure has been developed as a quick reference source. For a detailed description of the units of measure, please refer to the appropriate cost center description in this section.

Account Number	Cost Center	Standard Unit of Measure
Daily Hospital Services		
6010	Medical/Surgical Acute	Number of Patient Days
6170	Pediatric Acute	Number of Patient Days
6210	Psychiatric Acute	Number of Patient Days
6220	Psychiatric Adult - Specialty - Hospitals	Number of Patient Days
6230	Psychiatric Child/Adolescent - Specialty Hospitals	Number of Patient Days
6240	Psychiatric Geriatric - Specialty Hospitals	Number of Patient Days
6250	Obstetrics Acute	Number of Patient Days
6260	Adolescent Dual Diagnosed – Specialty Hospital	Number of Patient Days
6280	Definitive Observation	Number of Patient Days
6310	Medical/Surgical Intensive Care	Number of Patient Days
6330	Coronary Care	Number of Patient Days
6350	Pediatric Intensive Care	Number of Patient Days
6370	Neo-Natal Intensive Care	Number of Patient Days
6380	Burn Care	Number of Patient Days
6390	Psychiatric Intensive Care	Number of Patient Days
6410	Other Intensive Care	Number of Patient Days
6511	Normal Newborns	Number of Normal Deliveries
6520	Premature Nursery	Number of Premature Patient Days
6620	Rehabilitation	Number of Patient Days
6630	Psychiatric Long-Term Care	Number of Patient Days
6640	Chronic Care	Number of Patient Days
6650	Residential Care	Number of Patient Days

Account Number	Cost Center	Standard Unit of Measure
Ambulatory Services		
6710	Emergency Services	RVUs
6720	Clinic Services	RVUs
6740	Clinic Services Primary	RVUs
6750	Observation Service	Number of Hours
6800	Ambulance Service Rebundled	RVUs
6940	Psychiatric Day and Night Care Services	Number of Visits
6960	Free Standing Emergency Services	Number of Visits
7060	Same Day Surgery	Number of Patients
7060	Ambulatory Surgery Procedure	RVUs
7070	Operating Room – Clinic	Minutes
Ancillary Services		
7010	Labor and Delivery Services	RVUs
7040	Operating Room	Number of Surgery Minutes
7050	Ambulatory Surgery Services	Number of Surgery Minutes
7080	Anesthesiology	Number of Anesthesia Minutes
7110	Medical Supplies Sold	EIPA
7150	Drugs Sold	EIPA
7210	Laboratory Services	RVUs
7250	Blood	RVUs
7290	Electrocardiography	RVUs
7310	Interventional Cardiovascular	RVUs
7320	Radiology-Diagnostic	RVUs
7340	CT Scanner	RVUs
7350	MRI Scanner	RVUs
7355	Lithotripsy	Number of Procedures
7360	Radiology-Therapeutic	RVUs
7380	Nuclear Medicine	RVUs
7420	Respiratory Therapy	RVUs
7440	Pulmonary Function Testing	RVUs
7460	Electroencephalography	RVUs
7510	Physical Therapy	RVUs
7530	Occupational Therapy	RVUs
7550	Speech-Language Pathology	RVUs
7570	Recreational Therapy	Number of Treatments

Account Number	Cost Center	Standard Unit of Measure
Ancillary Services (Con't)		
7580	Audiology	RVUs
7590	Other Physical Medicine	Number of Treatments
7670	Psychiatric/Psychological Services	Number of Treatments
7710	Renal Dialysis	Number of Treatments
7730	Organ Acquisition	Number of Treatments
7911	Leukopheresis	RVUs
7912	Hyperbaric Chamber	Hours of Treatment
Unregulated Services		
6610	Skilled Nursing Care	Number of Patient Days
6970	Free Standing Clinic	Number of Visits
6980	Home Health Services	Number of Visits
7220	Laboratory-Non Pat.	RVUs
7720	Renal Dialysis-Outpatient	Number of Treatments
8760	Physicians-Part B Services	Number of FTE's
7090	Certified Nurse Anesthetist	Number of CNA Minutes
Other Operating Expenses		
Research		
8010	Research	Number of Research Projects
Education		
8220	Nursing Education	Average Number of Nursing Students
8240	Post-Graduate Teaching Program	Number of FTE Students
8260	Other Health Profession Education	Average Number of Students
8270	Community Health Education	Number of Participants

General Services		
8310	Dietary Services	Number of Patient Meals
8320	Cafeteria	Equivalent Number of Meals Served
8330	Laundry and Linen	Number of Dry and Clean Pounds Processed
8350	Social Services	Admissions
8360	Housing	Average Number of Persons Housed
8410	Plant Operations and Maintenance	Number of Gross Square Feet
8430	Ambulance Services	Number of Occasions of Service
8440	Parking	Number of Parking Spaces
8450	Housekeeping	Hours Assigned
8460	Central Services and Supply	EIPA
8470	Pharmacy	EIPA
8480	Organ Acquisition Overhead	Number of Organs
Fiscal Services		
8510	General Accounting	EIPD
8520	Patient Accounts	Number of Patient Days Plus Outpatient Visits
Administrative Services		
8610	Hospital Administration	EIPD
8690	Purchasing and Stores	EIPD
Medical Care Administration		
8710	Medical Records	Number of Inpatient Discharges plus 1/8 of Total Visits for Emergency Services, Clinic Services, Psychiatric Day Care Services, Freestanding Clinic Services and Freestanding Emergency Services
8720	Medical Staff Administration	EIPD
8730	HSCRC Regulated Physicians Part B Services (Non-Medicare)	Number of FTEs
8740	Physician Support Services	Number of FTEs
8750	Nursing Administration	Hours of Nursing Services Personnel

Account Number	Cost Center	Standard Unit of Measure
8810	Depreciation and Amortization	Not Applicable
8820	Leases and Rentals	Not Applicable
8830	Insurance-Hospital and Professional Malpractice	Not Applicable
8840	Insurance - Other	Not Applicable
8850	Licenses and Taxes (Other than Income Taxes)	Not Applicable
8860	Interest-Short Term	Not Applicable
8870	Interest-Long Term	Not Applicable

Daily Hospital Services Expenses .075

6010 MEDICAL/SURGICAL ACUTE

Function

Medical/Surgical Acute Care Units provide care to patients on the basis of physicians' orders and approved nursing care plans. Additional activities include, but are not limited to, the following:

Serving and feeding of patients; collecting sputum, urine, and feces samples; monitoring of vital life signs: operating of specialized equipment related to this function; preparing of equipment and assisting physicians during patient examination and treatment; changing of dressings and cleaning of wounds and incisions: observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed: observing patients for reaction to drugs; administering specified medication: infusing fluids, including I.V.'s and blood; answering of patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to Medical/Surgical acute patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees, (non-physician) supplies (non-medical and surgical) purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for all patients admitted to this unit unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occurs on the same day, the day is considered as the day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D - Line D1

6170 PEDIATRIC ACUTE

Function

Pediatric Acute Care Units provide care to Pediatric patients (Children less than 14 years) in Pediatric nursing units on the basis of Physicians' orders and approved nursing care plans. Additional activities include, but are not limited to, the following:

> Serving and feeding of patients; collecting of sputum, urine and feces samples; monitoring of vital life signs; operating of specialized equipment and assisting of physicians during patient examination and treatment: changing of dressings and cleaning of wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing the patients for reaction to drugs; administering specified medication; infusing fluids including I.V.'s and blood; answering of patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to Pediatric patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Units of Measure: Number of Patient Days

Report patient days of care for all patients admitted to this unit unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occurs on the same day, the day is considered as a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D - Line D2

6210 PSYCHIATRIC ACUTE - ACUTE/GENERAL HOSPITALS

Function

Psychiatric Acute Care Units provide care to patients admitted, to acute/general hospitals, for diagnosis as well as treatment on the basis of physicians' orders and approved nursing care plans. The units are staffed with nursing personnel specially trained to care for the mentally ill, mentally disordered, or other mentally incompetent persons. Additional activities include, but are not limited to the following:

> Serving and feeding of patients; collecting of sputum, urine, and feces samples; monitoring of vital life signs; operating of specialized equipment related to this function; preparing equipment and assisting physicians during patient examination and treatment; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medication; infusing fluids including I.V.'s and blood; answering of patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to Psychiatric patients in acute/general hospitals. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days for all patients admitted to this unit unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D - Line D3

6220 PSYCHIATRIC ADULT - SPECIALTY HOSPITALS

Function

Psychiatric Adult Care Units provide care to adult patients, between the ages of 18 and 64; admitted for diagnosis as well as treatment to private psychiatric hospitals on the basis of physicians' orders and approved nursing care plans. The units are staff with nursing personnel specially trained to care for the mentally ill, mentally disordered, or other mentally incompetent persons. Additional activities include, but are not limited to the following:

> Serving and feeding of patients; collecting of sputum, urine, and feces samples; monitoring of vital life signs; operating of specialized equipment related to this function; preparing equipment and assisting physicians during patient examination and treatment; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medication; infusing fluids including I.V.'s and blood; answering of patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to adult Psychiatric patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days for all patients admitted to this unit unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D - Line D70

6230 PSYCHIATRIC CHILD/ADOLESCENT - SPECIALTY HOSPITALS

Function

Psychiatric Child/Adolescent Care Units provide care to patients, under the age of 18, admitted for diagnosis as well as treatment to private psychiatric hospitals on the basis of physician's orders and approved nursing care plans. The units are staffed with nursing personnel specially trained to care for the mentally ill, mentally disordered, or other mentally incompetent persons. Additional activities include, but are not limited to the following:

Serving and feeding of patients; collecting of sputum, urine, and feces samples; monitoring of vital life signs; operating of specialized equipment related to this function; preparing equipment and assisting physicians during patient examination and treatment; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medication; infusing fluids including I.V.'s and blood; answering of patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to child or adolescent Psychiatric patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days for all patients admitted to this unit unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D - Line D71

6240 PSYCHIATRIC GERIATRIC-SPECIALTY HOSPITALS

Function

Psychiatric Geriatric Care Units provide care to geriatric patients, 65 years of age or older, admitted for diagnosis as well as treatment to private psychiatric hospitals on the basis of physicians' orders and approved nursing care plans. The units are staff with nursing personnel specially trained to care for the mentally ill, mentally disordered, or other mentally incompetent persons. Addition activities include, but are not limited to the following:

Serving and feeding of patients; collecting of sputum, urine, and feces samples; monitoring of vital life signs operating of specialized equipment related to this function; preparing equipment and assisting physicians during patient examination and treatment; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medication; infusing fluids including I.V.'s and blood; answering of patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to geriatric Psychiatric patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days for all patients admitted to this unit unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D - Line D73

6250 OBSTETRICS ACUTE

Function

Obstetrics Acute Care Units provide care to the mother following delivery on the basis of physicians' orders and approved nursing care plans is provided in the Obstetrics Acute Care Unit. Additional activities include, but are not limited, to the following:

Instruction of mothers in postnatal care and care of newborn; serving and feeding of patients; collecting of sputurn, urine and feces samples; monitoring vital life signs; operating specialized equipment related to this function; preparing equipment and assist physicians in changing of dressings and cleansing of wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medication; infusing fluids including I.V.'s and blood; answering of patients' call signals; keeping patients' rooms (personal effects) in order.

Description

The cost center contains the direct expenses incurred in providing daily bedside care to Obstetric patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for all patients admitted to this unit. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day. **A maternity patient in the Labor/Delivery ancillary area at the daily census may not be included in the census count of the Obstetrics Acute Care or other routine care unit unless the patient has occupied an inpatient routine bed at some time since admission. Absent extenuating circumstances, maternity patients are not admitted to this unit prior to delivery.**

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D - Line D4

6260 PSYCHIATRIC ADOLESCENT NEUROPSYCHIATRY- SPECIALTY HOSPITALS

Function

Psychiatric Adolescent Neuropsychiatry Unit provide care to adolescent patients who are dual diagnosed; i.e., are diagnosed as mentally retarded/developmentally disabled and are also diagnosed with a psychiatric disorder. The units are staffed with nursing personnel specially trained to care for dual diagnosed patients. Additional activities include, but are not limited to the following:

Serving and feeding of patients; collecting of sputum, urine, and feces samples; monitoring of vital life signs; operating of specialized equipment related to this function; preparing equipment and assisting physicians during patient examination and treatment; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medication; infusing fluids including I.V.'s and blood; answering of patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to child or adolescent Psychiatric patients who are mentally retarded/developmentally disabled in addition to being diagnosed with a psychiatric disorder. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days for all patients admitted to this unit unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D - Line D52

6280 DEFINITIVE OBSERVATION

Function

Definitive Observation is the delivery of care to patients requiring care more intensive than that provided in the acute care areas, yet not sufficiently intensive to require admission to an intensive care area. Patients admitted to this cost center are generally transferred there from an intensive care unit after their condition has improved.

The unit is staffed with specially trained nursing personnel and contains monitoring and observation equipment for intensified, comprehensive observation and care. Additional activities include, but are not limited to the following:

Serving and feeding of patients; collecting of sputum, urine and feces samples; monitoring of vital life signs operating specialized equipment and assisting physicians during patient examination and treatment; changing dressing and cleansing wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reactions to drugs; administering specified medication; infusing fluids including I.V.'s and blood; answering of patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to Definitive Observation patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for all patients admitted to this unit unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occurs on the same day, the day is considered as a day of admission and counts as one patient day.

Data Source

The number of days shall be taken from daily census counts.

Reporting Schedule

Schedule D - Line D5

6310 MEDICAL/SURGICAL INTENSIVE CARE

Function

A Medical/Surgical Intensive Care Unit provides patient care of a more intensive nature than that provided to the Medical and Surgical Acute patients. The unit is staffed with specially trained nursing personnel and contains monitoring and specialized support equipment for patients who, because of shock, trauma, or threatening conditions, require intensified comprehensive observation and care. Additional activities include, but are not limited to, the following:

Serving and feeding of patients: collecting of sputum, urine and feces samples; monitoring of vital life signs; operating of specialized equipment related to this function; preparing of equipment and assisting of physicians during patient examination and treatment; changing of dressings and cleansing of wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medication; infusing fluids including IVs and blood; answering of patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing intensive daily bedside care to Medical/Surgical Intensive Care patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs, if done in-house) on principal equipment; other direct expenses and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for all patients admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occurs on the same day, the day is considered as a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D - Line D6

6330		CORONARY CARE
	6331	Myocardial Infarction
	6332	Pulmonary Care
	6333	Heart Transplant
	6339	Other Coronary Care

Function

The delivery of care of a more specialized nature than that provided to the usual Medical, Surgical, and Pediatric patient is provided in the Coronary Care Unit. The unit is staffed with specially trained nursing personnel and contains, monitoring and specialized support or treatment equipment for patients who, because of heart seizure, open heart surgery or threatening conditions require intensified, comprehensive observation and care. Additional activities include, but are not limited to, the following:

> Serving and feeding of patients; collecting of sputum, urine and feces samples; monitoring of vital life signs; operating of specialized equipment related to this function; preparing of equipment and assisting of physicians during patient examination and treatment; changing of dressings and cleansing of wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medications; infusing fluids including IVs and blood; answering patients' call signals; keeping patients rooms (personal effects) in order.

Description

These cost centers contain the direct expenses incurred in providing intensive daily bedside care to Coronary Care patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs, if done in-house) on principal equipment other direct expenses and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for all patients admitted to each of these units, unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occurs on the same day, the day is considered as a day of admission and counts as one patient day.

Data Source

The Number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D - Line D7

6350 PEDIATRIC INTENSIVE CARE

Function

A Pediatric intensive care unit provides care to children less than 14 years of age of a more intensive nature than the usual Pediatric Acute level. The units are staffed with specially trained personnel and contain monitoring and specialized support equipment for patients who, because of shock, trauma, or threatening conditions, require intensified, comprehensive observation and care. Additional activities include, but are not limited to, the following:

> Serving and feed of patients; collecting of sputum, urine and feces samples; monitoring of vital life signs; operating of specialized equipment related to this function; preparing of equipment and assisting of physicians during patient examination and treatment; changing of dressings and cleansing of wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medication; infusing fluids including IVs and blood; answering patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to Pediatric Intensive Care patients. Included in these direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, maintenance costs (maintenance contracts or bio-medical engineers, if done in-house) on principal equipment, other direct expenses and transfers.

Standard Unit of Measure: Number of Patients Days

Report patient days of care for all patients admitted to this unit unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occurs on the same day, the day is considered as a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D - Line D8

6370 NEO-NATAL INTENSIVE CARE

Function

A Neo-Natal Intensive Care Unit provides care to newborn infants that are of a more intensive nature than care provided in newborn acute units. Care is provided on the basis of physicians' orders and approved nursing care plans. The units are staffed with specially trained nursing personnel and contain specialized support equipment for treatment of those newborn infants who require intensified, comprehensive observation and care. Additional activities include, but are not limited to the following:

Feeding infants; collecting sputum, urine and feces samples; monitoring vital life signs; operating specialized equipment needed for this function; preparing equipment and assisting physicians during infant examination and treatment; changing dressings or assisting physicians in changing dressings and cleansing wounds and incisions; bathing infants, observing patients for reaction to drugs; and administering specified medication; infusing fluids including IV's and blood.

Description

This cost center contains the direct expenses incurred in providing intensive daily bedside care to Neo-Natal Intensive Care patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, maintenance costs (maintenance contracts or bio-medical engineers, if done in-house) on principal equipment, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for all patients admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D - Line D9

6380 BURN CARE

Function

A Burn Care Unit provides care to severely burned patients that are of a more intensive nature than the usual acute nursing care provided in medical and surgical units. Burn units are staffed with specially trained nursing personnel and contain specialized support equipment for burn patients who require intensified, comprehensive observation and care. Additional activities include, but are not limited to:

Serving and feeding of patients: collecting sputum, urine and feces samples; monitoring vital life signs; operating specialized equipment needed for this function: preparing equipment and assisting physicians during patient examination and treatment; changing dressings and cleansing wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping them into and out of bed; observing patients for reactions to drugs; administering specified medication; infusing fluids including I.V.'s and blood; answering patients' call signals; and keeping patients' room in order.

Description

This cost center contains the direct expenses incurred in providing intensive daily bedside care to Burn Care Patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for all patients admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D - Line D10

6390 PSYCHIATRIC INTENSIVE CARE - SPECIALTY HOSPITALS

Function

Psychiatric Intensive Care Units provide care to psychiatric patients which are of a more intensive nature than the usual nursing care provided in routine patient care units in private psychiatric hospitals. The units are staffed with specially trained nursing personnel and contain monitoring and specialized support equipment for patients who, because of shock, trauma, or threatening conditions, require intensified, comprehensive observation and care. Additional activities include, but are not limited to, the following:

Serving and feeding of patients; collecting of sputum, urine and feces samples; monitoring of vital life signs; operating of specialized equipment and assisting physicians during patient examination and treatment; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medication; infusing fluids including I.V.'s and blood; answering patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to Psychiatric Intensive Care patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for all patients admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D - Line D11

6410 OTHER INTENSIVE CARE
6411 Shock Trauma
6412 Oncology

Function

Other Intensive Care Units provide patient care of a more intensive nature than that to the Medical and Surgical Acute patients. The unit is staffed with specially trained nursing personnel and contains monitoring and specialized support equipment for patients who require intensified comprehensive observation and care. Included are those units not required to be included in other specific intensive care cost centers. The Shock Trauma Unit and Oncology Unit as University of Maryland Hospital and the Oncology unit at the Johns Hopkins Hospital are included in this account. Additional activities include, but are not limited to the following:

Serving and feeding of patients: collecting sputum, urine and feces samples; monitoring vital life signs; operating specialized equipment and assisting physicians during patient examinations and treatment; changing dressings and cleansing wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients for reaction to drugs; administering specified medication; infusing fluids including I.V.'s and blood; answering patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing intensive daily bedside care to Other Intensive Care patients in those units not required to be included in other specific Intensive Care cost centers. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for all patients admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D - Line D12 or Line D13

6510 NEWBORN NURSERY

Function

Daily care for newborn infants (including "Boarder" babies) is provided in Newborn Nursery Units on the basis of physicians' orders and approved nursing care plans. Additional activities include, but are not limited to, the following:

Feeding infants; collecting sputum, urine and feces samples; monitoring vital life signs; operation of specialized equipment related to this function; preparation of equipment and assistance of physician during infant examination and treatment; changing or assisting physician in changing of dressing and cleansing of wounds and incisions; bathing infants; observing patients for reaction to drugs; administering specified medication; infusing fluids, including I.V.’s and blood.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to Newborn Nursery patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Newborn Patient Days

Report patient days of care for all infant patients (including "boarder" babies) admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one newborn patient day.

Data Source

The number of newborn nursery patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D - Line D14

6520 PREMATURE NURSERY

Function

Daily care for premature infants [infants born at any time through the 37th week of gestation (259 days)] is provided in these nursery units on the basis of physicians' orders and approved nursing care plans. Additional activities include, but are not limited to the following:

Feeding infants; collecting sputum, urine and feces samples: monitoring vital life signs; operating specialized equipment needed for this function; preparing equipment and assisting physicians during infant examination and treatment; changing dressings or assisting physicians in changing dressings and cleansing wounds and incisions; bathing infants; observing patients for reactions to drugs; administering specified medication; infusing fluids, including I.V.'s and blood.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to Premature Nursery patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Newborn Patient Days

Report patient days of care for all infant patients admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one newborn patient day.

Data Source

The number of newborn patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D - Line D15

6610 SKILLED NURSING CARE
6611 Medicare-Certified
6612 Medicare-Non-Certified

Function

Skilled Nursing Care is provided to patients on the basis of physicians' orders and approved nursing care plans and consists of care in which the patients require convalescent and/or restorative services at a level less intensive than the Medical, Surgical and Pediatric acute care requirements. This center is sometimes referred to as Extended Care. Additional activities include but are not limited to, the following:

Serving and feeding of patients; collecting of sputum. urine, and feces samples; monitoring of vital life signs; operating of specialized equipment and assisting physicians during patients' examinations and treatment; changing of dressings and cleaning of wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medication; answering of patients' call signals; keeping patients' room (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to patients requiring extended skilled nursing care usually lasting 30 days or more. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for patients admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge of death. If both admission, and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule UR4

6620 REHABILITATION

Function

The Rehabilitation unit provides care to physically disabled persons requiring coordinated, comprehensive services to enable them to achieve functional goals. Rehabilitation is provided through an integrated program of medical and other services under professional supervision. Additional activities may include but are not limited to, the following:

> Serving and feeding of patients; collecting of sputum, urine, and feces samples; monitoring of vital life signs; operating of specialized equipment and assisting physicians during patients' examinations and treatment; changing of dressings and cleaning wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medication: answering of patients' call signals; keeping patients' room (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to patients requiring physical rehabilitation services. Included as direct expenses are: salaries and wage, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for patients admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission, and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D - Line D54

6630 PSYCHIATRIC LONG TERM CARE

Function

Medical care nursing services and intensive supervision of chronic mentally ill, mentally disordered, or other mentally incompetent persons is rendered in the Psychiatric Long Term Care Unit.

Description

This cost center contains the direct expenses incurred in providing daily care to Psychiatric Long Term patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees. (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for all patients admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Not Applicable

6640 CHRONIC CARE

Function

Chronic care is the delivery of care to patients requiring constant medical and nursing care by reason of chronic illness or infirmity: or patients who have a chronic disability amenable to rehabilitation. Patients admitted to this unit require close monitoring and observation and continued skilled nursing services. The condition of patients admitted to this unit necessitates care too complex to be provided in a skilled Nursing Facility.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to chronic patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for patients admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission, and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D - Line D17

6650 RESIDENTIAL CARE

Function

Residential Care is the provision of safe, hygienic, sheltered living for residents not capable of fully independent living. Regular and frequent, but not continuous, medical and nursing services are provided. Also included is self care. Self-care units provide supportive, restorative, and preventive health care for ambulatory patients who are capable of caring for themselves under the supervision of a professional nurse. The unit is used by recovering patients who are making the transition to discharge or by patients who are undergoing tests and medical evaluation who require a minimal amount of nursing supervision. These patients generally eat in a central dining facility and do not require bedside nursing care.

Description

This cost center contains the direct expense incurred in providing residential care to patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for all patients admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Not Applicable

AMBULATORY SERVICE EXPENSES .076

6710 EMERGENCY SERVICES
6711 Emergency Room
6719 Other Emergency Services

Function

Emergency Services provide emergency services to the ill and injured who require immediate medical or surgical care on an unscheduled basis. (See Appendix D for definition of services)

Description

This cost center contains the direct expenses incurred in providing services in the Emergency Department. Direct expenses included are: salaries and wages, employee benefits, professional fees (non-physician), non-medical supplies, purchased services, other direct expenses.

Standard Unit of Measure: Number of Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (See Appendix D of this manual)

Data Source

The number of Relative Value Units shall be the actual count maintained by Emergency Services.

Reporting Schedule

Schedule D - Line D18

DELETED

6720 CLINIC SERVICES

Function

Clinics provide organized diagnostic, preventive, curative, rehabilitative, and educational services on a scheduled basis to ambulatory patients. Additional activities include, but are not limited to the following:

Participating in community activities designed to promote health education; assisting in administration of physical examinations and diagnosing and treating ambulatory patients having illness which respond quickly to treatment; referring patients who require prolonged or specialized care to appropriate other services; assigning patients to doctors in accordance with clinic rules; assisting and guiding volunteers in their duties; making patients' appointments through required professional service functions.

Description

The cost centers contain the direct expenses incurred in providing clinic services to ambulatory patients. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical-surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Relative Value Units

Clinic Relative Value Units as developed by the Health Services Cost Review Commission. A count of visits must also be maintained and reported on Schedule V2. Visits made by clinic patients to ancillary cost centers are not included here but are accumulated in the appropriate ancillary cost center.

Data Source

The number of Relative Value Units shall be the actual count maintained by the formally organized clinic within the hospital.

Reporting Schedule

Schedule D - Line D19

6750 OBSERVATION

FUNCTION

Observation services are those services furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, which are reasonable and necessary to determine the need for a possible admission to the hospital as an inpatient. Such services must be ordered and documented in writing as to time and method (FAX, telephone, etc.), given by a medical staff practitioner. Observation services may or may not be provided in a distinct area of the hospital. Notwithstanding the location of the service, all expenses, revenue, statistics, and price compliance must be included in the reporting of the Observation center. Extended recovery time for scheduled ambulatory surgery patients should be included in the reporting of the Same Day Surgery center. Additional activities include, but are not limited to the following:

Monitoring of vital life signs; collecting sputum, urine, and feces; operating of specialized equipment and assisting physicians during patient examination and treatment; changing of dressings and cleaning of wounds and incisions; observing and recording the emotional stability of patients; observing patients for reaction to drugs; administrating specified medication; and infusing fluids including I.V.s and blood.

Description

This cost center contains the direct expenses incurred in providing bedside care to observation patients. Included as direct expenses are: salaries and wages, employee benefits, non-physician professional fees, non-medical/surgical supplies, purchased services, and other direct expenses and transfers.

Standard Unit of Measure: Hours

Report the number of hours commencing at the time a valid order for observation is made and ending when a valid order to cease observation is made. This service usually does not exceed one day. Some patients may, however, require a second day of observation services. Only in rare and exceptional circumstances should reasonable and necessary observation services span more than 48 hours. The minimum observation time is one hour; any partial hours are rounded to the nearest full hour.

Data Source

The number of hours shall be the total of the actual count of clock hours of observation services provided.

Reporting Schedule

Schedule D - Line D55

6800 AMBULANCE SERVICES-REBUNDLED

Function

This cost center provides round-trip ambulance services for hospital inpatients from the hospital to the facility of a third party provider of non-physician diagnostic or therapeutic services. An ambulance is defined as a vehicle that is specifically designed for transporting patients; contains a stretcher, linens, first aid supplies, oxygen equipment and other lifesaving equipment required by State or local laws; and is staffed with personnel trained to provide first aid treatment.

Lifting and placing patient into and out of an ambulance; transporting patients to and from the third party provider.

Description

The cost center contains the direct expenses incurred in providing roundtrip ambulance service to inpatients. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased service, other direct expenses, and transfers.

Standard Unit of Measure: Number of Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of Relative Value Units shall be the actual count maintained by Ambulance Services Cost Center.

Reporting Schedule

Schedule D - Line D56

CHART OF ACCOUNTS

6940 PSYCHIATRIC DAY AND NIGHT CARE SERVICES

Function

The Psychiatric Day and Night Care Services provides intermittent care to patients either during the day with the patient returning to his home each night or during the evening and night hours with the patient performing his usual daytime functions.

Description

This cost center contains all the direct expenses of maintaining Psychiatric Day and Night Care Services. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Visits

A visit is each registration of a patient in a formally organized Psychiatric Day and Night Care unit of the hospital. Multiple services performed in the Psychiatric Day and Night Care unit during a single registration, e.g., (encounters with two or more physicians, two or more occasions of services, any combination of one or more encounters and occasions of service) are recorded as one visit.

Data Source

The number of visits shall be the actual count maintained by the Psychiatric Day and Night Care Services Unit.

Reporting Schedule

Schedule D - Line D20

6960 FREE STANDING EMERGENCY SERVICES

Free Standing Emergency Services provide emergency treatment to the ill and injured who require immediate medical or surgical care on an unscheduled basis at locations other than hospital. Additional activities include, but are not limited to the following:

Comforting patients; maintaining aseptic conditions; assisting physicians in performance of emergency care; monitoring of vital life signs; applying or assisting physician in applying bandages; coordinating the scheduling of patient through required professional service functions; administering specified medications; and infusing fluids, including I.V.'s and blood.

Description

This cost center contains the direct expenses incurred in providing emergency treatment to the ill and injured. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Visits

A visit is each registration of a patient in the free standing emergency service unit. Multiple services performed in the free standing emergency services unit during a single registration, e.g., (encounters with two or more physicians, two or more occasions of service, any combination of one or more encounters and occasions of service) are recorded as one visit. Services provided to emergency patients in ancillary cost centers are not included here, but are included in the applicable ancillary cost center.

Data Source

The number of visits shall be the actual count maintained by the Free Standing Emergency Service.

Reporting Schedule

Schedule D - Line D50

6970 FREE STANDING CLINIC SERVICES

Function

Free Standing Clinics provide organized diagnostic, preventive, curative, rehabilitative and educational services on a scheduled basis to ambulatory patients at locations other than the hospital campus. Additional activities include, but are not limited to, the following:

Participating in community neighborhood activities designed to promote health education, assisting in administration of physical examinations and diagnosing and treating ambulatory patients having illness which respond quickly to treatment; referring to appropriate other services; assigning patients to doctors in accordance with clinic rules; assisting and guiding volunteers in their duties; making patients appointments through required professional service functions.

Description

This cost center contains the direct expenses incurred in providing clinic services to ambulatory patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), other expenses and transfers.

Standard Unit of Measure: Number of Visits

A visit is each registration of a patient in a free standing clinic of the hospital. Multiple services performed in a free standing clinic during a single registration, e.g., (encounters with two or more physicians, two or more occasions of service, any combination of one or more encounters and occasions of service) are recorded as one visit.

Data Source

The number of visits shall be taken from the actual count maintained by the free standing clinics.

Reporting Schedule

Schedule UR1

7060 SAME DAY SURGERY SERVICES

Function

Same Day Surgery Services are provided by specially trained personnel preceding and immediately following same day surgery including monitoring of patients while recovering from anesthesia. Patients requiring more than six hours of recovery time as a result of a major diagnostic procedure are also considered Same Day Surgery patients. Additional services include, but are not limited to the following:

Registering same day surgery patients. Comforting same day surgery patients in the recovery room and maintaining aseptic techniques, monitoring vital life signs, operating specialized equipment related to this function; administering specified medication, observing patient's condition until all effects of the anesthesia have passed; preparing patients for their release.

Description

This cost center contains the direct expenses incurred in registering patients, preparing patients for surgery or major diagnostic procedures and monitoring of patients while recovering from anesthesia. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, and other direct expenses.

Standard Unit of Measure: Number of Same Day Surgery Patients

A Same Day Surgery patient is defined as a surgical patient who is registered for same day surgery, or a patient who is registered for a major diagnostic procedure who requires, due to the effect of the procedure, more than six hours of recovery time, and who is not subsequently admitted to the hospital.

Data Source

The number of same day surgery patients shall be an actual count maintained by the Same Day Surgery cost center.

Reporting Schedule

Schedule D - Line D22

6980 HOME HEALTH SERVICES

Function

Home Health Services is the provision of care to patient normally at their place of residence. Activities such as the following functions may be performed for patients outside the hospital; nursing care, intravenous therapy, respiratory therapy, electrocardiology, physical therapy, occupational therapy, recreational therapy, speech pathology, social service, dietary, and housekeeping.

Description

This cost center contains the direct expenses incurred in providing care to patients normally at their place of residence. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, travel to and from the patients residence, other direct expenses, and transfers.

Standard Unit of Measure: Number of Resident Visits

A home health visit is a personal contract in the place of residence of a patient made for the purpose of providing a service by a member of the staff of the home health agency or by others under contract or arrangement with the home health agency. If a visit is made simultaneously by two or more persons from the home health agency to provide a single service, for which one person supervises or instructs the other, it is counted as one visit (see Example 1). If one person visits the patient s home more than once during a day to provide services, each visit is recorded as a separate visit (see Example 2). If a visit is made by two or more persons from the home health agency for the purpose of providing separate and distinct types of services, each is recorded - i.e., two or more visits (see Example 3). Example 1 - If an occupational therapist and an occupational therapy assistant visit the patient together to provide therapy and the therapist is there to supervise the assistant, one visit is counted. Example 2 - If a nurse visits the patient in the morning to dress a wound and later must return to replace a catheter, two visits are counted. However, if the nurse visits the patient in the morning to dress a wound and replace a catheter, one visit is counted. Example 3 - If the therapist visits the patient for treatment in the morning and the patient is later visited by the assistant for additional treatment, two visits are counted.

Data Source

The number of resident visits shall be the actual count obtained from Home Health Services.

Reporting Schedule

Schedule UR2

ANCILLARY SERVICES EXPENSES .077

7010 LABOR AND DELIVERY SERVICES

Function

Labor and Delivery services are provided by specially trained personnel to patients in Labor and Delivery, including prenatal care in labor and delivery, including prenatal care in labor assistance in delivery, post-natal care in recovery, and minor gynecological procedures, if performed in the Delivery suite. Additional activities include, but are not limited to, the following:

Comforting patients in the labor and delivery and recovery rooms; maintaining aseptic techniques; preparing for deliveries and surgery; cleaning up after deliveries to the extent of preparation for pickup and disposal of used linen, gloves, instruments, utensils, equipment, and waste; arranging sterile setup for deliveries and surgery; preparing patient for transportation to delivery and recovery room; enforcing safety rules and standards; monitoring of patients while in recovery.

Description

The cost center contains the direct expenses incurred in providing care to maternity patients in labor, delivery, and recovery rooms. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Relative Value Units

~~Maryland~~ Relative Value Units as determined by the Health Services Cost Review Commission (See Appendix D of this manual). Relative value units for unlisted procedures cannot be estimated and reported to the Commission.

Data Source

The number of Relative Value Units shall be an actual count obtained from medical records, or as maintained by the Labor and Deliver unit.

Reporting Schedule

Schedule D - Line D23

7040 OPERATING ROOM
- 7041 General Surgery
- 7042 Open Heart Surgery
- 7043 Neurosurgery
- 7044 Orthopedic Surgery
- 7045 Kidney Transplant
- 7046 Other Organ Transplants
- 7047 Recovery Room
- 7049 Other Operating Room Services

Function

Surgical Services are provided to inpatients, and outpatients, if the hospital uses a common operating room for both inpatients and outpatients by physicians and specially trained nursing personnel who assist physicians in the performance of surgical and related procedures during and immediately following surgery. Additional activities include, but are not limited to the following:

Comforting patients in the operating room and recovery room; maintaining aseptic techniques; scheduling operations in conjunction with surgeons, assisting surgeon during operations; preparing for operations; cleaning up after operations to the extent of preparation for pickup and disposal of used linen, gloves, instruments utensils, equipment and waste; assisting in preparing patients for surgery; inspecting, testing and maintaining special equipment related to this function; preparing patients for transportation to recovery room; counting of sponges, needles and instruments used during operation; enforcing safety rules and standards; monitoring of vital life signs; observing patient's condition until all effects of the anesthesia have passed; preparing patient for transportation to acute care or intensive care units.

Description

These cost centers contain the direct expenses incurred in providing surgical services to patients and monitoring of patients while recovering from anesthesia. When a common operating room is used for both inpatients and outpatients, the direct costs for both is to remain in this cost center. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased supplies, maintenance costs (maintenance contracts or bio-medical engineers, if done in-house) on principal equipment, other direct expenses and transfers.

Standard Unit of Measure: Number of Surgery Minutes

Surgery minutes are the difference between starting time and ending time defined as follows: Starting time is the beginning of anesthesia administered in the operating room or the beginning of surgery if anesthesia is not administered or if anesthesia is administered in other than the operating room. Ending time is the end of the anesthesia or surgery if anesthesia is not administered. The time the anesthesiologist spends with the patient in the recovery room is not to be counted.

Data Source

The number of surgery minutes shall be an actual count obtained from the operating room log.

Reporting Schedule

Schedule D - Line D24

7050 AMBULATORY SURGERY SERVICES

Function

Ambulatory Surgery Services are those surgical services provided to outpatients in a discrete outpatient surgical suite by specially trained nursing personnel who assist physicians in the performance of surgical and related procedures both during and immediately following surgery. Additional activities include, but are not limited to, the following:

Comforting patients in the operating room; maintaining aseptic techniques; scheduling operations in conjunction with surgeons; assisting surgeon during operations; preparing for operations; cleaning up after operations to the extent of preparation for pickup and disposal of used linen, gloves, instruments, utensils equipment, and waste; arranging sterile setup for operation; assisting in preparing patient for surgery; inspecting, testing and maintaining special equipment related to this function; preparing patient for transportation to recovery room; continuing sponges, needles, and instruments used during operation; enforcing safety rules and standards; monitoring patient while recovering from anesthesia.

Description

This cost center contains the direct expenses associated with a separately identifiable outpatient surgery room. When a common operating room is used for both inpatients and outpatients, the direct costs for both must be accumulated in the "Operating Room" (Account 7040). Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Surgery Minutes

Surgery minutes are the difference between starting time and ending time defined as follows: The starting time is the beginning of anesthesia administered in the operating room or the beginning of surgery if anesthesia is not administered or if anesthesia is administered in other than the operating room. Ending time is the end of anesthesia or surgery if anesthesia is not administered. The time the anesthesiologist spends with the patient in the recovery room is not to be counted.

Data Source

The number of surgery minutes shall be an actual count obtained form the surgery room operating log.

Reporting Schedule

Schedule D - Line D47

DELETED

7070 OPERATING ROOM – CLINIC

Function

Surgical services are provided to clinic patients in operating and procedure rooms by physicians assisted by specially trained nursing personnel. Additional activities include, but are not limited to the following:

Comforting patients in the operating or procedure room immediately following surgery; preparing for operations and maintaining aseptic techniques; assisting surgeon during operations; cleaning up after operations; enforcing safety rules and standards; monitoring of vital life signs; and observing patient's condition until all effects of anesthesia have passed.

Description

The cost center contains the direct expenses incurred in-providing surgical services to clinic patients and monitoring of patients while recovering from anesthesia. Included as direct expenses are: non-physician salaries and wages, employee benefits, and professional fees, non-medical surgical supplies, purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Surgery Minutes

Surgery minutes is the difference between starting and ending time defined as follows: The starting time is the beginning of anesthesia administered in the operating or procedure room or the beginning of surgery if anesthesia is not administered or if anesthesia is administered in other that the operating or procedure room. Ending time is the end of anesthesia or surgery if anesthesia is not administered. The time the anesthesiologist spends with the patient outside of the operating or procedure room is not counted.

Data Source

The number of surgery minutes shall be the actual count maintained by the either the operating room log or the appropriate clinic personnel.

Reporting Schedule

Schedule D - Line D 24-A

7080 ANESTHESIOLOGY

Function

Anesthesia services are rendered in the hospital by, or under the direction of, either a physician trained in anesthesia or the operating surgeon.

Description

This cost center contains the direct costs incurred in the administering of anesthesia exclusive of the costs of professional services of physicians and/or certified nurse anesthetists and the appropriate physician supervision. Included as direct expenses are: salaries and wages, employee benefits, professional fees (other than physicians and certified nurse anesthetists), supplies, oxygen, gases, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Anesthesia Minutes

Anesthesia minutes are defined as the difference between starting time and ending time defined as follows: Starting time is the beginning of anesthesia administered in the operating room. Ending time is the end of anesthesia. The time the anesthesiologist spends with the patient in the recovery room is not to be counted. When anesthesia is administered in Labor and Delivery, such anesthesia minutes shall be counted.

Data Source

The number of anesthesia minutes shall be an actual count maintained by the Anesthesiology cost center.

Reporting Schedule

Schedule D - Line D25

7090 CERTIFIED NURSE ANESTHETISTS

Function

Anesthesia services are rendered in the hospital by physician or certified nurse anesthetists under the direction of either a physician trained in anesthesia or the operating surgeon.

Description

This cost center contains salaries, wages and fringe benefits of the certified nurse anesthetists and the physician's supervision costs associated with the administering of anesthesia by certified nurse anesthetists.

Standard Unit of Measure:
Number of Certified Nurse Anesthetists Minutes

Certified Nurse Anesthetist minutes are defined as the difference between starting time and ending time defined as follows: Starting time is the beginning of anesthesia administered by a certified nurse anesthetist in the operating room. Ending time is the time of anesthesia. The time the nurse anesthetist spends with the patient in the recovery room is not to be counted. When anesthesia is administered by a certified nurse anesthetist in the Labor and Delivery Room such certified nurse anesthetist minutes shall be counted.

Data Source

The number of certified nurse anesthetists' minutes shall be an actual count maintained by the Anesthesiology cost center.

Reporting Schedule

Schedule UR 7

7110 MEDICAL SUPPLIES SOLD
7111 Medical Supplies-Billable
7112 Medical Supplies-Non-Billable

Description

The Medical Supplies Sold cost center is used for the accumulation of the invoice cost of all disposable medical and surgical supplies and equipment used in daily hospital service centers, ambulatory service centers and certain ancillary service centers (Labor and Delivery and Delivery Services, Account 7010, Operating Room, Account 7040, Ambulatory Surgery, Account 7050, Speech-Language Pathology, Account 7550 and Audiology, Account 7580 Interventional Radiology/Cardiovascular, Account 7310 and Physical Therapy, Account 7510). The invoice/inventory cost of non-chargeable disposable supplies and equipment issued by the Central Services and Supplies cost center (Account 8460) to patient care cost centers shall be maintained in this cost center. If such items are purchased by patient care cost center, the invoice cost of preparing and issuing medical and surgical supplies and equipment must be accumulated in the Central Services and Supplies cost center (Account 8460). The cost of reusable (non-disposable) medical and surgical supplies must be accounted for in the Central Services and Supplies cost center (Account 8460). The applicable portion of such overhead will be allocated to this cost center during the cost allocation process.

Standard Unit of Measure: Equivalent Inpatient Admissions (EIPA)

Gross Patient Revenue x Inpatient Admissions (excl. nursery)
Gross Inpatient Revenue

Data Source

Gross Patient Revenue and Gross Inpatient Revenue shall be obtained from the General Ledger. Inpatient Admissions shall be obtained from daily census counts.

Reporting Schedule

Schedule D - Line D26

7150 DRUGS SOLD

7151 Drugs-Billable
7152 Drugs-non-Billable

Description

The Drugs Sold cost center is used for the accumulation of the invoice cost of all pharmaceuticals and intravenous solutions used, excluding drugs incident radiology. The cost of drugs incident to radiology, i.e. contrast media etc are to be transferred to the using cost center. The invoice/inventory cost of non-chargeable drugs (pharmaceuticals and I.V. solutions) issued by the Pharmacy (Account 8470) to other cost centers shall be maintained in this cost center. If such items are purchased by the using cost centers, the cost of those items must be transferred to this cost center. The overhead cost of preparing and issuing drugs must be accumulated in the Pharmacy cost center (Account 8470). The applicable portion of such overhead will be allocated to this cost center during the cost allocation process.

Standard Unit of Measure: Equivalent Inpatient Admissions (EIPA)

Gross Patient Revenue x Inpatient Admissions (Excl. Nursery)
Gross Inpatient Revenue

Data Source

Gross Patient Revenue and Gross Inpatient Revenue shall be obtained from the general ledger. Inpatient Admissions shall be obtained from daily census counts.

Reporting Schedule

Schedule D - Line D27

7210 LABORATORY SERVICES-REGULATED

7211	Chemistry
7212	Hematology
7213	Immunology (Serology)
7214	Microbiology (Bacteriology)
7215	Procurement and Dispatch
7216	Urine and Feces
7219	Other Clinical Laboratories
7231	Cytology
7232	Histology
7233	Autopsy
7239	Other Pathological Laboratories
7251	Blood-Whole
7252	Blood-Plasma
7253	Blood-Other
7254	Blood Storing and Processing

Function

These cost centers perform diagnostic and routing clinical laboratory tests and diagnostic and routine laboratory tests on tissues and cultures necessary for the diagnosis and treatment of hospital patients. (That is, test on specimens drawn at the hospital.) Additional activities include, but are not limited to, the following:

Transporting specimens from nursing floors and operating rooms; drawing of blood samples; caring for laboratory animals and equipment; mortuary operation; autopsy; maintenance of quality control standards; preparation of samples for testing.

This cost center also procures and collects whole blood, recruits donors; processes, preserves stores and issues blood after it has been procured. Additional activities include, but are not limited to the following:

Plasma fractionation; freezing and thawing blood; and maintaining inventory control.

Description

These cost centers contain the direct expenses incurred in the performance of laboratory tests necessary for diagnosis and treatment of hospital patients and diagnostic; routine clinical laboratory tests on tissues and cultures; procuring blood; recruiting donors, processing, storing and issuing whole blood after it has been procured. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, maintenance costs (maintenance contracts. or bio-medical engineering costs if done in-house) on principal equipment, other direct expenses, and transfers.

This cost center also contains the direct expenses incurred in procuring and drawing blood, recruiting and paying donors; processing, storing and issuing whole blood after it has been procured. Included as direct expenses are: salaries and wages employee benefits, professional fees (non-physician), supplies,

purchased services, other direct expenses and transfers. Include in this cost center the cost of spoiled or defective blood; and the service fee charged by out-side blood sources, whether or not the blood is replaced. Do not include in this cost center the expenses incurred in performing tests on blood (i.e., typing, cross-matching, etc.). These expenses must be charged to Laboratory Services (Account 7210). Do not include in this amount the expenses incurred for blood derivatives. These expenses must be charged to pharmacy (Account 7150). The cost of blood (amount paid or fair market value) is charged to this center, or an inventory account if applicable rather than debited to revenue or cleared through an agency account. When blood is purchased, cost is the amount paid. When blood is donated, cost is its fair market value at the date of donation and an offsetting credit is made to Donated Blood (Account 5770). If replacement is received by a hospital blood bank, the original amount charged the patient is debited to this cost center and credited to the patient's account (Accounts and Notes Receivable - Account 1030). If replacement blood is received by the hospital from the supplier is debited to the amount due the supplier (Accounts Payable-Account 2020) and credited to the patient's account (Accounts and Notes Receivable-Account 1030).

Standard Unit of Measure: Number of Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of Relative Value Units shall be an actual count maintained by the laboratory.

Reporting Schedule

Schedule D - Line D28

7220 LABORATORY SERVICES - NON-PATIENT

Function

These cost centers perform diagnostic and routine clinical laboratory tests and diagnostic and routine laboratory tests on tissues and cultures necessary for the diagnosis and treatment of non-hospital patients. (That is, tests on specimens not drawn at the hospital.)

This cost center contains the direct expenses incurred in the performance of laboratory tests necessary for diagnosis and treatment and diagnostic and routine on tissues and cultures for non-hospital patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) or principal equipment, other direct expenses, and transfers.

Standard Unit of Measure: Number of Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of Relative Value Units shall be an actual count maintained by the laboratory.

Reporting Schedule

Schedule UR5

7290 ELECTROCARDIOGRAPHY

Function

This cost center operates specialized equipment to (1) Record graphically electromotive variations in actions of the heart muscle; (2) Record graphically the direction and magnitude of the electrical forces of the heart's action, (3) Record graphically the sounds of the heart for diagnostic purposes; (4) Imaging; (5) Cardioversion; and/or (6) Tilt Table. Additional activities include, but are not limited to, the following:

Explaining test procedures to patient; operating electrocardiograph equipment; inspecting, testing and maintaining special equipment; attaching and removing electrodes from patient; a patient may remove electrodes and remit recording data from home when appropriate.

This cost center contains the direct expenses incurred in performing electrocardiographic examinations, as well as up to six hours of recovery time. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers. Cost of contrast material is included in this cost center.

Standard Unit of Measure: Relative Value Units

Relative Value Units as determined by the Health Services Cost Revie Commission (see Appendix D of this manual).

Data Source

The number of Relative Value Units shall be an actual count maintained by the Electrocardiography cost center.

Reporting Schedule

Schedule D - Line D30

7310 INTERVENTIONAL RADIOLOGY/CARDIOVASCULAR

Function

The Interventional Radiology/Cardiovascular Department provides special diagnostic, therapeutic, and interventional procedures that include the use of imaging techniques to guide catheters and other devices through blood vessels and other pathways of the body.

Description

This cost center shall contain the direct expenses incurred in providing the above function as well as patient registration and up to six hours of recovery time. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), purchased services, maintenance cost (maintenance contracts or bio-medical engineering costs if don in-house) on principal equipment, other direct expenses and transfers. (Disposable D26, Medical Supplies Sold). Cost of contrast material is included in the minute value and should not be assigned separately.

Standard Unit of Measure

IRC minutes are the difference between starting time and ending time plus one minute for each technical Imaging service performed as defined by American Medical Association's (AMA) Current Procedural Terminology (CPT) (i.e. add and additional minute to the start and stop time for each radiology CPT. Start and ending times are defined as follows: Starting time is the beginning of the procedure if general anesthesia is on administered; or the beginning of general anesthesia or conscious sedation administered in the procedure room. Ending time is the removal of the needle or catheter if general anesthesia is not administered; or the end of general anesthesia. In instances where general anesthesia is administered the time the anesthesiologist spends with the patient following the end of the procedure is not to be counted. Sheath removal and hemostasis is considered part of recovery and is not to be counted. Average procedural times are permitted so long as they are validated annually.

Data Source

The number of IRC minutes shall be the actual count maintained by the Interventional Radiology/Cardiovascular Department.

Reporting Schedule

Schedule D - Line D31

7320 RADIOLOGY-DIAGNOSTIC
7322 Ultrasonography
7339 Radiology-Diagnostic-Other

Function

This cost center provides diagnostic radiology services as required for the examination and care of patients under the direction of a qualified radiologist. Diagnostic radiology services include the patient registration, taking, processing, examining and unofficial interpretation by a non-physician or other qualified medical staff of radiology services defined below, and up to six hours of recovery time. Radiology examinations for this Cost Center include general diagnostic radiology, ultrasound, fluoroscopy and mammography and excludes Computed Tomography, Magnetic Resonance Imaging (MRI and MRA), Radiation Therapy, Nuclear Medicine, and Interventional Radiology/Cardiovascular and Radiology procedures with a surgical component. Additional activities include, but are not limited to, the following:

Consultation with patients and attending physicians; radioactive waste disposal, storage of radioactive materials.

Description

This cost center contains the direct expenses incurred in providing diagnostic radiology services. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (including Drugs incident to Radiology, i.e. contrast media) etc. purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment, other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Radiology Relative Values issued by the Health Services Cost Review Commission. (See Appendix D of this manual.)

Data Source

The number of Relative Value Units shall be the actual count maintained by the Radiology-Diagnostic cost center.

Reporting Schedule

Schedule D - Line D32

7340 CT SCANNER

Function

The CT Scanner function uses computerized tomography imaging in order to diagnose abnormalities.

Description

This cost center shall contain the direct expenses incurred in providing CT scans, patient registration and up to six hours of recovery time. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, (including Drugs incident to Radiology, i.e. contrast media), purchased services, equipment, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of Relative Value Units shall be the actual count maintained by the CT Scanner cost center.

Reporting Schedule

Schedule D - Line D33

7350 MRI SCANNER

Function

The MRI Scanner function uses magnetic resonance imaging in order to diagnose abnormalities.

Description

This cost center shall contain the direct expenses incurred in providing MRI scans, patient registration and up to six hours of recovery time. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician) supplies, (including Drugs incident to Radiology, i.e. contrast media) etc., purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment, other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of Relative Value Units shall be the actual count maintained by the MRI Scanner cost center.

Reporting Schedule

Schedule D - Line D51

7355 LITHOTRIPSY

Function

The Lithotripsy (Extracorporeal Shock Wave Lithotripsy) function provided a non-invasive procedure by which renal and ureteral calculi are pulverized using electrohydraulic shockwaves.

Description

This cost center shall contain the direct expenses incurred in providing Lithotripsy services with up to six hours of recovery time. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment, other direct expenses and transfers.

Standard Unit of Measure: Number of Procedures

A procedure is defined as a treatment session. A treatment session may consist of 500 to 1500 shocks. Count only those procedures for which a charge is made.

Data Source

The number of procedures shall be the actual count maintained by the Lithotripsy cost center.

Reporting Schedule

Schedule D - Line D53

7360 RADIATION-THERAPEUTIC

Function

This cost center provides radiation therapy services as required for the care and treatment of patients under the direction of a qualified radiation oncologist. Therapeutic radiology services include consultation, patient education, physician planning, simulation, dosimetry planning, blocking and shaping, quality assurance, treatment delivery, image guidance, on-treatment assessment, and follow up. Therapeutic radiation may be delivered using a variety of radiation sources including external photon beams, external live radiation source, intracavitary live radiation source, implantable live radiation source, intraoperative radiation, and particle beam therapy. The most common radiation therapy modalities include but are not limited to 3-D conformal treatment ("3-D"), Intensity Modulated Radiation Therapy ("IMRT"), Image Guided Radiation Therapy ("IGRT"), Stereotactic Radiosurgery ("SRS"), Stereotactic Body Radiation Therapy ("SBRT"), brachytherapy, and intraoperative radiation therapy ("IORT"). Details and descriptions of radiation therapy services and terminology can be found on the websites of the Centers for Medicare and Medicaid Services, the National Cancer Institute, and the American Society for Radiation Oncology.

Description

This cost center includes the direct expenses incurred in providing therapeutic radiology services. Included in these direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment, facility costs, other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Therapeutic Radiology RVUs were assigned using the 2015 CMS Physician Fee Schedule, technical component or global RVUs. The RVU Assignment Protocol is detailed in Appendix D Standard Unit of Measure References, account number 7360.

Data Source

The number of RVUs shall be the actual count maintained by the Therapeutic Radiology cost center.

Reporting Schedule

Schedule D - Line D34

7365 TRANSURETHRAL MICROWAVE THERMOTHERAPY

Function

This cost center provides Transurethral Microwave Thermotherapy services as required for the care and treatment of patients under the direction of a qualified urologist.

Description

This cost center contains the direct expenses incurred in providing Transurethral Microwave Thermotherapy services. Included in these direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment, other direct expenses and transfers.

Standard Unit of Measure: Number of Procedures

Data Source

The number of procedures shall be the actual count maintained by the Transurethral Microwave Thermotherapy cost center.

Reporting Schedule

Schedule D - Line D57

7380	NUCLEAR MEDICINE
7381	NUCLEAR MEDICINE-DIAGNOSTIC
7382	NUCLEAR MEDICINE-THERAPEUTIC

Function

This cost center provides diagnosis and treatment by injectable or ingestible radioactive isotopes as required for the care and treatment of patients under the direction of a qualified physician. Additional activities include, but are not limited to, the following:

Consultation with patients and attending physician; radioactive waste disposal; storage of radioactive materials.

Description

This cost center contains the direct expenses incurred in providing nuclear medicine services to patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment, other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of Relative Value Units shall be the actual count maintained by the Nuclear Medicine Cost Center.

Reporting Schedule

Schedule D - Line D35

7420 RESPIRATORY THERAPY

Respiratory Therapy is the administration of oxygen and certain potent drugs through inflation of positive pressure and other forms of rehabilitative therapy as prescribed by physicians. This function is performed by specially trained personnel who initiate, monitor, and evaluate patient performance, cooperation and ability during testing procedures. Additional activities include, but are not limited, to the following:

> Assisting physician in performance of emergency care; reviving and maintaining patients' vital life signs; maintaining open airways, breathing and blood circulation; maintaining aseptic conditions; transporting equipment to patients' bedsides; observing and instructing patients during therapy; visiting all assigned patients to ensure that physicians' orders are being carried out; inspecting and testing equipment; enforcing safety rules; and calculating test results.

Description

This cost center contains the direct expenses incurred in the administration of oxygen and other forms of therapy through inhalation. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of Relative Value Units shall be the actual count maintained by the Respiratory Therapy cost center.

Reporting Schedule

Schedule D - Line D36

7440 PULMONARY FUNCTION TESTING

Function

This cost center tests patients through measurement of inhaled and exhaled gases and analysis of blood, and evaluation of the patient's ability to exchange oxygen and other gases. This function is performed by specially trained personnel who initiate, monitor and evaluate patient performance, cooperation, and ability during testing procedures.

Description

This cost center contains the direct expenses incurred in the performance of patient and laboratory testing necessary for diagnostic and treatment of pulmonary disorders. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of Relative Value Units shall be an actual count maintained by the Pulmonary Function Testing cost center.

Reporting Schedule

Schedule D - Line D37

7460 ELECTROENCEPHALOGRAPHY

Function

This cost center provides diagnostic electroencephalography services. Specialized equipment is used to record electromotive variations in brain waves and to record electrical potential variation for diagnosis of muscular and nervous disorders. Additional activities include, but are not limited to, the following:

Wheeling portable equipment to patient's bedside; explaining test procedures to patient; operating specialized equipment; attaching and removing electrodes from patients.

Description

This cost center contains the direct expenses incurred in providing diagnostic electroencephalography services to patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment, and other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Diagnostic Neurology Relative Values as determined by the Health Services Cost Review Commission (See Appendix D of this manual.)

Data Source

The number of Relative Value Units shall be the actual count maintained by the Electroencephalography cost center.

Reporting Schedule

Schedule D - Line D38

7510 PHYSICAL THERAPY

7511 Electromyography

Function

The Physical Therapy cost center provides physical or corrective treatment of bodily or mental conditions by the use of physical chemical and other properties of heat, light, water, electricity, sound, massage, therapeutic exercise under the direction of a physician and/or registered physical therapist. The physical therapist provides evaluation, treatment planning, instruction and consultation. Activities include, but are not limited to the following:

Application of manual and electrical muscle tests and other evaluative procedures; formulation and provision of therapeutic exercise and other treatment programs; organizing and conducting physical therapy programs upon physician referral or prescription: instructing and counseling patients, relatives, or other personnel; consultation with other health workers concerning a patient's total treatment program; assistance by aides to patients in preparing for treatment and performance of routine housekeeping activities of the physical therapy service.

Description

This cost center contains the direct expenses incurred in maintaining a physical therapy program. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers. Include the direct costs associated with electromyography for reporting purposes.

Standard Unit of Measure: Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission. (See Appendix D of this manual.) Relative Value Units for unlisted modalities or for procedures should be reasonably estimated on the basis of other comparable modalities or procedures.

Data Source

The number of Relative Value Units shall be the actual count maintained by the Physical Therapy cost center.

Reporting Schedule

Schedule D - Line D39

7530 OCCUPATIONAL THERAPY - ACUTE/GENERAL HOSPITALS

Function

Occupational Therapy is the supplication of purposeful, goal-oriented activity in the evaluation, diagnosis, and/or treatment of persons whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, or the aging process, in order to achieve optimum functioning, to prevent disability, and to maintain health. Specific occupational therapy services include, but are not limited to, education and training in activities of daily living (ADL); the design, fabrication, and the application of splints; sensorimotor activities; the use of specifically designed crafts; guidance in the selection and use of adaptive equipment; therapeutic activities enhanced functional performance; prevocational evaluation and training; and consultation concerning the adaptation of physical environments for the handicapped. These services are provided to individuals or groups.

Description

This cost center contains the direct expenses incurred in maintaining an occupational therapy program in acute/general hospitals. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of Relative Value Units shall be obtained from an actual count maintained by the Occupational Therapy cost center.

Reporting Schedule

Schedule D - Line D40

7550 SPEECH-LANGUAGE PATHOLOGY

Function

This cost center provides and coordinates services to persons with impaired communication skills. This includes the evaluation and management of any existing disorders of communication or underlying processes and/or musculature centering entirely or in the part on the reception and production of speech and language related to organic and/or non-organic factors. Professional services provided by this cost center are grouped into a minimum of three major areas: 1) Diagnostic Assessment and Evaluation - including clinical appraisal of speech (articulation, voice, fluency), deglutition, language competencies and underlying processes (speech perception, visual perception, motor skills, cognitive skills, memory, attention, etc.) through standardized and informal tests, and hearing screening, to determine the need for and types of habilitation or rehabilitation required; 2) Treatment - including planning and conducting treatment programs on an individual or group basis, to develop, restore, improve or augment functional skills of persons disabled in the processes of speech, deglutition, language and/or underlying processes; and 3) Continued Evaluation/Periodic Re-evaluation-including both standardized and informal procedures to monitor progress and verify current status. Such activities may be coordinated with medical evaluation and treatment of hospitalized patients. Additional activities may include, but are not limited to, the following: preparation of written diagnostic evaluative and special reports; provisions of extensive counseling and guidance to communicatively-handicapped individuals and their families; and maintaining specialized equipment utilized in evaluation and treatment such as assistive communication devices and speech prostheses. These functions shall be implemented or supervised by a licensed speech language pathologist.

Description

This cost center contains the direct expenses incurred in maintaining a Speech-Language Pathology Cost Center. Any expenses related to the sale of speech prostheses or other communication aids must not be included here, but accounted for in Medical Supplies Sold cost center. Included as direct expenses are the salaries and wages, employee benefits professional fees (non-physician), supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Speech-Language pathology Relative Value Units as determined by the Health Services Cost Review Commission (See Appendix D of this manual). Relative Value Units for unlisted services or procedures should be reasonably estimated on the basis of other comparable services or procedures; these not listed should be justified by individual report.

Data Source

The number of Relative Value Units shall be obtained from an actual count maintained by the Speech-Language Pathology cost center.

Reporting Schedule

Schedule D - Line D41

7570 RECREATIONAL THERAPY - ACUTE/GENERAL HOSPITALS

Function

Recreational Therapy services include the employment of sports, dramatics, arts and other recreational programs to stimulate the patient's recovery rate. Additional activities include, but are not limited to the following:

Conducting and organizing instrumental and vocal musical activities and directing activities of volunteers in respect to these functions.

Description

This cost center contains the direct expenses incurred in maintaining a program of recreational therapy in acute/general hospitals. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Treatments

Count each procedure for which a separate charge is made as one treatment.

Data Source

The number of treatments shall be obtained from an actual count maintained by the Recreational Therapy cost center.

Reporting Schedule

Schedule D - Line D42

7580 AUDIOLOGY

Function

This cost center provides and coordinates services to persons with impaired peripheral and/or central auditory function. This includes the assessment and management of any existing communication handicaps centering in whole or in part on hearing. Some of the activities of this cost center are: 1) audiologic assessment (including basic audiologic testing and screening, related speech and language screening, examination for site of lesion, non-organic hearing impairment and various parameters of auditory processing abilities essential for communication function); 2) hearing aid evaluation (including selection, orientation, adjustment, and dispensing other technical related services); and 3) audiologic habilitation and rehabilitation (including the development and/or remediation of related speech language abilities.) Such activities may be coordinated with medical evaluation and treatment of hospital patients. Additional activities may include, but are not limited to the following: evaluating, dispensing, and demonstrating Assistive Listening Devices and Systems; evaluating excessively noisy environments; writing special reports; providing extended counseling and guidance; inspecting, testing, and maintaining special equipment. These functions shall be implemented or supervised by a licensed audiologist.

Description

This cost center contains the direct expenses incurred in maintaining an Audiology cost center. The expense related to the sale of hearing aids must not be included here but accounted for in the Medical Supplies Sold cost center. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Audiology Relative Value Units as determined by the Health Services Cost Review Commission. (See Appendix D of this manual.) Relative Value Units for unlisted services or procedures should be reasonably estimated on the basis of other comparable services or procedures, those not listed should be justified by individual report.

Data Source

The number of Relative Value Units shall be obtained from an actual count maintained by the Audiology Cost Center.

Reporting Schedule

Schedule D - Line D43

7590 OTHER PHYSICAL MEDICINE

Function

Other Physical Medicine includes educational and therapeutic activities related to the treatment, habilitation and rehabilitation of patients with neuromuscular and musculoskeletal impairments. Such activities are those not required to be included in the Physical Therapy, Occupational Therapy, Speech Pathology, Recreational Therapy, and Audiology cost centers.

Description

This cost center contains the direct expenses incurred in providing physical medicine activities not specifically required to be included in another cost center. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of treatments

Count each procedure for which a separate charge is made as one treatment.

Data Source

The number of treatments shall be obtained from an actual count maintained by the Other Physical Medicine cost center.

Reporting Schedule

Schedule D - Line D44

7670 PSYCHIATRIC/PSYCHOLOGICAL SERVICES - SPECIALTY HOSPITALS

7671	Individual Therapy
7672	Group Therapy
7673	Family Therapy
7674	Education
7675	Psychological Testing
7676	Electroconvulsive Therapy
7677	Activity Therapy
7689	Other Psychiatric/Psychological Therapies

Function

This cost center provides psychiatric and psychological services such as individual, group and family therapy to adults, adolescents and families; education; psychological testing; and electroconvulsive therapy.

Description

This cost center contains the direct expenses incurred in providing psychiatric and psychological services. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Hours/Treatments

Count each hour for which the service is provided. For group sessions, count one half hour for each patient participating per hour treatment. For education count one hour per patient for each hour of education. For Electroconvulsive Therapy count treatments.

Data Source

The number of hours/treatments shall be obtained from an actual count maintained by this service.

Schedule D

Individual Therapy	Schedule D - Line D74
Group Therapy	Schedule D - Line D75
Family Therapy	Schedule D - Line D76
Education	Schedule D - Line D78
Psychological Testing	Schedule D - Line D77
Electroconvulsive Therapy	Schedule D - Line D80
Activity Therapy	Schedule D - Line D81
Other Therapies	Schedule D - Line D79

7710		RENAL DIALYSIS - INPATIENT
	7711	Hemodialysis
	7713	Peritoneal Dialysis
	7715	Patient Dialysis Training
	7719	Other Dialysis

Function

Renal Dialysis is the process of cleaning the blood by the use of an artificial kidney machine or other method. Additional activities include, but are not limited to, the following:

Wheeling portable equipment to patients' bedside; explaining procedures to patient; operating dialysis equipment, inspecting, testing and maintaining special equipment.

Description

This cost center contains the direct expenses incurred in the Inpatient Renal Dialysis cost center. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Treatments

Count each treatment for which separate charge is made as one treatment regardless of the length of treatment.

Data Source

The number of treatments shall be the total actual count maintained by the Renal Dialysis cost center.

Reporting Schedule

Schedule D - Line D45

7720		RENAL DIALYSIS - OUTPATIENT
	7721	Hemodialysis - Outpatient
	7723	Peritoneal Dialysis - Outpatient
	7725	Patient Dialysis Training
	7717	Home Dialysis
	7729	Other Dialysis - Outpatient

Function

Renal Dialysis is the process of cleaning the blood by the use of an artificial kidney machine or other method. Additional activities include, but are not limited to, the following:

Wheeling portable equipment to patients' bedside; explaining procedures to patient; operating dialysis equipment, inspecting, testing and maintaining special equipment.

Description

This cost center contains the direct expenses incurred in the Renal Dialysis cost center. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment, other direct expenses and transfers.

This cost center contains the direct expenses incurred in the Outpatient Renal Dialysis cost center. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Treatments

Count each treatment for which separate charge is made as one treatment regardless of the length of treatment.

Data Source

The number of treatments shall be the total actual count maintained by the Outpatient Renal Dialysis cost center.

Reporting Schedule

Schedule UR3

7730 ORGAN ACQUISITION

Function

This cost center accumulates the costs of acquisition, storage, and preservation of all solid organs and allogeneic stem cells. This cost center also collects all hospital and physician costs associated with: living donor and recipient pre-transplant outpatient services, and recipient and living donor inpatient medical evaluations.

Description

The Organ Acquisition cost center is used for the accumulation of the direct expenses incurred in acquiring, storing, and preserving human solid organs and allogeneic stem cells. The expenses include: organ harvesting costs, organ transportation, organ preservation, as well as the cost of all hospital and physician inpatient and outpatient services provided to live donors and recipients in anticipation of a transplant. Such expenses include: hospital costs (but not physicians' costs) associated with harvesting of organs and stem cells from live donors; physician and hospital costs associated with the excision of organs from cadavers; organ importation and transportation costs; organ preservation costs; transplant registry fees; laboratory tests (including tissue typing of receipts and donors); general medical evaluation of recipients and donors (including medical evaluation and management services provided by physicians in their offices); inpatient hospital and physician services associated with the medical evaluation of recipients before admission for transplantation; and the inpatient hospital and physician services associated with the medical evaluation of living donors before admission for harvesting of the organ or stem cells. (The salary, wages, and employee benefits of the transplant coordination staff are excluded)

The direct costs exclusively identified with a specific transplanted organ or stem cells will be allocated to that organ. Other direct costs not identified with a specific transplanted organ or stem cells shall be allocated appropriately to all transplanted organs by organ type. The approved hospital overhead and mark-up shall be allocated to all transplanted organs and stem cells to develop patient charges.

Standard Unit of Measure: Number of Organs Transplanted plus Number of Allogeneic Stem Cells Transplant Procedures

Count each organ transplanted as one and each allogeneic stem transplant procedure.

Data Source

The number of organs transplanted and allegeneic stem cell procedures will be the actual count maintained by the organ acquisition cost center.

Reporting Schedule

Schedule D - Line D46

7910 OTHER ANCILLARY SERVICES
7911 Leukopheresis
7912 Hyperbaric Chamber

Function

Other Ancillary Services includes services of Leukopheresis and Hyperbaric Chamber. A leukopheresis program is designed to extract blood derivatives from suitable donors for the treatment of various types of cancer. A Hyperbaric Chamber provides treatment for: gas gangrene, decompression sickness, chronic refractory osteomyelitis, soft tissue neurosis and osteomyelitis and compressed skin graft.

Description

This cost center contains the direct expenses incurred in the operation of a leukopheresis center and a hyperbaric chamber. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure:

Leukopheresis: Relative Value Units as established by the Health Services Cost Review Commission. (See Appendix D of this manual.)

Hyperbaric Chamber: Count each hour of patient treatment as one unit.

Data Source

The Relative Value Units for Leukopheresis shall be the count maintained by the Leukopheresis center. The hours of treatment for Hyperbaric Chamber shall be the count maintained by the Hyperbaric Chamber center.

Reporting Schedule

Leukopheresis: Schedule D - Line D48
Hyperbaric Chamber: Schedule D - Line D49

8010 RESEARCH

Function

This cost center administers, manages and carries on research projects funded by outside donations, grants and/or the hospital. Additional activities include:

Maintenance of animal house and administration of specific research projects.

Description

This cost center contains the direct expenses incurred in carrying on research in the hospital. Separate cost centers must be maintained for each research activity for which separate accounting is required, either by a grant agreement, contract, or because of restrictions made upon donations. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Research Projects

A research project is any project which was active during the fiscal year.

Data Source

The number of research projects shall be the actual count of active projects maintained by the Research or General Accounting cost center.

Reporting Schedule

Schedule F1

Education Expenses .0782

8220		NURSING EDUCATION
	8221	Registered Nurses
	8222	Licensed Vocational (Practical) Nurses

Function

Hospitals may either operate a School of Nursing or provide the clinical training activities for student nurses when the degree is issued by a college or university. Nursing Education is a school for educating Registered Nurses and/or Licensed Vocational (Practical) Nurses. Additional activities include, but are not limited to, the following:

> Selecting qualified nursing students; providing education in theory and practice conforming to approved standards; maintaining personnel records; counseling of students regarding professional, personal and educational problems; selecting faculty personnel; assigning and supervising students in giving nursing care to selected patients; and administering aptitude and other tests for counseling and selecting purposes.

Description

This cost center shall be used to record the direct expenses incurred in, or providing clinical facilities for, the education of Registered Nurses and/or Licensed Vocational (Practical) Nurses. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Nursing Students

The number of Nursing Students in the Nursing Education cost center is defined as the average number of students enrolled during the year.

Data Source

The average number of Nursing Students in this educational program shall be the actual count maintained by the Nursing Education cost center.

Reporting Schedule

Schedule F2

8240 POSTGRADUATE MEDICAL EDUCATION - TEACHING PROGRAM
8241 Approved Teaching Program
8242 Non-Approved Teaching Program

Function

A Postgraduate Medical Education Teaching Program provides an organized program of postgraduate medical clinical education to interns and residents. To be approved, a medical internship or residency training program must be approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association. To be approved, intern or residency programs in the field of dentistry in a hospital osteopathic hospital must have the approval of the council on Dental Education of the American Dental Association. Additional activities include, but are not limited to the following:

Selecting qualified students; providing education in theory and practice conforming to approved standards; maintaining student personnel records; counseling of students regarding professional, and educational problems; and assigning and supervising students.

Description

This cost center shall be used to record the direct expenses incurred in providing an approved organized program of postgraduate medical clinical education. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services. Other direct expenses and transfers. All salaries and stipends paid to interns and residents in approved and non-approved teaching programs must be reflected in this cost center, in the "Salaries and Wages" natural expense classification (.07).

Standard Unit of Measure: Number of FTE Students

The number of FTE students in Postgraduate Medical Education Program is defined as the sum of the actual individual contracted residents and interns multiplied by the percentage of the Base Year that the residents and interns worked at the hospital. Residents and interns are to be reported in two categories: eligible, all authorized interns and residents prior to the first year of their first general specialty board eligibility, up to a maximum of five years, and who are not able to practice their specialty and ineligible, residents after the first year of their first general specialty board eligibility, who can practice their specialty or have been out of medical school more than 5 years.

Data Source

The number of FTE students in the educational program shall be the actual count maintained by the program or general accounting.

Reporting Schedule

F3

8260		OTHER HEALTH PROFESSION EDUCATION
	8261	School of Medical Technology
	8262	School of X-Ray Technology
	8263	School of Respiratory Therapy
	8264	Administrative Intern Program
	8265	Medical Records Librarian

Function

Other Health Profession Education is the provision of organized programs of medical clinical education other than for nurses (RN and LVN) doctors, and the provision of organized education programs for administrative interns and externs, Medical Records Librarians and other health professionals. Additional activities include, but are not limited to, the following:

> Selecting qualified students; providing education in theory and practice conforming to approved standards; maintaining student personnel records; counseling of students regarding professional, personal and educational problems; selecting faculty personnel; assigning and supervising students in giving medical care to selected patients; and administering aptitude and other tests for counseling and selection purposes.

Description

These cost centers contain the direct expenses relative to operating health education programs other than nursing and postgraduate medical programs, such as a School of Medical Technology, and other non-in-service education programs such as those listed above. A separate cost center should be established for each program. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Students

The number of students in Other Health Profession Education Programs is defined as the average number of students enrolled during the year.

Data Source

The average number of students in such programs shall be the actual count maintained by each such program.

Reporting Schedule

Schedule F3

8270 COMMUNITY HEALTH EDUCATION

Function

Community Health Education is the coordination, development, and presentation of community social and health education programs such as colostomy education, cardiopulmonary resuscitation (CPR) training, anti-smoking campaign, geriatric education, and childbirth training.

Such programs may be presented in the health facility or in community settings to former patients, families of patients, and other interested persons.

Description

This cost center contains the direct expenses incurred by the health facility in coordinating, developing, and presenting social and health education programs to the community. This cost center would not include cost incurred in the presentation of such information to patients. Any fees collected to offset the cost of community education programs is to be credited to Community Health Education Revenue (Account 5270).

Standard Unit of Measure: Number of Participants

Count each person attending one session of the community education program as one participant, regardless of the length of session.

Data Source

The number of participants must be the actual count maintained by the Community Education cost center.

Reporting Schedule

Schedule F5

General Services .0783

8310 DIETARY SERVICES

Function

Dietary Services includes the procurement, storage, processing and delivery of food and nourishment to patients in compliance with Public Health Regulations and physician's orders. Additional activities include, but are not limited to, the following: teaching patients and their families nutrition and modified diet requirements; determining patient food preferences as to type and method of preparation; preparing selective menus for various specific diet requirements; preparing or recommending a diet manual, approved by the medical staff, for use by physicians and nurses; and delivering and collecting food trays for meals and nourishments.

Description

This cost center contains the direct expenses incurred in preparing and delivering food to patients. Infant formula must be charged to the using cost center. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers. Also included is Dietary Service’s share of common costs of the Cafeteria and Dietary Services cost center. Examples of common costs include salaries of cooks who prepare food for both cost centers, common food costs, common administrative costs, etc. These common costs shall be accumulated in a sub-account of this cost center and distributed (preferably on a monthly basis) to the Dietary and Cafeteria cost centers, based upon the ratio of number of meals served in each cost center. A detailed explanation of the method to be used in computing the number of meals served in the Cafeteria is included in the explanation of the Cafeteria Standard Unit of Measure.

Standard Unit of Measure: Number of Patient Meals

Count only regularly scheduled meals (3, 4 or 5 meal schedule) and exclude snacks and fruit juices served between regularly scheduled meals. Also excluded are tube feedings and infant formula.

Data Source

The number of patient meals must be the actual count of patient meals maintained by the Dietary cost center.

Reporting Schedule

Schedule C - Line C1

8320 CAFETERIA

Function

Cafeteria includes the procurement, storage, processing, and delivery of food to employees and other non-patients in compliance with Public Health Regulations.

Description

This cost center contains all directly identifiable expenses incurred in preparing and delivering food to employees and other non-patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, other direct expenses and transfers. Also included is the Cafeteria's share of common costs of the Cafeteria and Dietary Services cost centers, which are accumulated in a sub-account of Dietary Services and distributed, preferably on a monthly basis. The cost of edible supplies for vending machines served by the health facility must be included in this cost center.

Standard Unit of Measure: Equivalent Number of Meals Served

To obtain an equivalent meal in a pay cafeteria, divide total cafeteria revenue by the average selling price of a full meal. The average full meal should include meat, potato, vegetable, salad, beverage and dessert. When there is a selection of entrees, desserts and so forth, that are available at different prices, use an average in calculating the selling price of a full meal. Count a free meal served as a full meal.

Data Source

Cafeteria revenue must be taken from the general ledger.

Reporting Schedule

Schedule E7

8330 LAUNDRY AND LINEN

Function

Laundry and Linen performs the storing, issuing, mending, washing and processing of in-service linens. The services include uniforms, special linens and disposable linen substitutes.

Description

This cost center shall contain the direct expenses incurred in providing laundry and linen services for hospital use, including student, non-paid workers, and employee quarters. Cost of disposable linen must be recorded in this cost center. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Dry and Clean Pounds Processed

Record the weight of linen processed (laundered and dried) plus the equivalent weight of disposable linen substitutes used. Linen is weighed after it has been cleaned and processed. Include uniforms and linen from personnel quarters and employee housing. If linen is not weighed, a conversion from pieces to pounds is allowed. If soiled linen is weighed, divide by 1.1.

Data Source

The number of dry and clean pounds processed (laundered and dried) must be taken from actual counts maintained in the Laundry and Linen cost center. If the hospital uses an outside laundry services, the number of dry and clean pounds processed must be maintained and reported.

Reporting Schedule

Schedule C - Line C2

8350 SOCIAL SERVICES

Function

The Social Services cost center obtains, analyzes, and interprets social and economic information to assist in diagnosis, treatment and rehabilitation of patients. These services include counseling of staff, patients in case units and group units; participation in development of community social and health programs and community education. Additional activities include, but are not limited to, the following:

> Interviewing of patients and relatives to obtain social history relevant to medical problems and planning; interpreting problems of social situations as they relate to medical conditions and/or hospitalization; arranging for post discharge care of chronically ill; collecting and revising information on community health and welfare resources. In private psychiatric hospitals, the function and expenses associated with this service is limited to those involving administration and supervision of social service functions.

Description

This cost center contains the direct expense incurred in providing social services to patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Admissions

Record the total number of admissions (excl. nursery) to the hospital.

Data Source

The number of admissions shall be taken from daily patient census counts.

Reporting Schedule

Schedule C - Line C3

8360	HOUSING	
	8361	Employee Housing
	8362	Non-Paid Worker Housing
	8365	Student Housing

Function

Housing is the provision of living quarters to hospital employees and non-paid workers; and maintenance of residence for students, including interns and residents, participating in education programs carried on by the hospital.

Description

This cost center shall contain the direct expenses incurred in providing living quarters for hospital employees; non-paid workers; and students involved in educational programs carried on by the hospital. Expenses of on-call room shall be included in this cost center. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Average Number of Persons Housed

Record the number of persons housed each month, regardless of the number of days each person is in the facility. Accumulate the monthly totals and divide by 12 to obtain the average number of persons housed.

Data Source

The average number of persons housed shall be determined from the record of employees housed maintained in the Housing cost center.

Reporting Schedule

Schedule E9

8410 PLANT OPERATIONS AND MAINTENANCE
- 8411 Plant Operations
- 8412 Plant Maintenance
- 8413 Grounds
- 8414 Security
- 8415 Energy

Function

Plant Operations and Maintenance includes the maintenance and service of utility systems such as heat, light, water, air conditioning, and air treatment (include the expenses incurred for the purchase of electricity, fuel, water, and steam); the maintenance and repair of buildings, parking facilities, and equipment; painting; elevator maintenance; vehicle maintenance; performance of minor renovation of buildings and equipment and maintenance of grounds of the institution, such as landscaped and paved areas, streets on the property, sidewalks, fenced areas and fencing, external recreation areas, and parking facilities. Additional activities include, but are not limited to the following:

> Trash disposal; boiler operation and maintenance; service and maintenance of water treatment facilities; drainage systems and utility transmission systems including all maintenance performed under contract; technical assistance on equipment purchases and installation; coordinating construction; establishing priorities for repairs and utility projects; maintaining the safety and well-being of hospital patients, employees, visitors and protection of the hospital facilities.

Description

This cost center shall contain the direct expenses incurred in the operation and maintenance of the hospital plant and equipment. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, utilities (except telephone and telegraph), other direct expenses and transfers.

Standard Unit of Measure: Amount of Gross Square Feet

Gross square feet are defined as the total floor area of the hospital facility including common areas (hallways, stairways, elevators, lobbies, closets, etc.).

Data Source

The amount of gross square feet shall be taken from current blueprints of the hospital facility or from actual measurement if blueprints are not available.

Reporting Schedule

Schedule C - Line C5

8430 AMBULANCE SERVICES

Function

This cost center provides ambulance service to the ill and injured who require medical attention on a scheduled and unscheduled basis, with the exception of those ambulance services determined to be Part A hospital services. Additional activities include, but are not limited to, the following:

> Lifting and placing patients into and out of an ambulance; transporting patients to and from the hospital: first aid treatment administered by a physician or paramedic prior to arrival at the hospital.

Description

The cost center contains the direct expense incurred in providing ambulance service to the ill and injured. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Occasions of Service

Ambulance service provided a patient is counted as one occasion of service regardless of special services rendered at the point of pickup or during transport. For example, the administration of oxygen and first aid during the pickup and delivery of the patient would not be counted as a separate occasion of service.

Data Source

The number of occasions of service shall be the actual count maintained by Ambulance Services.

Reporting Schedule

Schedule E1

8440 PARKING

Function

Parking includes the provision of parking facilities to patients, physicians, employees and visitors.

Description

This cost center shall contain the direct expenses of parking facilities owned and/or operated by the hospital. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Parking Spaces

For parking structures and parking lots, count the number of parking spaces.

Data Source

The number of parking spaces shall be taken from blueprints of the parking area, or based on actual count if blueprints are not available.

Reporting Schedule

Schedule E2

8450 HOUSEKEEPING

Function

This cost center is responsible for the care and cleaning of the interior physical plant, including the care (washing, waxing, stripping) of floors, walls, ceilings, partitions, windows (inside and outside), furniture (stripping, disinfecting and making beds upon discharge), fixtures excluding equipment) and furnishings and emptying of room trash containers, as well as the costs of similar services purchased from outside organizations.

Description

This cost center shall contain the direct expenses incurred for maintaining general cleanliness and sanitation throughout the hospital and other areas serviced (such as student and employee quarters). Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Hours Assigned to Maintain General Cleanliness and Sanitation

The number of hours assigned is the time it assigned to maintain general cleanliness and sanitation of the interior floor area routinely serviced by housekeeping personnel.

Data Source

The number of hours assigned to maintain general cleanliness and sanitation should be taken from the hospitals records.

Reporting Schedule

Schedule C - Line C6

8460 CENTRAL SERVICES AND SUPPLIES

Function

Central Services and Supplies prepares and issues medical and surgical supplies and equipment to patients and to other cost centers. Additional activities include, but are not limited to, the following:

> Requisitioning and issuing of appropriate supply items required for patient care; preparing sterile irrigating solutions; collecting, assembling, sterilizing, and redistributing reusable items; cleaning, assembling, maintaining, and issuing portable apparatuses.

Description

This cost center contains the direct expenses incurred in preparing and issuing medical and surgical supplies and equipment to other cost centers and to patients. Also included is the expense related to reusable medical and surgical items. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies (non-medical and surgical), reusable medical and surgical supplies, purchased services, other direct expenses and transfers. The invoice cost of all disposable (non-reusable) medical and surgical supplies shall be recorded or transferred to Medical Supplies Sold (Account 7110). For a further discussion refer to Section 100.515 of this manual.

Standard Unit of Measure: Equivalent Inpatient Admissions (EIPA)

$$\frac{\text{Gross Patient Revenue}}{\text{Gross Inpatient Revenue}} \times \text{Inpatient Admissions (Excl. Nursery)}$$

Data Source

Gross Patient Revenue and Gross Inpatient Revenue shall be obtained from the general ledger. Inpatient admissions shall be obtained from daily census counts.

Reporting Schedule

Schedule C - Line C7

8470 PHARMACY

Function

The Pharmacy procures, preserves, stores, compounds, manufactures packages, controls, assays, dispenses, and distributes medications (including I.V. solutions) for inpatients and outpatients under the jurisdiction of a licensed pharmacist. Pharmacy services include the maintaining of separate stocks of commonly used items in designated areas. Additional activities include, but are not limited to, the following:

Development and maintenance of formulary established by the medical staff; consultation and advice to medical staff and nursing staff on drug therapy; adding drugs to I.V. solutions; determining incompatibility of drug combinations; stocking of floor drugs and dispensing machines.

Description

This cost center contains the direct expenses incurred in maintaining a pharmacy under the jurisdiction of a licensed pharmacist. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers. The invoice cost of pharmaceuticals and intravenous solutions shall be recorded or transferred to Drugs Sold (Account 7150). (For a further discussion refer to Section 100.516 of this manual.)

Standard Unit of Measure: Equivalent Inpatient Admissions (EIPA)

Gross Patient Revenue x Inpatient Admissions (Excl. Nursery)

Gross Inpatient Revenue

Data Source

Gross patient revenue and gross inpatient revenue shall be obtained from the general ledger. Inpatient admissions shall be obtained from daily census counts.

Reporting Schedule

Schedule C - Line C8

8480 ORGAN ACQUISITION OVERHEAD

Function

This cost center accumulates the direct costs of Transplant Coordination staff.

Description

The Organ Acquisition Overhead cost center contains the direct expenses of the transplant coordination staff. Included as direct expenses are: salaries and wages, employee benefits.

Standard Unit of Measure: Number of Organs Transplanted plus Number of Allogeneic Stem Cells Transplant Procedures

Count each organ transplanted and each allegeneic stem cell procedure as one.

Data Source

The number of organs transplanted and allegeneic stem cell procedures will be the actual count maintained by the organ acquisition cost center.

Reporting Schedule

Schedule C - Line C15

Fiscal Services .0784

8510 GENERAL ACCOUNTING

Function

This cost center performs general accounting (i.e., non-patient billing and accounting) activities of the hospital such as the preparation of ledgers, budgets and financial reports, payroll accounting, accounts payable accounting, plant and equipment accounting, inventory accounting, non-patient accounts receivable accounting (tuition, sales to other institutions), etc.

Description

This cost center shall include the direct expenses incurred in providing the general accounting requirements of the hospital. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchases services, other direct expenses and transfers.

Standard Unit of Measure: Equivalent Inpatient Days

Gross Patient Revenue x Inpatient Days (Excl. Nursery)

Gross Inpatient Revenue

Data Source

Gross patient revenue and gross inpatient revenue shall be obtained from the general ledger. Inpatient days shall be obtained from daily census counts.

Reporting Schedule

Schedule C - Line C9

8250		PATIENT ACCOUNTS, ADMITTING, AND REGISTRATION
	8521	Patient Accounting
	8522	Credit and Collection
	8523	Cashiering
	8524	Inpatient Admitting
	8525	Emergency Room Registration
	8526	Clinic Registration
	8527	Referred Ambulatory Registration
	8528	Other Outpatient Registration

Function

The processing of patient charges, including processing charges to patients' accounts, preparing claims, extending credit, collecting accounts receivable, cashiering, and other patient-related billing and accounting activities, is handled by this cost center. Additional activities include interviewing patients and others relative to the extension of credit, checking references and use of outside collection agencies. The admitting of inpatients for hospital services including filling out admission forms, scheduling admission times, accompanying patients to room or service areas after admission and arrangement of admission details is performed by this cost center. All outpatient registration activities are also included here, including emergency, clinic, and referred patients.

Description

This cost center shall include the direct expenses incurred in patient-related credit, billing, and accounting activities; inpatient admitting; and outpatient activities registration. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Patient Days Plus Outpatient Visits

Report patient says of care for all patients (excluding nursery) based on daily census. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day. An outpatient visit is each registration of an outpatient in Emergency Services, Clinic Services, Psychiatric Day and Night Care Services, Free Standing Clinic Services, and Home Health Services; and the registration of referred ambulatory patients.

Data Source

The number of patient days shall be taken from daily census counts. The number of visits shall be the actual count maintained by Emergency Services, Clinic Services, Renal Dialysis, Psychiatric Day and Night Care Services, Free Standing Clinic Services, and Home Health Services.

Reporting Schedule

Schedule C - Line C10

Administrative Services .0785

8610 HOSPITAL ADMINISTRATION
- 8611 Office of Hospital Administrator
- 8612 Governing Board
- 8613 Public Relations
- 8614 Spiritual Care
- 8615 Communications
- 8616 Personnel
- 8617 Management Engineering
- 8618 Health Sciences Library
- 8619 Auxiliary Groups
- 8621 Fund Raising

Function

Hospital Administration performs overall management and administration of the institution. This function also includes the following activities: public relations, spiritual care, communications, personnel management engineering, health sciences library, auxiliary groups, and fund raising. The function of cost centers 8615 through 8621 are described on the following pages.

Description

This cost center contains the direct expenses associated with the overall management and administration of the institution including those of the Governing Board. The expenses associated with furnishing information for public use in maintaining the hospital's position in the community must be included here. The expenses associated with spiritual care (chaplaincy), communications, personnel, management engineering, health sciences library, auxiliary groups and fund raising must be included here. Care should be taken to ascertain that all costs included in this cost center do not properly belong in a different cost center. For example, expenses chargeable to hospital administration do not include legal fees incurred in connection with the purchase of property (which should be capitalized). Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Equivalent Inpatient Days (EIPD)

Gross Patient Revenue x Inpatient Days (Excl. Nursery)

Gross Inpatient Revenue

Data Source

Gross patient revenue and gross inpatient revenue shall be obtained from the general ledger. Inpatient days shall be obtained from daily census counts.

Reporting Schedule

Schedule C - Line C11

8615 COMMUNICATIONS

Function

The Communications cost center operates the communications systems within and outside the hospital, including the telephone system, radio and telemetry communications systems, public address systems, closed-circuit television, messenger services and mail processing.

Description

This cost center shall include the direct expenses incurred in carrying on communications (both in and out of the hospital), including the telephone switchboard and related telephone services, messenger activities, internal information systems and mail services. Specific expenses include postage and telephone company charges for equipment and monthly services. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers. For reporting purposes, the costs of patient telephones will be transferred to Schedule E6, Patient Telephones.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule C - Line C11

8616 PERSONNEL

Function

Personnel provides adequate staffing of hospital departments and maintain employee satisfaction and morale. Activities include recruitment, employee selection, salary and wage administration, employee health services, fringe benefit program administration, and the premium paid, over the applicable hospital employee costs per hour plus fringe benefits, for temporary personnel procured from non-related temporary help agencies.

Description

This cost center shall be used to record the direct expenses incurred in carrying out the personnel function of the hospital. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers. Direct expenses incurred in this center and the temporary personnel premium paid will be reported in Hospital Administration.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule C - Line C11

8617 MANAGEMENT ENGINEERING

Function

Management Engineering is an administrative service which assists hospital administrators in performing their managerial functions by providing specialized knowledge and skill in the mathematical, physical and social sciences, together with the principles and methods of engineering analysis, development and implementation. Management Engineering performs a wide variety of services including, but not limited to, the following: productivity analysis and improvement; cost containment; planning and control procedures; systems analysis and design; facilities layout; computer sciences and operations research.

Description

This cost center contains the direct expenses incurred by the management engineering function. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers. The direct expenses incurred in this cost center will be reported with Hospital Administration.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule C - Line C11

8718 HEALTH SCIENCES LIBRARY

Function

The Health Sciences Library procures, stores, indexes, classifies, annotates and abstracts books, catalogs, journals and other related published materials principally for medical staff use and reviews library records for completeness and compliance with established standards.

Description

This cost center contains the direct expenses incurred in maintaining a health sciences library. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule C - Line C11

8619 AUXILIARY GROUPS

Function

Costs incurred in connection with hospital-related auxiliary groups including coordinator of auxiliary group activities and special meetings or auxiliary groups conducted by the hospital are maintained in this cost center.

Description

This cost center contains the direct expenses incurred in connection with hospital auxiliary or volunteer groups. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses, and transfers. The direct expenses incurred in this cost center will be reported with Hospital Administration.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule C - Line C11

8622 FUND RAISING

Function

Fund Raising carries on fund-raising activities such as special luncheons and other meetings and special mailings.

Description

This cost center contains the direct expenses associated with fund raising (both restricted and unrestricted). Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers. The direct expenses incurred in this center will be reported with Hospital Administration.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule C - Line C11

8690 PURCHASING AND STORES

Function

Purchasing and Stores includes the procuring of supplies, equipment and services necessary to hospital operations, the receipt of supplies and materials from vendors and their routing and distribution to specific using areas and the receipt and central storage of all non-pharmaceutical supplies and materials prior to their issue to using departments. Additional activities include, but are not limited to, the following:

Receipt and processing of requisitions; monitoring of perpetual supply items; obtaining of quotes from selected vendors; and monitoring of receipt of supplies.

Description

This cost center shall contain the direct expenses incurred in providing supplies, equipment and services necessary to hospital operations. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Equivalent Inpatient Days (EIPD)

$$\frac{\text{Gross Patient Revenue}}{\text{Gross Inpatient Revenue}} \times \text{Inpatient Days (Excl. Nursery)}$$

Data Source

Gross patient revenue and inpatient revenue shall be obtained from the general ledger. Inpatient days shall be obtained from daily census counts.

Reporting Schedule

Schedule C - Line C4

Medical Staff Administration

8710 MEDICAL RECORDS .0786

Function

Medical Records includes the maintenance of a records system for the use, transportation, retrieval, storage and disposal of patient medical records; and the production of indices, abstracts and statistics for hospital management and medical staff uses. This function also includes tumor registry activities.

Description

This cost center contains the direct expenses incurred in maintaining the medical records function. Also, costs associated with microfilming of medical records shall be included in this account. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure

Number of Inpatient Discharges (excluding nursery) plus one-eighth of total visits for Emergency Services, Clinic Services, Psychiatric Day and Night Care Services, Free Standing Clinic Services and Free Standing Emergency Services.

Data Source

The number of visits shall be the actual count maintained by the Emergency Services, Clinic Services, Psychiatric Day and Night Care Services, Free Standing Clinic Services and Free Standing Emergency Services cost centers. The number of discharges shall be the actual count maintained by Medical Records.

Reporting Schedule

Schedule C - Line C12

8720 MEDICAL STAFF ADMINISTRATION
8723 Medical Photography and Illustration
8729 Medical Staff Administration-Other

Function

This cost center is used to record certain general expenses associated with medical staff administration, such as the salary and related expenses of the Chief of Medical Staff and assigned non-physician employees. This cost center also provides medical photography and illustration services for other cost centers of the hospital. The cost center also includes the function of infection control program.

Description

This cost center contains the expenses associated with medical staff administration and medical photography and illustration and infection control programs. Interns and residents' salaries (or stipends) must not be included here, but rather in the Post Graduate Medical Education-Teaching Program (Account 8240). Compensation paid to physicians (other than Chief of the Medical Staff) must not be included here. Refer to Section 100.552 for the proper distribution of physician compensation. Included as direct expenses are: salaries and wages, employee benefits, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Equivalent Inpatient Days (EIPD)

$$\frac{\text{Gross Patient Revenue}}{\text{Gross Inpatient Revenue}} \times \text{Inpatient Days (Excl. Nursery)}$$

Data Source

Gross patient revenue and gross inpatient revenue shall be obtained from the general ledger, inpatient days will be obtained from daily census counts.

Reporting Schedule

Schedule C - Line C13

8730 PHYSICIANS PART B SERVICES (REGULATED)

Function

This cost center is used to report the professional component expenses associated with services to non-Medicare hospital patients provided by regulated hospital-based physicians.

Description

This cost center contains professional component expenses associated with regulated hospital-based physicians in accordance with the procedures of section 100.55. Professional component expenses include the applicable percentage of professional fees and of salaries and employee benefits. Interns and Residents' salaries (or stipends) must not be included here but rather in the Post Graduate Medical Educational-Teaching Program (Account 8240).

Standard Unit of Measure: Number of FTEs

The number of FTEs in regulated Physicians Part B Services is defined as the sum of the actual on-site hours worked divided by 2080.

Data Source

The number of FTEs in regulated Physicians Part B Services shall be the actual count maintained by general accounting.

Reporting Schedule

Schedule P2A to P2I

8735 PHYSICIANS PART B SERVICES (UNREGULATED)

Function

This cost center is used to report the professional component expenses associated with services to hospital patients provided by unregulated hospital-based physicians.

Description

This cost center contains professional component expenses associated with unregulated hospital-based physicians in accordance with the procedures of section 100.55. Professional component expenses include the applicable percentage of professional fees and of salaries and employee benefits. Interns and Residents' salaries (or stipends) must not be included here but rather in the Post Graduate Medical Education-Teaching Program (Account 8240).

Standard Unit of Measure: Number of FTEs

The number of FTEs in unregulated Physicians Part B Services is defined as the sum of the actual on-site hours worked divided by 2080.

Data Source

The number of FTEs in unregulated Physicians Part B Services shall be the actual count maintained by general accounting.

Reporting Schedule

Schedule UR5

8740 PHYSICIAN SUPPORT SERVICES

Function

This cost center is used to report the expenses associated with services to hospital patients provided by physician support personnel.

Description

This cost center contains the expenses associated with physician support personnel. Refer to Section 200.0371 (.08 Non-Physician Medical Practitioners) for a description of physician support personnel. Physician Support Services expenses include wages and salaries and employee benefits.

Standard Unit of Measure: Number of FTEs

The number of FTEs in Physician Support Services is defined as the sum of the actual on-site hours worked divided by 2080.

Data Source

The number of FTEs in Physician Support Services shall be the actual count maintained by general accounting.

Reporting Schedule

Schedule P3A to P3H

8750		NURSING ADMINISTRATION
	8751	In-service Education-Nursing
	8759	Nursing Administration-Order

Function

Nursing Administration performs the administration and supervision of the nursing function in the hospital including scheduling and transfer of nurses among the services and units, nursing staff supervision, evaluation and discipline. This cost center also includes continuing education of hospital-employed nursing personnel, (i.e., RNs, LPNs, aides, and orderlies) including regularly scheduled classes, in-house seminars and special training sessions.

Description

This cost center shall contain the direct expenses associated with nursing administration and with conducting a nursing in-service education program. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers. Supervisors assigned to specific cost centers shall be included in those cost centers on a direct basis. The salaries, wages and fringe benefits paid float personnel shall be recorded in the cost center in which they work. This may be done directly, or they may be recorded originally in the Float Nursing Personnel cost center (Account 8992) and distributed (preferably at the end of each payroll period) to using cost centers based upon hours worked. If the latter method is used, all salaries, wages and fringe benefits of float personnel must be transferred out of the "Float" Nursing Personnel cost center. Any idle time would be allocated together with actual hours worked. Scheduling and other administrative functions relative to float personnel are considered costs of Nursing Administration. If hospital employees in other nursing activities, their salaries, wages and fringe benefits shall be separated based upon number of hours spent in each activity and distributed to the appropriate cost centers, preferably after each payroll period. This cost center shall not include costs related to in service student time. These costs must remain in the cost center in which the student works.

Standard Unit of Measure: Hours of Nursing Service Personnel

The hours of nursing service personnel shall include RNs, LPNs, aides, orderlies and other under the supervision of Nursing Administration.

Data Source

The hours of nursing personnel shall be calculated from payroll data.

Reporting Schedule

Schedule C - Line C14

Unassigned Expenses .0787

8810 DEPRECIATION AND AMORTIZATION
- 8811 Land Improvements
- 8812 Buildings and Improvements
- 8813 Leasehold Improvements
- 8814 Fixed Equipment
- 8815 Intangibles
- 8816 Movable Equipment

Functions

Depreciation and Amortization is a cost center for recording depreciation and amortization expenses on land improvements, buildings and improvements, leasehold improvements, fixed equipment, intangibles and movable equipment.

Depreciation

This cost center contains depreciation and amortization expenses on land improvements, buildings and improvements, leasehold improvements, fixed equipment, intangibles and movable equipment. All such expenses must remain in this cost center.

Standard Unit of Measure

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule UA

8820		LEASES AND RENTALS
	8821	Land
	8822	Buildings and Improvements
	8824	Fixed Equipment
	8825	Movable Equipment

Function

Leases and Rentals is a center for the recording of leases and rental expenses on land, buildings and improvements, fixed equipment and movable equipment.

Description

This cost center contains all lease and rental expenses relating to land, building and improvements, fixed equipment and movable equipment. All lease and rental expenses are to remain in this cost center.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule UA

8830 INSURANCE - HOSPITAL AND PROFESSIONAL MALPRACTICE

Function

This cost center is used to record all hospital and professional malpractice insurance expenses.

Description

This cost center contains the expense incurred in maintaining hospital and professional liability insurance policies.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule UA

8840 INSURANCE-OTHER

Function

This cost center is used to record all insurance expenses except malpractice insurance, UIC, Workman's Compensation and employee benefit insurance.

Description

This cost center contains the expenses incurred in maintaining all insurance policies except professional and hospital malpractice insurance, UIC, Workman's Compensation and employee benefit insurance. For example, fire, theft, employee fidelity bonds, liability (non-professional), property damage, auto, boiler, and business interruption would be included here.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule UA

8850 LICENSES AND TAXES (OTHER THAN INCOME TAXES)

Function

This cost center is used to record all business license expenses incidental to the operation of the hospital, all other license expense, and all taxes (other than on income).

Description

This cost center contains the business license expense, other license expense (including unassigned permits), tax expense which are incidental to the operating of the hospital. Fees paid to a city and/or county (or other governmental unit except the State Tax Board) for doing business in city and/or county must be recorded in this cost center.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule UA

8860 INTEREST - SHORT TERM

Function

This cost center is used to record all interest incurred on borrowings for working capital purposes.

Description

This cost center contains the interest expense relating to borrowings for hospital operations. Interest incurred on mortgage notes and other borrowings for the acquisition of equipment must not be included in this cost center. Interest on borrowings during construction phases must be treated in accordance with Section 100.286 of this manual.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule UA

8870 INTEREST - LONG TERM

Function

This cost center contains all interest incurred on capital, mortgages and other loans for the acquisition of property, plant and equipment.

Description

This cost center contains all interest expense incurred on capital, mortgages, and other loans for the acquisition of property, plant, and equipment. This includes the interest on the current portion of long term debt.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule UA

8880		MEDICAL CARE REVIEW
	8881	PSRO
	8882	Other Medical Care Review

Function

This cost center is used to record the expenses incurred in the conducting of ongoing evaluation of the quality of care given and includes periodic review of the utilization of the bed facilities, and of the diagnostic, nursing therapeutic resources of the hospital, with respect to both the availability of these resources to all patients in accordance with their medical need and the recognition of the medical practitioner's responsibility for the costs of health care. This review should cover necessity of admission, length of stay, level of care, quality of care, utilization of ancillary services, professional services furnished, effectiveness of discharge planning and the availability and alternate use of out of hospital facilities and services. Three review programs may be included in this center: Pre-admission screening, concurrent review (including admission certification and continued stay review) and retrospective medical care evaluation studies. The review committee should include medical staff, hospital administration, nurses and home health planners.

Description

This cost center contains the expenses associated with medical care review programs. Included as direct expenses are: salaries and wages, employee benefits, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule UA

Holding Accounts .0788

8991 CENTRAL PATIENT TRANSPORTATION

Function

Central Patient Transportation is the transporting of patients between services in and about the hospital. This does not include the transportation of patients to the hospital. This control cost center is provided for those hospitals wishing to identify the cost of this service. However, all costs in this cost center must be transferred to the appropriate Ancillary Services Cost Center for reporting purposes.

Description

This cost center shall contain the direct expenses incurred in central patient transportation only if there is an established central patient transportation cost center. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers. These costs shall be reclassified to Ancillary Services Cost Centers. See Section 100.519 for a further discussion.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Applicable Ancillary Services Cost Centers.

8992 NURSING FLOAT PERSONNEL

Function

To record the expenses of nursing personnel who work in more than one cost center on a "float" basis.

Description

The expenses of nursing personnel who work in more than one cost center on a "float" basis must be recorded in the cost center in which they work. This may be done directly, or may be recorded originally in this account and distributed (preferably at the end of each payroll period) to using cost centers based upon hours worked in each cost center. Any expenses attributable to nursing float personnel, including on call and standby must be distributed based upon actual hours worked by the individual nurses during the applicable payroll period. Scheduling and other administrative functions relative to float personnel are considered costs of nursing administration.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Appropriate D Schedules

8993 EMPLOYEE BENEFITS

Function

This cost center may be used to record payroll-related employee benefits. This cost center is provided for those hospitals wishing to identify the cost of this service. However, all costs in this cost center must be closed out for reporting purposes to the other functional cost centers as specified in sub-section .513 of section 100.

Description

This cost center is a holding account for payroll-related employee benefits expense. Included in payroll-related employee benefits are FICA, SUI, vacation, holiday, and sick leave, group health insurance, group life insurance, pension and retirement, and workmen's compensation insurance.

Standard Unit of Measure:

No unit of measure is prescribed since this cost center must have a zero balance for reporting purposes.

Data Source

Not Applicable

Reporting Schedule

Schedule C – Lines C1-C14, Schedule D – Lines D1-D81, E1-E9, F1-F4, P2A-P21, P3A-P3H, P4A to P4I, & OADP

8994 DATA PROCESSING

Function

The Data processing cost center performs the operation of the hospital's electronic data processing system, including key-punching of input, storage and safeguarding of data, operating data processing equipment, data processing job scheduling, distributing output and identifying and solving hardware and software problems.

Description

This cost center shall contain the costs incurred in operating an electronic data processing center. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers. Expenses incurred in the operation of terminals of the EDP center throughout the hospitals shall be included in the Data Processing cost center. However, outside service bureau costs directly chargeable to a specific routine or ancillary service cost center shall be included in that specific cost center in the "Purchased Services - Data Processing" natural classification (.75). Outside service bureau costs benefiting more than one cost center shall be included in the Data Processing cost center.

Standard Unit of Measure

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule OADP and appropriate C, D, E and F Schedules

Non-Operating Revenue and Expense .0789

Non-Operating revenue and expenses include those revenues and expenses not directly related to patient care, related patient services, or the sale of related goods. The following items are indicated:

9010 GAINS OR LOSSES ON SALE OF HOSPITAL PROPERTY

This account is credited for gains and debited for losses arising as a result of the disposal of hospital property.

Reporting Schedule

Schedule G

9020 UNRESTRICTED CONTRIBUTIONS

All contributions, donations, legacies, and bequests, which are made to the hospital without restrictions by the donors, must be credited to this account. When a hospital receives contributions in significant amounts, such contributions should be clearly described and fully disclosed in the income statement.

Reporting Schedule

Schedule G

9030 DONATED SERVICES

Many hospitals receive donated services of individuals. Fair value of donated services must be recorded when there is the equivalent of an employer-employee relationship and an objective basis for valuing such services. The value of services donated by organizations may be evidenced by a contractual relationship which may provide the basis of valuation. Donated Services are most likely to be recorded in a hospital operated by a religious group. If members of the religious group are not paid (or are paid less than the fair value of the services rendered) the lay-equivalent value of their services (or the difference between lay-equivalent value of services rendered and compensation paid) must be recorded as the expense in the cost center in which the service was rendered with the credit to this account.

Reporting Schedule

Various Schedules

9040 INCOME, GAINS AND LOSSES FROM UNRESTRICTED INVESTMENTS

Income, and gains and losses from investments of unrestricted funds must be recorded in this account.

Reporting Schedule

Schedule G

9050 UNRESTRICTED INCOME FROM ENDOWMENT FUNDS

This account is credited with the unrestricted revenue and net realized gains on investments of endowment funds.

Reporting Schedule

Schedule G

9060 UNRESTRICTED INCOME AND OTHER RESTRICTED FUNDS

This account is credited with the revenue and net realized gains on investments of restricted funds (other than endowment funds) if the income is available for unrestricted purposes.

Reporting Schedule

Schedule G

9070 TERM ENDOWMENT FUNDS BECOMING UNRESTRICTED

When restricted endowment funds become available for unrestricted purposes, they must be reported in this account.

Reporting Schedule

Schedule G

9080 TRANSFERS FROM RESTRICTED FUNDS FOR NON-OPERATING REVENUE

This account reflects the amounts of transfers from restricted funds to match non-operating expenses in the current period for restricted fund activities.

Reporting Schedule

Schedule G

9110 DOCTORS' PRIVATE OFFICE RENTAL REVENUE

This account is credited with the revenue earned from rental of office space and equipment to physicians and other medical professionals for use in their private practice.

Reporting Schedule

Schedule E3

9120 OFFICE AND OTHER RENTAL REVENUE

This account is credited with rentals received from other than doctors, other medical professionals and other non-retail rental activities for office space located in the hospital and for other rental of property, plant and equipment not used in hospital operations.

Reporting Schedule

Schedule E4

9131 RETAIL OPERATIONS REVENUE

This account must be credited with revenue earned from other retail operations such as gift shop, barber shop, beauty shop, drug store, or newsstand located in space owned by the hospital.

Reporting Schedule

Schedule E5

9150 OTHER NON-OPERATING REVENUE

This account is credited with non-operating revenue not specifically required to be included in the above accounts, including unrestricted tax revenue and funds appropriated by governmental entities.

Reporting Schedule

Schedule G

9210 DOCTORS' PRIVATE OFFICE RENTAL EXPENSES

This account contains the expenses incurred in connection with the rental of office space and equipment to physicians, and other medical professionals for use in their private practice.

Reporting Schedule

Schedule E3

9220 OFFICE AND OTHER RENTAL EXPENSE

This cost center contains the expenses incurred in connection with the rental to other than physicians, other medical professionals and non-retail rental activities.

Reporting Schedule

Schedule E4

9230 RETAIL OPERATIONS EXPENSE

This cost center contains the expense incurred in connection with retail operations such as gift shop, barber shop, drug store, beauty shop or newsstand.

Reporting Schedule

Schedule E5

9250 OTHER NON-OPERATING EXPENSES

This cost center contains non-operating expenses not specifically required to be included in the above accounts.

Reporting Schedule

Schedule G

9410 PROVISION FOR INCOME TAXES

9411	Federal-Current
9412	Federal-Deferred
9413	State-Current
9414	State-Deferred
9415	Local-Current
9416	Local-Deferred

These cost centers contain income tax expense and related deferred taxes.

9500 EXTRAORDINARY ITEMS

Cost Centers (Accounts 9500–9599) should be used to segregate extraordinary items from the results of ordinary operations and to disclose the nature thereof. Each hospital is to follow "Generally Accepted Accounting Principles" (GAAP) to determine when items are to be considered extraordinary.

REPORTING REQUIREMENTS

OVERVIEW

Commission regulation 10.37.01.03 has been amended to authorize the Commission to prescribe the format for the submission of required reports. Effective immediately, reports MUST be filed in the format prescribed below or hospitals will be subject to fines as provided for by COMAR 10.37.01.03 N. Format references can be found at the end of this document.

1. ANNUAL REPORTS

A. Reports due 120 days after the end of the hospital's fiscal year (The Commission approved a blanket 30 day extension for reports listed in Sections A & B of Annual Reports and Sections A,B, & C of Alternative Method of Rate Determination Reports.)

1) Annual Report of Revenue, Expenses, and Volumes - Format #1

2) Audited Financial Statements - Format #2 & Format #8

3) Trustee Disclosure Information – Format #15

   1. List of Trustees with business addresses. Designate individual trustees who have engaged in business in the amount of $10,000 or more with the hospital.
   2. Individual disclosure form of each trustee doing business in the amount of $10,000 or more of business with the hospital.
   3. If no trustees have engaged in business in the amount of $10,000 or more with the hospital, a letter submitted to the assigned email address should so indicate.

4) Credit and Collection Policy – Format #8

5) Annual Debt Collection/Financial Assistance Report – Format #9

6) Hospital Outpatient Services Survey – Format #1 & Format #4

B. Report due 140 days after end of fiscal year.

Special Audit Report - Should include audit procedures for alternative method of rate determination if hospital related entity's fiscal year is the same as hospital - Format #1 & Format #8

C. Report due 6 months and 15 days after end of fiscal year

Federal IRS Form 990 – Format # 8

REPORTING REQUIREMENTS

D. Report due June 1 each year

Wage & Salary Survey - Format #4

E. Report due December 15th each year

Community Benefit Report – Format #4 or Format #12

F. Report due January 15th or 30 days after the due date of Hospital's Medicare Cost Report

Schedule IRS – Intern, Residents Survey – Format #4

II. ALTERNATIVE METHOD OF RATE DETERMINATION REPORTS

A. Reports due 90 days after the end of the related entity's fiscal year:

Audited Financial Statements of Hospital Related Entities; contracting entities related to the hospital participating in HSCRC approved Alternative Methods of Rate Determination arrangements - Format #3 & Format # 8

B. Reports due 110 days after the end of the related entity's fiscal year:

Special Audit Report - if fiscal year of related entity is different from the hospital (see I B above) - Format #2 and #8

C. Reports due 90 days after the end of the related entity's fiscal year:

Annual AR1, AR2, AR3 Reports - Format #3

D. Reports due 30 days after the end of the quarter:

Quarterly AR1, AR2, AR3 Reports - Global Pricing/Capitation - Format #3

REPORTING REQUIREMENTS

III. CASE MIX DATA

A. Reports are due according to the Production Schedule posted on the HSCRC website:

www.hscrc.maryland.gov/hsp_info1.cfm

1. Outpatient Abstracts – Format #5

B. Reports are due according to the Production Schedule posted on the HSCRC website:

www.hscrc.maryland.gov/hsp_info1.cfm

1. Inpatient Discharge Abstracts - Format #5
2. Psychiatric Discharge Abstracts - Format #5

IV. QUARTERLY REPORTS

A. Reports due 30 days after the end of the calendar quarter:

1. Outpatient Plastic / Cosmetic Surgery Operating Room Give-Up Policy Report – Format #13
2. Uncompensated Care Write-Offs Report – Format #13
3. Denials Report – Format #13
4. Shared Savings Report – Format #14

B. Reports due 45 days after the end of the calendar quarter:

1. General Inpatient Hospice Care Project Report – Format #13
2. Denied Admissions Report – Format #13

IV. MONTHLY REPORTS

A. Reports due 30 days after the end of the month: **

1. Hospital volumes and revenues (formerly known as MS, NS, PS, RS, CSS, and OVS) - Format #6 and #7

2. Hospital financial information and unaudited financial statements (formerly known as FSA, FSB) - Format #6 and #7

Extensions:

Hospitals may file written requests for reasonable extensions of time to file any or all of the requested reports. Requests shall be supported by justification for approval of the extension request. Requests for extensions shall be made at a reasonable time **before the due date** of the required report. Such requests should be directed to the Executive Director.

REPORTING REQUIREMENTS

Acceptable Formats

1) a) Two (2) hard copies by mail or courier to:
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

b) Download approved spreadsheet from www.hscrc.maryland.gov/hsp_info2.cfm, e-mail completed Excel spreadsheet to hscrc.annual@maryland.gov

2) Original and one hard copy by mail or courier to:
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

3) One hard copy by mail or courier to:
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

4) Download approved spreadsheet from www.hscrc.maryland.gov:

Email completed Excel spreadsheet and any PDF documents to:

Wage and Salary	hscrc.wagesalary@maryland.gov
Community Benefit Report	hscrc.cbr@maryland.gov
Hospital Outpatient Services Survey	hscrc.opsurvey@maryland.gov

5) A dedicated secure private connection (point-to point circuits) to connect your hospital to our State Vendor for the data submission.

6) Internet based reporting at https.//rates.hscrc.maryland.gov/project1

7) PDF of the hospital internal unaudited financial statements, price variance letter. Excel file of supplemental births schedule and CSS schedule (MSS/CDS) e-mail:

hscrc.monthly@maryland.gov

REPORTING REQUIREMENTS

8)	PDF File Only	Emailed to:
	Audited Financial Statements	hscrc.audited@maryland.gov
	Special Audit Report	hscrc.specialaudits@maryland.gov
	Credit and Collection Policy	hscrc.creditcollection@maryland.gov
	IRS Form 990 & Approved Applications For Extension on Time to File	hscrc.form990@maryland.gov
9)	Excel File & PDF	Emailed to:
	Annual Debt Collection/Financial Assistance Report (DCFA) & Documentation	hscrc.dcfa@maryland.gov
10)	Download approved spreadsheet from the HSCRC website: www.hscrc.maryland.gov/hsp_Rates4.cfm under **Case Mix**	
11)	One hard copy by mail or courier with original signatures:	Andrea Strong Health Services Cost Review Commission 4160 Patterson Avenue Baltimore, Maryland 21215 Andrea.Strong@maryland.gov
12)	Internet Based Reporting	cb.hscrc.maryland.gov
13)	Assigned Template	Via Repliweb to:
	General Inpatient Hospice Care Project Report	hscrc.hospice@maryland.gov
	Outpatient Plastic / Cosmetic Surgery Operating Room Give-Up Policy Report	hscrc.Opcosmetics@maryland.gov
	Uncompensated Care Write-Offs Report	hscrc.ucc@marland.gov
	Denials Report	hscrc.acctswrittendenials@maryland.gov
	Denied Admissions Report	hscrc.DeniedAdmissions@maryland.gov
14)	Excel Only	Emailed to:
	Shared Savings Report	hscrc.shared-savings@maryland.gov
15)	Internet Based Reporting at https://hscrc.maryland.gov/Pages/Trustee-Disclosure-Information.aspx	
	Trustee Disclosure Letters and Extension Requests	Emailed to: hscrc.trustees@maryland.gov

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OVERVIEW .01

The detailed instructions presented in this section are provided to enable each hospital under the jurisdiction of the Commission to report financial and statistical data in a uniform and consistent format.

REPORTING REQUIREMENTS .02

The reporting requirements of each hospital are listed in sub-sections .0210 to .0220 below. The required schedules are presented in Section 600.

A table of contents check off form is provided to list applicable/non-applicable schedules. This form requires the signature of the Chief Financial Officer.

Annual reports of Revenues, Expenses and volumes .0210

The annual reports of Revenues, Expenses and Volumes consist of the following schedules and are detailed in Sub-Sections .06 to .22 and .79 of Section 500.

Volume Data - Schedules V1A, V1B, V1C, V2A, V2B, V3A, V3B, V3C, V3D, V5;
Unassigned Expense - Schedule UA;
Hospital Based Physicians - Schedules P1A, P1B;
Physicians Part B Services - Schedules P2A - P2I;
Physician support Services - Schedules P3A to P3H;
Residents, Interns Services P4A to P4I; & P5A to P5I;
Overhead Expense Summary Schedule OES;
General Service Centers - Schedules C1 to C14;
Patient Care Centers - Schedules D1 to D81;
Auxiliary Enterprises - Schedules E1 to E9;
Other Institutional Programs - Schedules F1 to F4;
Allocation of Expenses (Cafeteria, Parking, Data Processing, etc.) OADP
Reconciliation of Base Year Expenses to Schedule RE - Schedule RC;
Statement of Revenues and Expenses - Schedule RE;
Overhead Expenses Apportionment - Schedules J1, J2;
Overhead Statistical Apportionment - Schedules JS1, JS2;
Building Facility Allowance - Schedule H1;
Department Equipment Allowance - Schedule H2;
Distribution of Capital Facility Allowance-Schedules H3A, H3B;
Capital Facility Allowance Summary-Schedule H4;
Other Financial Considerations-Schedule G

Cash and Marketable Assets-Schedule GR;
Payor Differential-Schedules PDA;
Revenue Center Rate Summary-Schedules M, MA, MB;
Unregulated Services - Schedules URI to UR7
Annual Cost Survey - Schedule ACS
Transactions with Related Entities – TRE

The above schedules are detailed in Sections 500.06 to 500.22 and 500.76 to 500.90.

Annual Financial Statements .0211

The Annual Financial Statements consist of the following schedules and detailed in Sub-Section .30 of Section 500.

Balance Sheet - Unrestricted Funds - (AUB)
Balance Sheet - Restricted Funds (ARB)
Statement of Change in Equity - (AFB)
Statement of Revenues and Expenses - (ARE)
Statement of Change in Financial Position - (AFP)

Monthly Financial Statements .0212

The Monthly Financial Statements consist of the following schedules and are detailed in Sub-Section .31 of Section 500.

Balance Sheet - Unrestricted Funds - Schedule QUB
Balance Sheet - Restricted Funds - Schedule QRB
Statement of Revenues and Expenses - Schedule QRE

Monthly Financial Statement Summary .0213

The Monthly Financial Statement Summary consists of the following schedule and is detailed in Sub-Section .32 of Section 500.

Financial Statement Summary - Schedule FS

Annual Statement of Change in Building and Equipment Fund Balances .0214

The Annual Statement of Change in Building and Equipment Fund Balances consists of the following schedule and is detailed in Sub-Section .33 of Section 500.

Statement of Change in Building and Equipment Fund Balances - Schedule CFA

Revenue and Volume Comparisons (RVC)

The above schedule is detailed in Section 500.51.

Annual Report of Revenues, Expenses and volumes .0218

Two (2) copies of the following annual reports of revenues, expenses and volumes are required to be submitted to the Commission within 90 days after the end of each hospital's fiscal year.

Inpatients and patient Days (V1A, V1B, V1C, V1D);
Outpatient Visits (V2A, V2B)
Ancillary Service Units (V3A, V3B, V3C, V3D);
Equivalent Inpatient Days and Admissions (V5);
Unassigned Expenses (UA);
Hospital Based Physicians, P1A, P1B);
Physicians Part B Services (P2A to P2I);
Physicians Support Services (P3A to P3H);
Residents, Interns Services (P4A to P4I & P5A to P5I);
Overhead Expense Summary (OES);
General Service Center (C);
Patient Care Center (D);
Auxiliary Enterprise (E1 to E9);
Other Institutional Programs (F1 to F4);
Allocation of Expenses (Cafeteria, Parking, Data Processing, etc.) OADP;
Reconciliation of Base Year Expenses to Schedule RE (RC);
Statement of Revenues and Expenses (RE);
Overhead Expenses Apportionment - Schedules (J1, J2);
Overhead Statistical Apportionment - Schedules (JS1, JS2);
Building Facility Allowance - Schedule (H1);
Department Equipment Allowance (H2);
Distribution of Capital Facility Allowance (H3A, H3B);
Capital Facility Allowance Summary (H4);
Other Financial Considerations (G)
Cash and Marketable Assets (GR);
Payor Differential (PDA);
Revenue Center Rate Summary (M, MA, MB);
Unregulated Services (UR1 to UR6);
Annual Cost Survey (ACS);
Transactions with Related Entities (TRE);

The above schedules are detailed in Section 500.06 to 500.22 and 500.90.

ANNUAL REPORTS OF REVENUES, EXPENSES AND VOLUMES .03

The reporting requirements under this Sub-Section include base year expenses and volume data by functional cost center, certain base year revenue by functional cost center and base year revenues and expenses in the aggregate. The requirements also include the projection of volume data by functional cost center and the projections of revenues and expenses in the aggregate.

The above reporting requirements necessitated by the needs of the Commission to review and compare hospital costs in order to determine their reasonableness.

GENERAL SEQUENCE FOR COMPARISON OF ANNUAL REPORTS OF REVENUES AND VOLUMES .04

A recommended sequence for completion of the Annual Reports of Revenues, Expenses and Volumes is outlined below.

1. Completion of Base Year and Projected Volume Data on Schedules V1A, V1B, V1C, V1D, V2A, V2B, V3A, V3B, V3C and V3D.
2. Calculation of EIPDs and EIPAs on Schedule V5.
3. Completion of Base Year expenses on Schedules P1A and P1B.
4. Completion of Schedule OES.
5. Completion of Base Year expenses on Schedules OADP, UA, C, D, E1 to E9, F1 to F4, P2A to P2I, P3A to P3H, P4A to P4I and P5A to P5I.
6. Completion of Schedule RE.
7. Completion of Schedule RC.
8. Completion of Schedule OADP.
9. Allocation of Base Year expenses from Schedules UA and C to Schedules E1 to E9 and F1 to F4.
10. Completion of Schedules E2, E7, E8, and E9 which include:
    a. Volume Data Section
    b. Base Year Data Section
    c. Base Year Profit (Loss) Section
    d. Base Year FTEs
11. Completion of the Base year FTE Line on Schedules C, D, E1, E3, E4, E5, E6, F1, to F4 P2A to P21, P3A to P3H, P4A to P41 and P5A to P5I.
12. Completion of Schedules E1, E3, E4, E5, and E6 which includes:
    a. Volume Data Section
    b. Base Year Data Section
    c. Base Year Profit (loss) Section

13. Completion of Schedules F1 to F4 which includes:
    a. Volume Data Section
    b. Base Year Data Section
    c. Base Year Profit (Loss) Section
14. Completion of Schedules UR1 to UR6 which includes:
    a. Volume Data Section
    b. Base Year Data Section
    c. Base Year Profit (Loss) Section
15. Completion of Schedule UA which includes:
    a. Base Year Data Section
16. Completion of Schedules J1, J2, JS1, JS2
17. Completion of Schedule H1
18. Completion of Schedule H2A
19. Completion of Schedules H3A to H3B
20. Completion of Schedule H4
    a. Base year Data Section
21. Completion of Schedule CFA
22. Completion of Schedule G
    a. Base Year Data Section
23. Completion of Schedule GR
    a. Base year Data Section
24. Completion of Schedule PDA
    a. Base Year Data Section
25. Completion of Schedules M, MA and MB
26. Completion of Schedule ACS

Corrections to Annual Reports of Revenues, Expenses and Volumes .05

Revisions of data for the annual reporting schedules must be submitted on the appropriate schedules completing the heading Section and entering the revised data only. The word "revised" must be printed above the Base Year or Budget Year Line.

SCHEDULE V1 ROUTINE SERVICE VOLUMES AND PATIENT DAYS .06

Overview .061

Schedules V1A is provided to enable each hospital to report certain inpatient statistics, including admissions (discharges) and patient days, for the following daily hospital service centers:

Center Nomenclature	Patient Care Center	Mode
Medical Surgical Acute	D1	MSG
Pediatrics Acute	D2	PED
Psychiatric Acute	D3	PSY
Obstetrics Acute	D4	OBS
Definite Observation	D5	DEF
Medical Surgical Intensive Care	D6	MIS
Coronary Care	D7	CCU
Pediatric Intensive Care	D8	PIC
Neo-Natal Intensive Care	D9	NEO
Burn Care	D10	BUR
Psychiatric Intensive Care	D11	PSI
Shock Trauma	D12	TRM
Oncology	D13	ONC
Newborn Nursery	D14	NUR
Premature Nursery	D15	PRE
Rehabilitation	D54	RHB
Psychiatric Adult	D70	PAD
Psychiatric Child/Adolescent	D71	PCD
Psychiatric Geriatric	D73	PSG
Pediatric Step-Down	D83	PSD

The line “Source” indicates computations to be made or the source of the data requested. Refer to Section 200.075 for description of the above daily hospital service centers.

Detailed Instructions .062

Heading Section

Institution Name Line
Enter on this line the complete name of the reporting hospital.

Institution Number Line
Enter on this line the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital’s Medicare Provider Number e.g. 0099.

Fiscal Year line
Enter on this line the year for which the fiscal year data is reported, e.g. 06- 10

Sch. V1 Col. 1- Admissions
Enter in this column, in each applicable daily hospital service center line, the number of admissions to the reporting hospital in the fiscal year.

Sch. V1 Col. 2- Patient Days
Enter in this column, in each applicable daily hospital service center line, the number of patient days for the fiscal year.

The patient days reported in each daily hospital service center should agree with the patient days reported on Schedule MS for the fiscal year. Submit appropriate explanations/reconciliations for any differences.

Sch. V1 Col. 3- Intra- Hospital Transfer In
Enter on this line, in each applicable daily hospital service center column, the number of patients transferred into each daily hospital service center of the reporting hospital in the fiscal year.

Sch. V1 Col.4 -Length of Stay
Enter in this column, in each applicable daily hospital service center line, the result of dividing Col. 2 (Patient Days) by the sum of Column 3 (Intra-Hospital Transfers In) and Col. 1 (Admissions).

Sch. V1 Col. 5 -Average Licensed Beds
Enter in the column, in each applicable daily hospital service cost center, the average number of licensed beds for the fiscal year.

In determining the average number of licensed beds, add the number of licensed beds at the beginning or end of each month and divide the result by 12.

The average number of licensed beds each month must agree with the licensed beds by month submitted on Schedule MS for the fiscal year.

Sch. V1 Col. 6 -% of Occupancy
Enter in this column, in each applicable daily hospital service line, the result of dividing the Patient Days by the results of multiplying Col. 5 (Average licensed beds) by 365 days or 366 leap year

Round each result to 3 decimal places e.g. 10000 / (30x365) = .913

SCHEDULE V2- AMBULATORY UNITS .07

Overview .071

Schedule V2 is provided to enable each hospital to report units of service for the following ambulatory service centers:

Center Nomenclature	Patient Care Center	Mode
Emergency Services	D18	EMG
Clinic Services	D19	CL
Day/Night Care Services	D20	PDC
Same Day Surgery	D22	SDS
Free Standing Emergency	D50	FSE
Observation	D55	OBV
Oncology Clinic	D58	OCL
Clinic Services 340B	D83	CL- 340
Referred Ambulatory Services	N/A	PAP

The line "Source" indicates computations to be made or the source of the data requested. Refer to Section 200.076 for description of the above daily hospital service centers.

Detailed Instructions .072

Heading Section

Institution Name Line
Enter on this line the complete name of the reporting hospital.

Institution Number Line
Enter on this line the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number e.g. 0099.

Fiscal Year Line
Enter on this line the year for which the fiscal year data is reported, e.g. 06-10

Sch. V2 Col. 1- Inpatient Visits
Enter in this column, in each applicable ambulatory service center line, the number of inpatient visits from the reported fiscal year.

Sch. V2 Col. 2- Outpatient Visits
Enter in this column, in each applicable ambulatory service center line, the number of outpatient visits from the reported fiscal year.

Sch. V2 Col. 3 -Total Visits
Total visits is the sum of Inpatient Visits (Col. 1) and Outpatient Visits (Col.2).

Sch. V2 Col. 4- Inpatient RVUs
Enter in this column, in each applicable ambulatory service center line, the number of inpatient RVUs from the reported fiscal year.

Sch. V2 Col.5 -Outpatient RVUs
Enter in this column, in each applicable ambulatory service center line, the number of outpatient RVUs from the reported fiscal year.

Sch. V2 Col. 6 -Total RVUs
Total RVUs is the sum of Inpatient RVUs (Col. 4) and Outpatient RVUs (Col.5).

SCHEDULE V3- ANCILLARY SERVICE UNITS .08

Overview .081

Schedule V3 is provided to enable each hospital to report units of service for the following ancillary service centers:

Center Nomenclature	Patient Care Center	Mode
Labor & Delivery	D23	DEL
Operating Room	D24	OR
Operating Room- Clinic	D24A	ORC
Anesthesiology	D25	ANS
Laboratory Services	D28	LAB
Electrocardiography	D30	EKG
Interventional Rad/Card	D31	IRC
Radiology	D32	RAD
Cat Scanner	D33	CAT
Radiology Therapeutic	D34	RAT
Nuclear Medicine	D35	NUC
Respiratory Therapy	D36	RES
Pulmonary Function Testing	D37	PUL
Electroencephalography	D38	EEG
Physical Therapy	D39	PTH
Occupational Therapy	D40	OTH
Speech Language Pathology	D41	STH
Recreational Therapy	D42	REC
Audiology	D43	AUD
Other Physical Medicine	D44	OPM
Organ Acquisition	D46	OA
Leukopheresis	D48	LEU
Hyperbaric Chamber	D49	HYP
MRI Scanner	D51	MRI
Lithotripsy	D53	LIT
Electroconv. Therapy	D80	ETH
Radiology Therapeutic 340B	D84	RAT- 340
Operating Room Clinic 340B	D85	ORC- 340
Laboratory 340B	D86	LAB- 340

The line “Source” indicates computations to be made or the source of the data requested. Refer to Section 200.077 for description of the above daily hospital service centers.

Detailed Instructions .082

Heading Section

Institution Name Line
Enter on this line the complete name of the reporting hospital.

Institution Number Line
Enter on this line the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g. 0099.

Fiscal Year Line
Enter on this line the year for which the fiscal year data is reported, e.g. 06-10

Sch. V3 Col.1 – Inpatient Volume
Enter in this column, in each applicable ancillary service center line, the inpatient volume for each ancillary service. The total inpatient units reported in each ancillary service center column should agree with the inpatient units reported on Schedule PS for the fiscal year. Submit appropriate explanations/reconciliations for any differences.
Do not report non-billed units incurred for quality control standards, duplicates and repeats for which the patient is not charged.

Sch. V3 Col.2 -Outpatient Volume
Enter in this column, in each applicable ancillary service center line, the outpatient volumes for each ancillary service. The outpatient units reported in each ancillary service center column should agree with the outpatient units reported on Schedules PSA and PSB for the base year. Submit appropriate explanations/reconciliations for any difference.
Do not report non-billed units incurred for quality control standards, duplicates and repeats for which the patient is not charged.

Sch. V3 Col.3 -Total Volume
Total volume is the sum of Inpatient Volume (Col. 1) and Outpatient Volume (Col. 2).

SCHEDULE V5 - EQUIVALENT INPATIENT DAYS AND ADMISSIONS .09

Overview .091

Schedule V5 is provided to enable each hospital to express outpatient visits and inpatient days as equivalent inpatient days (EIPD) and outpatient visits and inpatient admissions as equivalent inpatient admissions (EIPA).

The column headed Source indicates computations to be made or the source of the data requested.

Round the revenue on Lines A, B, C, F, G, and H to 1 decimal place (nearest hundred), e.g., $29,610,711.28 is entered as 29610.7.

Detailed Instructions .092

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line the year for which the base year data is reported, e.g., 06–79.

Budget Year Line

Enter on this line the year for which the budgeted data is reported, e.g., 06–80.

Equivalent Inpatient Days (EIPDs) Section

Line A - Gross Inpatient Revenue

Column 1

Enter on this line, in the Base Year Column, the gross inpatient revenue of the reporting hospital for the base year.

The gross inpatient revenue reported should agree with the gross inpatient revenue reported on Schedule RSC for the base year. Submit appropriate explanations/reconciliations for any differences.

Column 2

Enter on this line, in the Budget Year Column, the reporting hospital's projection of gross inpatient revenue for the budget year.

Line B - Inpatient Grant Revenue

Column 1

Enter on this line, in the Base Year Column, the gross inpatient revenue from grants of the reporting hospital for the base year.

Inpatient grant revenue is received from donors such as a state or federal agency as restricted funds for the purpose of providing patient care to inpatients of a hospital. Refer also to Section 100 24, Fund Accounting.

The inpatient grant revenue should be included on Schedule RE, Line L, Column 1,-Base Year.

Column 2

Enter on this line, in the Budget Year Column, the reporting hospital's projection of inpatient grant revenue for the budget year.

The budget year inpatient grant revenue should be included on Schedule RE, Line L, Column 2, Budget Year.

Line C - Total Inpatient Revenue

Columns 1 and 2

Enter on this line, ~~in each column,~~ the result of adding Line A, Gross Inpatient Revenue, with Line B, Inpatient Grant Revenue.

Line D - Total Inpatient Days (Excl. Nursery)

Column 1

Enter on this line, in the Base Year Column, the patient days from Schedule V1D, Line G, Column 4, Sub-Total.

Column 2

Enter on this line, in the Budget Year Column, the patient days from Schedule V1D, Line H, Column 4, Sub-Total.

Line E - Inpatient Unit Revenue

Columns 1 and 2

Enter on this line, in each column, the result of dividing Line C, Total Inpatient Revenue, by Line D, Total Inpatient Days (Excl. Nursery).

Round each result to 5 decimal places, e.g., 2248.7 - 10000 = .22487.

Line F - Gross Outpatient Revenue

Column 1

Enter on this line, in the Base Year Column, the gross outpatient revenue of the reporting hospital for the base year.

The gross outpatient revenue reported should agree with the gross outpatient revenue reported on Schedule RS for the base year. Submit appropriate explanations/reconciliations for any differences.

Column 2

Enter on this line, in the Budget Year Column, the reporting hospital's projection of gross outpatient revenue for the budget year.

The projection of gross outpatient revenue should agree with the gross outpatient revenue reported on Schedule RE, Lines B and D, Column 2, Budget Year.

Line G - Outpatient Grant Revenue

Column 1

Enter on this line, in the Base Year Column, the gross outpatient revenue from grants of the reporting hospital for the base year.

Outpatient grant revenue is received from donors, such as a state or federal agency, as restricted funds for the purpose of providing patient care to outpatients of a hospital. Refer also to Section 100.24, Fund Accounting.

The outpatient grant revenue should be included on Schedule RE, Line L. Column 1, Base Year.

Column 2

Enter on this line in the Budget Year Column, the reporting hospital's projection of outpatient grant revenue for the budget year.

The budget year outpatient grant revenue should be included on Schedule RE, Line L, Column 2, Budget Year.

Line H - Total Outpatient Revenue

Columns 1 and 2

Enter on this line, in each column the result of adding Line F, Gross Outpatient Revenue, with Line G, Outpatient Grant Revenue.

Line 1 - Total Outpatient Visits

Column 1

Enter on this line in the Base Year Column the total of the outpatient visits from Schedule V2A. Line A. Columns 1, 2, 3 and 5 and Schedule V2B, Line A, Column 3.

Column 2

Enter on this line, in the Budget Year Column, the outpatient visits from Schedule V2A, Line D. Columns 1, 2, 3 and 5 and Schedule V2B, Line D, Column 3.

Line J - Outpatient Unit Revenue

Columns 1 and 2

Enter on this line, in each column, the result of dividing Line H, Total Outpatient Revenue, by Line I, Total Outpatient Visits.

Round each result to 5 decimal places, e.g., 450.9 divided by 25038 = .01801.

Line K - Inpatient - Outpatient Unit Revenue Ratio

Columns 1 and 2

Enter on this line, in each column, the result of dividing Line E, Inpatient Unit Revenue, by Line J, Outpatient Unit Revenue.

Round each result to 4 decimal places, e.g., 22487 divided by .01801 - 12.4858

Line L - Inpatient Equivalent of Outpatient Visits

Columns 1 and 2

Enter on this line, in each column, the result of dividing Line I, Total Outpatient Visits, by Line K, Inpatient - Outpatient Unit Revenue Ratio.
Round each result to the nearest whole unit, e.g., 25038 ÷ 12.4858 = 2005.

Line M - Equivalent Inpatient Days (EIPDs)

Columns 1 and 2

Enter on this line, in each column, the result of adding Line D, Total Inpatient Days (Excl. Nursery), and Line L, Inpatient Equivalent of Outpatient Visits.

Transfer the EIPDs from the Base Year Column to Schedule C-Column 1, Lines C4,C9,C11, and C13.

Equivalent Inpatient Admissions (EIPAs) Section

Line N - Total Inpatient Admissions (Excl. Nursery)

Column 1

Enter on this line, in the Base Year Column, the inpatient admissions (discharges) from Schedule VID, Line A, Column 4, Sub-Total.

Column 2

Enter on this line, in the Budget Year Column, the inpatient admissions (discharges) from Schedule V1D, Line D, Column 4, Sub-Total.

Line O - Inpatient Unit Revenue

Columns 1 and 2

Enter on this line, in each column, the result of dividing Line C, Total Inpatient Revenue, by Line N, Total Inpatient Admissions (Excl. Nursery).

Round each result to 5 decimal places, e.g., 2248.7 ÷ 5038 = .44635.

Line P - Outpatient Unit Revenue

Columns 1 and 2

Enter on this line, in each column, the result of dividing Line H, Total Outpatient Visits, by Line 1 Outpatient Unit Revenue.

Round each result to 5 decimal places, e.g., 450.9 divided by 25038 = .01801.

Line Q - Inpatient - Outpatient Revenue Ratio

Columns 1 and 2

Enter on this line, in each column, the result of dividing Line O, Inpatient Unit Revenue, by Line P. Outpatient Unit Revenue.

Round each result to 4 decimal places, e.g., 44635 divided by .01801 = 24.7835.

Line R - Inpatient Equivalent of Outpatient Visits

Columns 1 and 2

Enter on this line, in each column, the result of dividing Line 1, Total Outpatient Visits, by Line Q, Inpatient - Outpatient Unit Revenue Ratio.

Round each result to the nearest whole unit, e.g., 25038 divided by 24.7835 = 1010.

Line S - Equivalent Inpatient Admissions (EIPAs)

Columns 1 and 2

Enter on this line, in each column, the result of adding Line N, Total Inpatient Admissions (Excl. Nursery), with Line R, Inpatient Equivalent of Outpatient Visits.

Transfer the EIPAs from the Base Year Column to Schedule C - Column 1, Lines C7 and C8.

SCHEDULE OADP Allocation of Expenses (Cafeteria, Parking and Data Processing) .10

Overview .101

Schedule OADP is provided to enable each hospital to distribute data processing expenses, full time equivalent (FTE) and non-payroll related employee benefits, such as cafeteria, parking, housing and day care centers to benefitting cost centers.

Schedule OADP must be completed by each hospital that completes line 1 of Schedules E2, E7, E8 or E9. Schedule OADP must also be completed by each hospital that maintains a data processing center or leases/rents data processing services from a shared computer or service bureau.

The column headed Source indicates computations to be made or the source of the data requested.

Refer to Section 200.075 for description of the above daily hospital service centers.

Round the FTE data on line B and D to 1 decimal place.

Round the loss on FTE on Line C to 5 decimal places.

Detailed Instructions .102

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number e.g. 0099.

Base Year line

Enter on this line the year for which the base year data is reported, e.g. 06- 10

Allocation of Cafeteria/Parking Expense

Loss per FTE Section

Line A- Col. 1 Gain (Loss) to be Allocated as Fringe Benefit

Enter on this line in the total column, the amount of the gain (loss) to be allocated as a fringe benefit, transferred from E2, E7 and E8, Line 1, column 3.

Line B- Number of FTEs

Line B Col. 1- Number of FTEs

Enter on this line, the number of FTEs for the reported base year.

Line B1- Loss Per FTE

Line B1 Col.1
Enter on this line, in the Total Column, the result of dividing Line A, Loss to be allocated as fringe by Line B, Number of FTEs, e.g. 110.9 divided by 985.7= .12521.

Allocation of Data Processing

Line C1- Base Year Expenses

Col.2- Wages, Salaries and Benefits

Enter in this line, the expenses of the reporting hospital incurred in the base year for the following major natural classifications of expense categories:

.10 Salaries and Wages

Expenses which are normally reported in the above categories are:

.01 Management and Supervision
.02 Technician and Specialist
.11 Environment, Hotel and Food Service Employee
.12 Clerical and Other Administrative Employee
.21 FICA
.22 SUI and FUI (UIC)
.23 Group Health Insurance
.24 Group Life Insurance
.25 Pension and Retirement
.26 Workmen’s Compensation Insurance
.27 Union Health and Welfare
.28 Other Payroll Related Employee Benefits
.29 Employee Benefits (Non-Payroll Related)

Column 3 -Other Expenses

Enter in this line, the expenses of the reporting hospital incurred in the base year for the following major natural classification of expenses categories:

.30 Professional Fees
.50 Non-Medical and Non-Surgical Supplies
.70 Purchased Services
.80 Other Direct Expenses

Expenses which are normally reported in the above categories

.56 Office and Administrative Supplies
.75 Data Processing
.76 Management and Contracted Services
.84 Dues, Books and Subscription
.85 Outside Training Sessions
.86 Travel- Other
.87 Postage

Classification .88, Printing and Duplicating, is to be reported in Hospital Administration, Account 8610. Note, however that data processing paper is reported in classification .56, Office and Administrative Supplies.

Classification .95 .96 and .97, Lease/Rentals are not to be reported in this cost center but are to be reported in Leases and Rentals, Account 8820 and Schedule UR, Unassigned Expense. Refer also to Section 100.511, Building and Fixtures, and Section 100.512, Movable Equipment.

Column 4- Total Expenses

Enter in this column, in the Total Expenses Column, the results of adding the expenses from Column 1 and 2.

Line C2- Donated Services and Commodities

Column 2

Enter on this line, in the Wages, Salaries and Fringe Benefits Column, the donated services expenses in accordance with Section 100.11 Basis of Valuation, utilizing the natural expense categories outlined in instructions for Line A, Column 1, of this schedule.

Column 3

Enter on this line, in the Other Expenses Column, the donated commodities in accordance with Section 100.11, Basic Valuation; utilizing the natural expense categories outlined in the instructions for Line A, Column 2 of this schedule.

Column 4-

Enter on this line, in the Total Expense Column, the result of adding the donated services and commodities from Column 2 and Column 3

Line C3- Base Year Adjusted Expenses

Enter on this line, in each expense column and the Total Expenses Column, the result of adding Line C1 and Line C2.

Distribution of Gain (Loss) Per FTE Section

Lines D1 to D351

Col. 1- FTEs-

Enter in this column, in the Number of FTEs column, the number of FTEs transferred from the general service centers (Schedule C, Lines C1 to C15, Column 8), patient care service centers (Schedule D, Lines D1 to D81, Column 9), auxiliary enterprise centers (Schedule E1 to E9, Column 7), other institutional program centers (Schedule F1 to F4, column 7), medical staff service centers (Schedules P2A to P2G. Line J, Columns 1 to 7), physician support services centers (Schedules P3A to P3G, Line J, Column 1 to 7) and residents, interns services centers (Schedules P4A to P4G, Line J, 1 to 7).

Col. 2- Gain (Loss) on Calculation-

Enter in this column the results of multiplying the Gain (loss) per FTE (Col.1 Line B1) by the No. of FTEs noted in Col. 1.

Distribution of Data Processing Allocation

Col. 3- Allocation Amount

Enter the allocation amount per cost center based on an allocation methodology noted below.
This allocation methodology should be based on Actual Worked Time, Charge/Service Tickets, Total Dollar Spent, or a combination of metrics, to ensure an appropriate allocation of costs to the rate center.

Col.4- Basis

Enter on these lines, in the Basis Column, the percentage expressed as a decimal, allocated to each cost center, e.g. .751

Round the entries to 3 decimal places.

Col. 5- Wages, Salaries and Fringe Benefit-

Enter on these lines the amount when you multiply the Wages, Salaries and Fringe Benefit (Col.2 Line C3) by the Basis percentage (Col. 4).

Col. 6- Other Expenses-

Enter on these lines the amount when you multiply the Other Expense (Col. 3 Line C3) by the Basis percentage (Col. 4).

Col. 7- Data Processing Allocation-

Enter on each line the sum of Col. 5- Wages, Salaries and Fringe Benefits plus Col. 6- Other Expenses.

Col. 8- Total Allocated Expense

Enter on each line the sum of Col. 2 – Gain (Loss) on Calculation and Col.7- Data Processing Allocation.

SCHEDULE UA - UNASSIGNED EXPENSE .11

Overview .111

Schedule UA is provided to enable each hospital to report the following expenses which are not assigned to specific departments:

Nomenclature	Account Number	Code
Depreciation and Amortization	8810	DEP
Leases and Rentals	8820	LEA
Malpractice Insurance	8830	MAL
Other Insurance	8840	OIN
Licenses and Taxes	8850	LIC
Interest Short Term	8860	IST
Interest Long Term	8870	ILT
Medical Care Review	8880	MCR

Descriptions and functions of these accounts are located in Section 200.0787, Unassigned Expenses.

Refer to Section 100.28 Accounting for Plant, Property and Equipment and Section 100.51, Direct Recording of Costs for additional details concerning depreciation.

Refer to Section 100.51, Direct Recording of Costs for additional details concerning leases and rentals.

The column entitled Source indicates computations to be made or the source of the data requested.

Unassigned expenses associated with auxiliary enterprises and unregulated services should be reported on Schedule RE, Line V, Non-operating Expenses and Unregulated Expenses.

Unassigned expenses associated with Other Institutional Programs (OIPs) should be included in Line A, Base Year Expenses.

Round all dollar amounts to 1 decimal place (nearest hundred), e.g., $88,638.19 is entered as 88.6.

Only the Base Year Data section is required to be completed for the annual reporting requirements.

Detailed Instructions .112

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line the year for which the base year data is reported, e.g., 06–79.

Budget Year Line

Enter on this line the year for which the budgeted data is reported, e.g., 06–80.

Base Year Data Section

Line A - Base Year Expenses

Column 1

Enter on this line, in the Malpractice Insurance Column, the malpractice insurance expense incurred in the base year in accordance with Section 200.0787, Unassigned Expenses, Account 8830.

Column 2

Enter on this line, in the Other Insurance Column, the other insurance expense incurred in the base year in accordance with Section 200.0787, Unassigned Expenses, Account 8840.

Column 3

Enter on this line in the Medical Care Review Column, the medical care review expenses incurred in the base year in accordance with Section 200.0787, Unassigned Expenses, Account 8880.

Column 4

Enter on this line, in the Sub-Total Column, the result of adding Column 1, Malpractice Insurance, Column 2, Other Insurance and Column 3, Medical Care Review.

Column 5

Enter on this line, in the Depreciation & Amortization Column, the depreciation and amortization expense incurred in the base year in accordance with Section 200.0787, Unassigned Expenses, Account 8810. Include depreciation of capitalized leased equipment.

Column 6

Enter on this line, in the Leases and Rental Column, the leases and rentals expense incurred in the base year in accordance with Section 200.0787, Unassigned Expenses, Account 8820. Exclude costs of capitalized leased equipment.

Column 7

Enter on this line, in the Licenses and Taxes Column, the licenses and taxes expense in the base year in accordance with Section 200.0787, Unassigned Expenses, Account 8850.

Column 8

Enter on this line, in the Interest Short Term Column, the short term interest expense incurred in the base year in accordance with Section 200.0787, Unassigned Expenses, Account 8860.

Column 9

Enter on this line, in the Interest Long Term Column, the long term interest expense incurred in the base year in accordance with Section 200.0787, Unassigned Expenses, Account 8870.

Column 10

Enter on this line, in the Total Expenses Column, the result of adding Column 4, Sub-Total, Column 5, Depreciation and Amortization, Column 6, Leases and Rentals, Column 7, Licenses and Taxes, Column 8, Interest Short Term, and Column 9, Interest Long Term.

Transfer the total expenses to Schedule RC, Line B, Column 1, Base Year.

Line B - Allocation to Aux. Ent. & UR's

Column 1, 2, 3, 5, 6, 7, 8, 9

Enter on this line, in each applicable expense column, the allocation of base year expenses to Auxiliary Enterprises, Schedules E1 to E9 and Unregulated Services, UR Schedules.

Column 4

Enter on this line, in the Sub-Total Column, the result of adding column 1, Malpractice Insurance, Other Insurance, and Column 3, Medical Care Review.

Column 10

Enter on this line, in the Total Expenses Column, the result of adding Column 4, Sub-Total, Column 5, Depreciation and Amortization, Column 6, Leases and Rentals, Column 7, Licenses and Taxes, Column 8, Interest Short Term and Column 9, Interest Long Term.

Transfer the total expenses to the appropriate Schedule E1 to E9, Lines D1 to D6, Column 2, Other Expenses and UR Schedules, Lines D1 to D6, Column 2, Other Expenses.

Line C - Base Year Expenses - Adj.

Columns 1 to 10

Enter on this line, in each expense column, the Sub-Total Column and the Total Expenses Column, the result of adding Line A, Base Year Expenses and Line B, Allocation to Aux. Ent. & Unregulated Services.

Verify that the addition of the expenses in Column 1, Column 2 and Column 3 equal the expenses in the Sub-Total Column and that the addition of the expenses in Columns 4 to 8 equals the expenses in the Total Expenses Column.

Budget Year Data Section

Line D - Inflation

Columns 1, 2 and 3

Enter on this line, in each expense column, the projected inflation for the budget year utilizing Commission supplied inflation factors, price leveled for the appropriate time period.

Column 4 and 10

Enter on this line, in Column 4, Sub-Total and Column 10, Total Expenses, the result of adding Column 1, Malpractice Insurance, Column 2, Other Insurance and Column 3, Medical Care Review.

Line E - Operating Economies

Columns 1, 2, 3, 5, 6, 7, 8, 9

Enter on this line, in each applicable expense column, the projection of operating economies for the budget year.

Operating economies are defined as planned changes in staffing, operating policies, etc., which will result in a reduction in unit costs.

Column 3

Enter on this line, in the Sub-Total Column, the result of adding Column 1, Malpractice Insurance, Column 2, Other Insurance and Column 3, Medical Care Review.

Line F - New Programs

Columns 1, 2, 3, 5, 6, 7, 8, 9

Enter on this line, in each applicable expenses column, the projection of new programs for the budget year.

New Programs are defined as planned changes in staffing, operating policies, etc., which will result in an increase in unit costs.

Column 4

Enter on this line, in the Sub-Total Column, the result of adding Column 1, Malpractice Insurance, Column 2, Other Insurance and Column 3, Medical Care Review.

Column 10

Enter on this line, in the Total Expenses Column, the result of adding Column 4, Sub-Total, Column 5, Depreciation and Amortizations, Column 6, Leases and Rentals, Column 7, Licenses and Taxes, Column 8, Interest Short Term and Column 9, Interest Long Term.

Line G - Misc. Adjustments

Columns 1, 2, 3, 5, 6, 7, 8, 9

Enter on this line, in each applicable expense column, the projection of miscellaneous adjustments for the budget year.

Miscellaneous adjustments are defined as planned increases in costs not accounted for on Lines D, E, and F, e.g., projected salary increases above the Commission supplied inflation factor.

Column 4

Enter on this line, in the Sub-Total Column, the result of adding Column 1, Malpractice Insurance, and Column 2, Other Insurance.

Column 10

Enter on this line, in the Total Expenses Column, the result of adding Column 4, Sub-Total, Column 5, Depreciation and Amortization, Column 6, Leases and Rentals, Column 7, Licenses and Taxes, Column 8, Interest Short and Column 9, Interest Long Term.

Line H - Budget Year Expenses

Columns 1 to 10

Enter on this line, in each expense column, the Sub-Total Column and the Total Column, the result of adding Line C, Base Year Expenses, Line D, Inflation, Line E, Operating Economies, Line F, New Programs and Line G, Miscellaneous Adjustments.

Verify that the addition of the expenses in Columns 1, 2 and 3 equal the expenses in the Sub-Total Column and that the addition of the expenses in Column 4 to 9 equals the expenses in the Total Expenses Column.

Transfer the total expenses to Schedule RC, Line B, Column 2, Budget Year.

SCHEDULES P1A, P1B, - HOSPITAL BASED PHYSICIANS ALLOCATION .12

Overview .121

Schedules P1A and P1B are provided to enable each hospital to distribute hospital based physicians compensation to benefiting cost centers. Refer to Section 100.55 and Appendix A for a definition of hospital based physicians.

Schedules P1A and P1B must be completed by each hospital that compensates hospital based physicians in accordance with Section 100.551, Financial Arrangements and Section 100.552, Work Arrangement.

Only report the compensation of:

1) Salaries physicians;
2) Physicians paid directly by the hospital for services rendered;
3) Physicians whose fees for services rendered are billed under the hospital's provider number.
4) Compensation incurred for hospital based physicians engaged in; research, medical care review, administration and supervision, education and as Chief of Staff for the benefit of all patients, plus the compensation incurred for hospital based physicians part B services for non-Medicare patients.

Round all expenses to 1 decimal place (nearest hundred), e.g., $85, 900.82 is entered as 85.9.

Detailed Instructions .122

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Fiscal Year Line

Enter on this line the year for which the fiscal year data is reported, e.g., 06-79.

Cost Center Section

Lines A1 to A52

Schedules P1, P1B - Column 1

Enter in this column, on each applicable cost center line, the compensation, including payroll related fringe benefits, incurred in the fiscal year for hospital based physicians engaged in research projects.

Refer to Section 200.0781, Research Expenses, Account 8010 for a definition and description of research costs.

Schedules P1A, P1B - Column 2

Enter in this column, on each applicable cost center line, the compensation, including payroll related fringe benefits, incurred in the fiscal year for hospital based physicians functioning as the Chief of the Medical Staff.

Schedules P1A, P1B - Column 3

Enter in this column, on each applicable cost center line, the compensation, including payroll related fringe benefits, incurred in the fiscal year for hospital based physicians engaged in peer review, quality assurance and PSRO activities.

Refer to Section 200.0787, Account 8880, Medical Care Review for a definition and description of medical care review activities.

Schedule P1A, P1B - Column 4

Enter in this column, on each applicable cost center line, the compensation, including payroll related fringe benefits, incurred in the fiscal year for hospital based physicians engaged in administration and supervision of departments.

Transfer the expenses in this column from each cost center line, A1 to A52, to the appropriate Schedule D1 to D54, Line B, Column 2, Physician Supervision Expenses.

Schedules P1A, P1B - Column 5

Enter in this column, on each applicable cost center line, the compensation, including payroll related fringe benefits, incurred in the fiscal year for hospital based physicians engaged in diagnosis or treatment of identifiable non-Medicare patients.

Transfer the total expenses in Column 5, line B to Schedule P2, Line A, Column 1.

Schedules P1A, P1B - Column 6

Enter in this column, on each applicable cost center line, the compensation, including payroll related fringe benefits, incurred in the fiscal year for hospital based physicians engaged in education activities.

Transfer the expenses in this column from each cost center line, A1 to A52, to the appropriate Schedule P4A to P4G, Line B, Column 1 to 6.

Refer to Section 200.0782, Education Expenses, for definitions and descriptions of education activities.

Schedule P1A, P1B - Column 7

Enter in this column, on each applicable cost center line, the total compensation, including payroll related fringe benefits, incurred in the fiscal year for hospital based physicians.

Verify that the addition of column 1, Research, Column 2, Chief of Medical Staff, Column 3, Medical Care Review, Column 4, Administration and Supervision, Column 5, Non-Medicare Professional Component and Column 6, Education, equals Column 7, Total for each cost center, Lines A1 to A52.

Line B - Totals

Schedule P1B - Columns 1 to 7

Enter on this line, in each column and the Total Columns, the result of adding Lines A1 to A52, Fiscal Year Expenses.

Verify that the addition of Column 1, Column 2, Column 3, Column 4, Column 5 and Column 6 equals Column 7.

Transfer the total expenses Column 1, Research, to Schedule F1, Line B, Column 1, Wages, Salaries and Fringe Benefits.

Transfer the total expenses in Column 2, Chief of Medical Staff, to Schedule C13, Line B, Column 1, Wages, Salaries and Fringe Benefits.

Transfer the total expenses in Column 3, Medical Care Review, to Schedule UA. Line A, Column 3, Medical Care Review. Include all PSRO incurred expenses, even if directly reimbursed through the hospital's Medicare Intermediary.

Transfer the total expenses in Column 5, Non-Medicare Professional Component to Schedule P2H, Line A, Column 7, Total.

Transfer the total expenses in Column 6, Education, to either Schedule P4H, Line B, Column 7, Total or Schedule P5H, Line B, Column 7, total.

Reporting Schedule Section

Line C - Cost Center Schedule

Schedule P1B - Columns 1 to 6

The entries on this line refer to the cost centers to which the hospital based physicians compensation is transferred.

SCHEDULES P2A - P2I - PHYSICIANS PART B SERVICES (NON-MEDICARE) .13

OVERVIEW .131

Schedules P2A - P2I are provided to enable each hospital to report compensation and fringe benefits expense for hospital-based physicians engaged in providing diagnosis or treatment of identifiable non-Medicare patients for all functional cost centers (Physicians Part B Services) at the hospital.

Schedules P2A-P2I must be completed for all hospitals with non-Medicare Part B physicians' costs in rates.

Round the expenses on Lines A, B, C, D, F, G, H and I to 1 decimal place (nearest hundred), e.g., $128,610.50 is entered at 128.6.

Round the FTE data on Lines J and K to 1 decimal place, e.g., 10912 hours divided by 2080 = 5.2.

Detailed Instructions .132

Heading Section

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Fiscal Year Line

Enter on this line the year for which the fiscal year date is reported, e.g., 06–90.

Fiscal Year Data Section

Line A - Fiscal Year Expenses

Schedule P2A - Columns 1 to 7

Schedule P2B - Columns 1 to 7

Schedule P2C - Columns 1 to 7

Schedule P2D - Columns 1 to 7

Schedule P2E - Columns 1 to 7

Schedule P2F - Columns 1 to 7

Schedule P2G - Columns 1 to 7

Schedule P2H - Columns 1 to 7

Schedule P2I - Columns 1 to 6

Enter on this line, in each applicable cost center column, the non-Medicare professional component expenses transferred from Schedules P1A and P1B, Lines A1 to A54, Column 5, Part B Services.

Schedule P2I - Column 7

Enter on this line, in the Total Column, the non-Medicare professional component expenses transferred from Schedule P1B, Line B, Column 5, Part B Services, except Private Psychiatric Hospitals.

Verify the result of adding Line A, Fiscal Year Expenses, from each cost center column (Schedule P2A, Columns 1 to 7, Schedule P2B, Columns 1 to 7, Schedule P2C, Columns 1 to 7, Schedule P2D, Columns 1 to 7, Schedule P2E, Columns 1 to 7, Schedule P2F, Columns 1 to 7, Schedule P2G, Columns 1 to 7, Schedule P2H, Columns 1 to 7, Schedule P2I, Columns 1 to 6) to Schedule P2I, Line A, Column 7, Total.

Transfer the total expenses to Schedule RC, Line C, Column 1, Fiscal Year.

Line B - Allocation from Cafeteria, Parking, Etc.

Schedule P2A - Columns 1 to 7

Schedule P2B - Columns 1 to 7

Schedule P2C - Columns 1 to 7

Schedule P2D - Columns 1 to 7

Schedule P2E - Columns 1 to 7

Schedule P2F - Columns 1 to 7

Schedule P2G - Columns 1 to 7

Schedule P2H - Columns 1 to 7

Schedule P2I - Columns 1 to 6

Enter on this line the allocation of non-Medicare general services expenses and data processing expenses from Schedule OES, Line P, Column 4, plus the allocation of cafeteria, parking, etc. from Schedule OAC, Line 74 to 121, Columns 2 and 4.

Schedule P2H - Column 7

Enter on this line, in the Total Column, the result of adding the allocation from each cost center column (Schedule P2A, Columns 1 to 7, Schedule P2B, Columns 1 to 7, Schedule P2C, Columns 1 to 7, Schedule P2D, Columns 1 to 7, Schedule P2E, Columns 1 to 7, Schedule P2F, Columns 1 to 7, and Schedule P2G, Columns 1 to 7, Schedule P2H, Columns 1 to 7 and Schedule P2I, Columns 1 to 6).

Line C - Donated Services

Schedule P2A - Columns 1 to 7

Schedule P2B - Columns 1 to 7

Schedule P2C - Columns 1 to 7

Schedule P2D - Columns 1 to 7

Schedule P2E - Columns 1 to 7

Schedule P2F - Columns 1 to 7

Schedule P2G - Columns 1 to 7

Schedule P2H - Columns 1 to 7

Schedule P2I - Columns 1 to 6

Enter on this line, in each applicable cost center column, donated services expenses in the fiscal year in accordance with Section 100.11, Basis of Valuation.

Schedule P2I - Column 7

Enter on this line, in the Total Column, the result of adding the donated services from each cost center column (Schedule P2A, Columns 1 to 7, Schedule P2B, Columns 1 to 7, Schedule P2C, Columns 1 to 7, Schedule P2D, Columns 1 to 7, Schedule P2E, Columns 1 to 7, Schedule P2F, Columns 1 to 7, Schedule P2G, Columns 1 to 7 and Schedule P2I, Columns 1 to 6).

Line D - Fiscal Year Expenses Adjusted

Schedule P2A - Columns 1 to 7

Schedule P2B - Columns 1 to 7

Schedule P2C - Columns 1 to 7

Schedule P2D - Columns 1 to 7

Schedule P2E - Columns 1 to 7

Schedule P2F - Columns 1 to 7

Schedule P2G - Columns 1 to 7

Schedule P2H - Columns 1 to 7

Schedule P2I - Columns 1 to 6

Enter on this line, in each cost center column and the Total Column, the result of adding Line A, Base Year Expenses, with Line B, Allocation from General Services, Data Processing plus Cafeteria, Parking, etc., and Line C, Donated Services.

Verify the result of adding the base year expenses adjusted from each cost center column (Schedule P2A, Columns 1 to 7, Schedule P2B, Columns 1 to 7, Schedule P2C, Columns 1 to 7, Schedule P2D, Columns 1 to 7, Schedule P2E, Columns 1 to 7, Schedule P2F, Columns 1 to 7, and Schedule P2G, Columns 1 to 7, Schedule P2H, Columns 1 to 7 and Schedule P2I, Columns 1 to 6) to Schedule P2I, Line D, Column 7, Total.

Inflation Factor Section

Line E - Inflation Factor

Schedule P2A - Columns 1 to 7

Schedule P2B - Columns 1 to 7

Schedule P2C - Columns 1 to 7

Schedule P2D - Columns 1 to 7

Schedule P2E - Columns 1 to 7

Schedule P2F - Columns 1 to 7

Schedule P2G - Columns 1 to 7

Schedule P2H - Columns 1 to 7

Schedule P2I - Columns 1 to 6

Enter on this line, in each applicable cost center column, the Commission supplied inflation factor for wages, salaries and fringe benefits, price leveled for the appropriate time period, e.g., .07 × 1.5 = .105.

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Line J - Adj. Fiscal Year Hours Worked divided by 2080

Schedule P2A - Columns 1 to 7

Schedule P2B - Columns 1 to 7

Schedule P2C - Columns 1 to 7

Schedule P2D - Columns 1 to 7

Schedule P2E - Columns 1 to 7

Schedule P2F - Columns 1 to 7

Schedule P2G - Columns 1 to 7

Schedule P2H - Columns 1 to 7

Schedule P2I - Columns 1 to 6

Enter on this line, in each cost center column, the result of dividing the adjusted fiscal year hours worked by 2080, e.g., 10,912 divided by 2080 = 5.2.

Transfer the FTE data from each cost center column to Schedules OAC thru OAD, Lines 74 to 121 in Columns 1, Number of FTEs.

Worked hours are to be counted in accordance with Section 200.0371, Salaries and Wages. Include hours worked for donated services.

Schedule P2I - Column 7

Enter on this line, in the Total Column, the result of adding the FTEs from each center column (Schedule P2A, Columns 1 to 7, Schedule P2B, Columns 1 to 7, Schedule P2C, Columns 1 to 7, Columns P2D, Columns 1 to 7, Schedule P2E, Columns 1 to 7, Schedule P2F, Columns 1 to 7, Schedule P2G - Columns 1 to 7, Schedule P2H - Columns 1 to 7 and Schedule P2I, Columns 1 to 6).

SCHEDULES P3 - PHYSICIAN SUPPORT SERVICES .14

Overview .141

Schedule P3 are provided to enable each hospital to report wages, salaries and fringe benefits for physician support administration and supervision support services, excluding Certified Nurse Anesthetists, for the following functional cost centers.

Nomenclature	Account Number	Code
Medical Surgical Acute	8740	MSG
Pediatrics Acute	8740	PED
Psychiatric Acute	8740	PSY
Obstetrics Acute	8740	OBS
Definitive Observation	8740	DEF
M/S Intensive Care	8740	MIS
Coronary Care	8740	CCU
Pediatric Intensive Care	8740	PIC
Neo-Natal Intensive Care	8740	NEO
Burn Care	8740	BUR
Psychiatric Intensive Care	8740	PSI
Shock Trauma	8740	TRM
Oncology	8740	ONC
Newborn Nursery	8740	NUR
Premature Nursery	8740	PRE
Rehabilitation	8740	RHB
Emergency Services	8740	EMG
Clinic Services	8740	CL
Psych. Day & Night Care	8740	PDC
Labor & Delivery Services	8740	DEL
Operating Room	8740	OR
Operating Room Clinic	8740	ORC
Anesthesiology	8740	ANS
Laboratory Services	8740	LAB
Blood Bank	8740	BB
Electrocardiography	8740	EKG
Interventional Radiology/Cardiovascular	8740	IRC
Radiology-Diagnostic	8740	RAD
CT Scanner	8740	CAT
Radiology-Therapeutic	8740	RAT
Nuclear Medicine	8740	NUC
Respiratory Therapy	8740	RES
Pulmonary Function	8740	PUL

Nomenclature	Account Number	Code
Electroencephalography	8740	EEG
Physical Therapy	8740	PTH
Occupational Therapy	8740	OTH
Speech-Language Pathology	8740	STH
Recreational Therapy	8740	REC
Audiology	8740	AUD
Other Physical Medicine	8740	OPM
Renal Dialysis	8740	REL
MRI Scanner	8740	MRI
Same Day Surgery	8740	SDS
Kidney Acquisition	8740	KA
Ambulatory Surgery	8740	AOR
Leukopheresis	8740	LEU
Hyperbaric Chamber	8740	HYP
Free Standing Emergency Service	8740	FSE
MRI Scanner	8740	MRI
Lithotripsy	8740	LIT
Chronic	8740	CRH
Clinic- 340B	8740	CL-340
Radiology Therapeutic- 340B	8740	RAT- 340
Operating Room Clinic- 340B	8740	ORC- 340
Laboratory- 340B	8740	LAB- 340

Detailed Instructions .142

Heading Section

Institution Line:
Enter on this line the complete name of the reporting hospital

Institution Number Line
Enter on this line, the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number e.g. 0099.

Schedule P3 Fiscal Year Expenses (Column 1)
Enter in this column for each applicable rate center the salaries, compensation and fringe benefits expenses incurred for the administrative and supervision portion of the hospital's non-physician medical practitioners.

Non-physician medical practitioners are:

Physician Assistants
Clinical Nurse Specialist
Nurse Practitioners
Clinical Psychologist
Other non-physician medical practitioners that can bill professionally

Please note the expenses in this column must be identical to the Medicare Part A expenses reported on W/S A-8-2 of the Medicare cost report. In addition hospital must maintain time studies to support the expense allocation on Schedule P3. If no time studies are developed then the entire expense per rate center should be reported on the hospital Schedule UR Physician Support Part B Services.

Schedule P3- Allocation from Cafeteria, Parking Etc. (Column 2)
Enter in this column for each applicable rate center, the allocation of cafeteria, parking etc. from Schedule OADP Lines 148 to 198.

Schedule P3 – Donated Services (Column 3)
Enter in this column for each applicable rate center, the fiscal year donated services expenses in accordance with Section 100.11, Bases of Valuation.

Schedule P3- Total (Column 4)
Enter in these columns the results of adding Column 1- Fiscal Year Expenses, Column 2 – Allocation of Cafeteria, Parking Etc. and Column 3 Donated Services.

Schedule P3- Fiscal Year Hours Worked divided by 2080 (Column 5)
Enter in this column for each applicable rate center the result of dividing the hours worked for the fiscal year by 2080. E.g. 10,912 divided by 2080 = 5.2

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SCHEDULES P4A TO P4I - RESIDENTS, INTERNS SERVICES .15

Overview .151

Schedules P4A thru P4I are provided to enable each hospital to report the total costs including compensation and fringe benefits for residents, interns and physician supervision of residents, interns services engaged in an organized program of post-graduate medical clinical education for the following cost centers:

Nomenclature	Account Number	Code
Medical Surgical Acute	8240	MSG
Pediatrics Acute	8240	PED
Psychiatric Acute	8240	PSY
Obstetrics Acute	8240	OBS
Definitive Observation	8240	DEF
M/S Intensive Care	8240	MIS
Coronary Care	8240	CCU
Pediatric Intensive Care	8240	PIC
Neo-Natal Intensive Care	8240	NEO
Burn Care	8240	BUR
Psychiatric Intensive Care	8240	PSI
Shock Trauma	8240	TRM
Oncology	8240	ONC
Newborn Nursery	8240	NUR
Premature Nursery	8240	PRE
Rehabilitation	8240	RHB
Emergency Services	8240	EMG
Clinic Services	8240	CL
Psych. Day & Night Care	8240	PDC
Labor & Delivery Services	8240	DEL
Operating Room	8240	OR
Operating Room Clinic	8240	ORC
Anesthesiology	8240	ANS
Laboratory Services	8240	LAB
Blood Bank	8240	BB
Electrocardiography	8240	EKG
Interventional Radiology/Cardiovascular	8240	IRC
Radiology-Diagnostic	8240	RAD
CT Scanner	8240	CAT
Radiology-Therapeutic	8240	RAT
Nuclear Medicine	8240	NUC
Respiratory Therapy	8240	RES

Nomenclature	Account Number	Code
Pulmonary Function	8240	PUL
Electroencephalography	8240	EEG
Physical Therapy	8240	PTH
Occupational Therapy	8240	OTH
Speech-Language Pathology	8240	STH
MRI Scanner	8240	MRI
Same Day Surgery	8240	SDS
Lithotripsy	8240	LIT
Rehabilitation	8240	RHB
Adult Psychiatric	8240	PAD
Psychiatric Child/Adolescent	8240	PCD
Psychiatric Intensive Care	8240	PSI
Psycho-Geriatric	8240	PSG
Psychiatric Day Care	8240	PSD
Individual Therapy	8240	ITH
Group Therapy	8240	GTH
Activity Therapy	8240	ATH
Family Therapy	8240	FTH
Psychiatric Testing	8240	PST
Education	8240	PSE
Chronic	8240	CRH
Pediatric Step Down	8240	PSD
Clinic- 340B	8240	CL- 340
Radiology Therapeutic- 340B	8240	RAT- 340
Operating Room Clinic- 340B	8240	ORC- 340
Laboratory- 340B	8240	LAB- 340

The column headed Source indicates computations to be made or the source of the data requested.

Round the expenses on Lines A, B, C, D, F, G, H and I to 1 decimal place (nearest hundred), e.g., $128,610.50 is entered as 128.6.

Round the FTE data on Lines J and K to 1 decimal place, e.g., 10,912 hours divided by 2080 - = 5.2.

Detailed Instructions .152

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line, the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Fiscal Year Line

Enter on this line the year for which the fiscal year data is reported, e.g., 06-90.

Fiscal Year Data Section

Line A - Fiscal Year Wages and Salaries

Schedule P4A - Columns 1 to 7

Schedule P4B - Columns 1 to 7

Schedule P4C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

Enter on this line, in each applicable cost center column, the wages, salaries and fringe benefits expenses incurred in the fiscal year for residents and interns.

Schedule P4I - Column 7

Enter on this line, in the Total Column, the result of adding Line A. Fiscal Year Expenses, from each cost center column, (Schedule P4A, Columns 1 to 7, Schedule P4B, Columns 1 to 7, Schedule P4C, Columns 1 to 7, Schedule P4D, Columns 1 to 7, Schedule P4E, Columns 1 to 7, Schedule P4F, Columns 1 to 7, Schedule P4G, Columns 1 to 7, Schedule P4H, Columns 1 to 7 and Schedule P4I, Columns 1 to 6.)

Line B - Fiscal Year Physician Supervision

Schedule P4A - Columns 1 to 7

Schedule P4B - Columns 1 to 7

Schedule P4C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E- Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

Enter on this line, in each applicable cost center column, the physician supervision expenses transferred from Schedules P1A and P1B, Lines A1 to A50, Column 6, Education, except Private Psychiatric hospitals.

Schedule P4I - Column 7

Enter on this line, in the Total Column, the result of adding Line B, Fiscal Year Physician Supervision, from each cost center column, (Schedule P4A, Columns 1 to 7, Schedule P4B, Columns 1 to 7, Schedule P4C, Columns 1 to 7, Schedule P4D, Columns 1 to 7, Schedule P4E, Columns 1 to 7, Schedule P4F, Columns 1 to 7, Schedule P4G, Columns 1 to 7, Schedule P4H, Columns 1 to 7 and Schedule P4I, Columns 1 to 6.)

Line C - Fiscal Year Other Expenses

Schedule P4A - Columns 1 to 7

Schedule P4B - Columns 1 to 7

Schedule P4C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

Enter on this line, in each applicable cost center column, the other expenses incurred in the fiscal year in the resident, intern program.

Schedule P4I - Column 7

Enter on this line, in the Total Column, the result of adding Line C, Fiscal Year Other Expenses, from each cost center column, (Schedule P4A, Columns 1 to 7, Schedule P4B, Columns 1 to 7, Schedule P4E, Columns 1 to 7, Schedule P4F, Columns 1 to 7, Schedule P4G, Columns 1 to 7, Schedule P4H, Columns 1 to 7 and Schedule P4I, Columns 1 to 6.)

Line D - Total Fiscal Year Expenses

Schedule P4A - Columns 1 to 7

Schedule P4B - Columns 1 to 7

Schedule P4C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

Enter on this line, in each cost center column and the Total Column, the result of adding Line A, Fiscal Year Wages and Salaries, Line B, Fiscal Year Physician Supervision and Line C, Fiscal Year Other Expenses.

Verify the result of adding the fiscal year expenses from each cost center column (Schedule P4A, Columns 1 to 7, Schedule P4B, Columns 1 to 7, Schedule P4C, Columns 1 to 7, Schedule P4D, Columns 1 to 7, Schedule P4E, Columns 1 to 7, Schedule P4F, Columns 1 to 7, Schedule P4G, Columns 1 to 7, Schedule P4H, Columns 1 to 7 and Schedule P4I, Column 1 to 6.) equals the expenses in the Total Column.

Transfer the total expenses from both schedules P4I and P5I to Schedule RC, Line D, Column 1, Fiscal Year.

Line E - Allocation from Cafeteria, Parking, Etc.

Schedule P4A - Columns 1 to 7

Schedule P4A - Columns 1 to 7

Schedule P4C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

Enter on this line, in each applicable cost center column, the allocation of cafeteria, parking, etc. from Schedule OADP, lines 204 to 325.

Schedule P4I - Column 7

Enter on this line, in the Total Column, the result of adding the allocation from each cost center column (Schedule P4A, Columns 1 to 7, Schedule P4B, Columns 1 to 7, Schedule P4C, Columns 1 to 7, Schedule P4D, Columns 1 to 7, Schedule P4E, Columns 1 to 7, Schedule P4F, Columns 1 to 7, Schedule P4G, Columns 1 to 7, Schedule H, Columns 1 to 7, and Schedule P4I, Columns 1 to 6.

Line F - Fiscal Year Expenses Adjusted

Schedule P4A - Columns 1 to 7

Schedule P4B - Columns 1 to 7

Schedule P4C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

Enter on this line, in each cost center column and the Total Column, the result of adding Line A, Fiscal Year Wages and Salaries with Line B, Fiscal Year Physician Supervision and Line C, Fiscal Year Other Expenses.

Verify the result of adding the fiscal year expenses adjusted from each cost center column (Schedule P4A, Columns 1 to 7, Schedule P4B, Columns 1 to 7, Schedule P4C, Columns 1 to 7, Schedule P4D, Columns 1 to 7, Schedule P4E, Columns 1 to 7, Schedule P4F, Columns 1 to 7, Schedule P4G, Columns 1 to 7, Schedule P4H, Columns 1 to 7, and Schedule P4I, Columns 1 to 6 to Schedule P4I, Column 7, Total.

Inflation Factor Section

Line G - Inflation Factor - Wages and Salaries

Schedule P4A - Columns 1 to 7

Schedule P4B - Columns 1 to 7

Schedule P4C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

Enter on this line, in each applicable cost center column, the Commission supplied inflation factor for wages, salaries and fringe benefits, price leveled to the appropriate time period, e.g., .07 × 1.5 = .105.

Line H - Inflation Factor - Other

Schedule P4A - Columns 1 to 7

Schedule P4B - Columns 1 to 7

Schedule P4C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

Enter on this line, in each applicable cost center column, the Commission supplied inflation factor for other expenses, price leveled to the appropriate time period, e.g., .07 × 1.5 = .105.

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FTE Data Section

Line N - Fiscal Year Residents and Interns FTE's (A)

Schedule P4A - Columns 1 to 7

Schedule P4B - Columns 1 to 7

Schedule P4C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

Enter on this line, in each cost center, the total of the result of multiplying each Resident or Intern, individually, by the percentage of the Fiscal Year Worked in that particular cost center, e.g. 8 Residents worked a full year, 7/1 - 6/30, and 1 Resident worked 3 months, 7/1 - 9/30. Therefore 8 × 100% = 8 and 1 × 25% = .25 or a total of 8.25 Resident FTE's.

Schedule P4I - Column 7

Enter on this line, in the Total Column, the result of adding the FTEs from each cost center column (Schedule P4A, Columns 1 to 7, Schedule P4B, Columns 1 to 7, Schedule P4C, Columns 1 to 7, Schedule P4D, Columns 1 to 7, Schedule P4E, Columns 1 to 7, Schedule P4F, Columns 1 to 7, Schedule P4G, Columns 1 to 7,

Schedule P4H, Columns 1 to 7 and Schedule P4I, Columns 1 to 6.

Line O - Fiscal Year Hours Worked divided by 2080 (B)

Schedule P4A - Columns 1 to 7

Schedule P4B - Columns 1 to 7

Schedule P4C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

Enter on this line, in each cost center column, the result of dividing the fiscal year hours worked by 2080, e.g., 10,912 divided by 2080 = 5.2, for Line B, Fiscal Year Physician Supervision.

Transfer the FTE data from each cost center column, for Line N and O combined, to Schedules OAF to OAI in Column 1 Number of FTEs.

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SCHEDULE C- GENERAL SERVICE CENTER .16

Overview .161

Schedule C is provided to enable each hospital to report expenses, and FTEs for the following general service centers:

Center Nomenclature	Account Number	Code
C1- Dietary Services	8310	DTY
C2 – Laundry and Linen	8330	LL
C3- Social Services	8350	SSS
C4- Purchasing and Stores	8690	PUR
C5- Plant Operations	8410	POP
C6- Housekeeping	8450	HKP
C7-Central Services and Supply	8460	CSS
C8- Pharmacy	8470	PHM
C9- General Accounting	8510	FIS
C10- Patient Accounts	8520	PAC
C11-Hospital Admin	8610	MGT
C12- Medical Records	8710	MRD
C13- Medical Staff Administration	8720	MSA
C14- Nursing Administration	8750	NAD
C15- Organ Acquisition Overhead	8480	OA

Each general service center line must be completed by the hospital according to the functional descriptions contained in Section 200.0783, General Services, Section 200.0784, Fiscal Services, Section 200.0785, Administrative Services, Section 200.0786, Medical Staff Administrative (Private Psychiatric hospitals will report only administrative and clerical costs for social services).

If a hospital does not have the functions of a specific center, the center should be marked “NOT APPLICABLE”.

Round expenses to 1 decimal point (nearest hundred) e.g. 66,428.93 are entered as 66.4.

Round the FTE data to 1 decimal place. e.g. 22,612 divided by 2,080= 10.9.

Refer to Section 200.037, Natural Classification of Expense, for descriptions of the expense categories and Section 300, Account Distribution Index, for the distribution of various expenses by natural classification of expenses to functional cost centers.

Refer to Section 100.515, Medical Supplies, for additional discussion of the proper handling of the Central Services and Supply function.

Refer to Section 100.516 drugs, for discussion of the proper handling off the Pharmacy function.

Volume data for some general service centers are related to patient care volumes and others are generally fixed. For example, the numbers of pounds of Laundry processed vary based on the length of the period being measured and also on the volume of patient days and outpatient visits. However housekeeping volume data, square feet, remains relatively constant over the periods of time and does not generally vary with volume of patient days and outpatient visits.

For those general services functions that have allocations to Physicians Part B services or to Auxiliary Enterprises (AE), Other Institutional Programs (OIP) and Unregulated Services (UR) report only those units which pertain to the hospital function. For example, if a hospital's Housekeeping department services a dormitory for nursing students, classrooms for students etc. the units to be reported will be net of the non-hospital units.

The following is a listing of the general service functions standard units of measure to be utilized for volume data. Refer to Section 200.0783, General Services, Section 200.0784, Fiscal Services 200.0785, Administrative Services, Section 200.0786, and Medical Staff Administration for detailed descriptions of the standard units of measure.

Nomenclature	Standard Unit of Measure
C1- Dietary Services	Number of Patient Meals
C2-Laundry & Linen	Number of Dry and Cleaned Pounds Processed
C3- Social Services	Admissions
C4- Purchases & Stores	EIPD
C5- Plant Operations	Number of Net Square Feet
C6- Housekeeping	Number of Hours Assigned
C7- Central Supplies & Supply	EPIA
C8- Pharmacy	EPIA
C9- General Accounting	EIPD
C10- Patient Accounts	Number of Patient Days Plus Outpatient
C11- Hospital Administration	EPID
C12- Medical Records	Number of Inpatient Discharges Plus 1/8 of O/P Visits
C13- Medical Staff Administration	EIPD
C14- Nursing Administration	Hours of Nursing Service Personnel Supervised
C15- Organ Acquisition	Transplant Coordination Staff Expense

Detailed Instructions .162

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital located in Appendix B. the assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g. 0099.

Fiscal Year

Enter on this line the year for which the fiscal year is reported, e.g. 0610.

Sch. C Col.1- Units

Enter in this column, for each applicable general service center line, the reporting hospital's fiscal year units. e.g. Dietary-Number of Patient meals

Sch. C Col.2 -Wages Salary & Benefits

Enter in this column, for each applicable general service center line, the expenses of the reporting hospital incurred in the fiscal year for the following major expense categories:

.10 Salaries and Wages
.20 Employee Benefits

Expenses which are normally reported as components of general service function for the above categories are:

.01 Management and Supervision
.02 Technician and Specialist
.11 Environment, Hotel and Food Service Employee
.12 Clerical and Other Administrative Employee
.21 FICA
.22 SUI and FUI (UIC)
.23 Group Health Insurance
.24 Group Life Insurance
.25 Pension and Retirement
.26 Workmen's Compensation Insurance
.27 Union Health and Welfare
.28 Other Payroll Related Employee Benefits
.29 Employee Benefits (Non-Payroll Related)

Include only those non-payroll related employee benefits which are not allocated from Schedule OADP.

Sch. C Col. 3- Other Expenses

Enter in this column, in each applicable general service center line, the expenses of the reporting hospital incurred in the fiscal year for the following major expense categories:

.30 Professional Fees
.40 Medical and Surgical Supplies
.50 Non-Medical and Non-Surgical Supplies
.60 Utilities
.70 Purchased Services
.80 Other Direct Expenses

Expenses which are normally reported as components of general service functions for the above categories by schedule are:

.33 Consulting and Management Fees
.34 Legal Fees
.35 Audit Fees
.49 Other Medical Care Materials & Supplies
.51 Food- Meats, Fish and Poultry
.52 Food- Other
.53 Tableware and Kitchen Utensils
.54 Linen and Bedding
.55 Cleaning Supplies
.56 Office and Administrative Supplies
.57 Employee Wearing Apparel
.58 Instruments and Minor Equipment
.59 Other Non-Medical and Non-Surgical Supplies
.61 Electricity
.62 Fuel
.63 Water
.64 Disposal Service
.65 Telephone/Telegraph
.66 Purchased Steam
.69 Utilities- Other
.70 Maintenance and Repairs
.74 Laundry and Linen
.76 Management and Contracted Services
.77 Collection Agency
.78 Transcription Services
.79 Other Purchased Services
.84 Dues, Books and Subscription
.85 Outside Training Sessions
.86 Travel- Other
.87 Postage
.88 Printing and Duplicating
.89 Other Expenses

Sch. C Col. 4 -Total Expenses

Total expenses is the sum of Wages, Salary & Fringe Benefits (Col. 2) and Other Expenses (Col.3).

Sch. C Col.5- Allocated to Auxiliary Enterprises, Other Institutional Programs (OIP), and Unregulated Services (UR)

Enter in this column for each applicable general service line, the allocation of the fiscal year expenses for the Auxiliary Enterprises, Schedule E1 to E9, Other Institutional Programs, Schedules F1 to F4, and Unregulated Services.

Transfer the expenses from Schedule C Col. 5, to the appropriate Schedule E2 to E9, Schedule D lines D1 to D6 Column 3, Total Expenses, Revenues and Schedules F1 to F4, lines D1 to D6, Column 3, Total Expenses, and Revenues

Sch. C Col. 6 –Allocated Expenses

Amount for this column traces to Sch. OADP Col. 10 – Total Allocated Expense

Sch. C Col. 7- Adjusted Total Expenses

Adjusted total expenses is the sum of Total Expenses (Col.4) and the sum Allocation to Aux. Ent, OIP, and UR Expenses (Col.5) and Adjusted Expenses (Col. 6)

Sch. C Col. 8 Expense Per Unit

The Expense per Unit is calculated by dividing the Adjusted Total Expense (Col. 6) by the number of Units (Col. 1)

Sch. C Col. 9 - FTEs

Enter on this line, on each applicable general service center line, the result of dividing the Worked Hours by 2080 (hours worked). e.g., 20,800/2080= 10

Worked hours are to be counted in accordance with Section 200.0371, Salaries and Wages. Include hours worked for donated services and data processing.

SCHEDULE D- PATIENT CARE CENTERS .17

Overview .171

Schedule D is provided to enable each hospital to report expenses and FTEs for the following patient care centers:

Center Nomenclature	Account Number	Code
D1- Medical Surgical Acute	6010	MSG
D2- Pediatric Acute	6170	PED
D3- Psychiatric Acute	6210	PSY
D4- Obstetric Acute	6250	OBS
D5- Definitive Observation	6280	DEF
D6- Medical Surgical Intensive Care	6310	MIS
D7- Coronary Care	6330	CCU
D8- Pediatric Intensive Care	6350	PIC
D9- Neonatal Intensive Care	6370	NEO
D10- Burn Care	6380	BUR
D11- Psychiatric Intensive Care	6390	PSI
D12- Shock Trauma	6411	TRM
D13- Oncology	6411	ONC
D14- Newborn Nursery	6412	NUR
D15- Premature Nursery	6510	PRE
D16 Skilled Nursing Care	6610	NF
D17- Chronic Care	6640	CRH
D18- Emergency Services	6710	EMG
D19 - Clinic Services	6720	CL
D20- Psych Day/Night Care	6940	PDC
D22- Same Day Surgery	7060	SDS
D23- Labor & Delivery	7010	DEL
D24- Operating Room	7040	OR
D24A- Operating Room Clinic	7070	ORC
D25- Anesthesiology	7080	ANS
D26- Medical Supplies Sold	7110	MSS
D27- Drugs Sold	7150	CDS
D28- Laboratory Services	7210	LAB
D30- Electrocardiography	7290	EKG
D31- Interventional Rad/Cardio	7310	IRC
D32- Radiology Diagnostic	7320	RAD
D33- Cat Scanner	7340	CAT
D34- Radiology-Therapeutic	7360	RAT
D35- Nuclear Medicine	7380	NUC
D36- Respiratory Therapy	7420	RES
D37- Pulmonary Function Testing	7440	PUL

Center Nomenclature	Account Number	Code
D38- Electroencephalography	7460	EEG
D39- Physical Therapy	7510	PTH
D40- Occupational Therapy	7530	OTH
D41- Speech Therapy	7550	STH
D42- Recreational Therapy	7570	REC
D43- Audiology	7580	AUD
D44- Other Physical Medicine		OPM
D45- Renal Dialysis	7710	RDL
D46- Organ Acquisition	7730	OA
D47- Ambulatory Surgery	6930	AOR
D48- Leukopheresis	7911	LEU
D49- Hyperbaric Chamber	7912	HYP
D50- Freestanding Emergency	6960	FSE
D51- MRI Scanner	7350	MRI
D53- Lithotripsy	7355	LIT
D54- Rehabilitation	6620	RHB
D55- Observation	6750	OBV
D56- Ambulance Services Rebundled	7920	AMR
D57- Transurethral Microwave Thermo Therapy	7365	TMT
D58- Oncology Clinic		ONC
D59- Transurethral Needle Ablation		TNA
D70- Psychiatric- Adult	6220	PAD
D71- Psychiatric- Child/Adolescent	6230	PCD
D73- Psychiatric- Geriatric	6249	PSG
D74- Individual Therapies	7671	ITH
D75- Group Therapies	7672	GTH
D76- Family Therapies	7673	FTH
D77- Psychological Testing	7675	PST
D78- Education	7674	PSE
D79- Other Therapies	7689	OPT
D80- Electro-Convulsive Therapy	7676	ETH
D81- Activity Therapy	7677	ATH
D82- Pediatric Step Down		PSD
D83- Clinic- 340B	6720	CL-340
D84- Radiology- Therapeutic- 340B	7360	RAT-340
D85- Operating Room Clinic- 340B	7070	ORC-340
D86- Laboratory Services- 340B	7210	LAB-340
D87- Drugs Sold- 340B	7150	CDS-340

Each patient care line must be completed by the hospital according to the functional descriptions contained in Section 200.073, Patient Care and Other Operating Expense Accounting- General, Section

200.075, Daily Hospital Services Expenses, section 200.076, Ambulatory Services Expenses and Section 200.077, Ancillary Services Expenses.

If a hospital does not have the functions of a specific center, the center should be mark "NOT APPLICABLE".

Round expenses to 1 decimal point (nearest hundred) e.g. 66,428.93 is entered as 66.4.

Round the FTE data to 1 decimal place. e.g. 22,612 divided by 2,080= 10.9.

Refer to Section 200.037, Natural Classification of Expense, for descriptions of the expense categories and Section 300, Account Distribution Index, for the distribution of various expenses by natural classification of expenses to functional cost centers.

Refer to Section 100.515, Medical Supplies, for additional discussion of the proper handling of the Central Services and Supply function.

Refer to Section 100.516 drugs, for discussion of the proper handling off the Pharmacy function.

The following is a listing of the patient care functions standard unit of measure to be utilized for data.

Refer to Section 200.075, Daily Hospital Services Expenses, section 200.076, Ambulatory Services Expenses and section 200.077, Ancillary Services Appendix D, Standard Unit of Measure References, for the detailed descriptions of the standard units of measure.

Nomenclature	Standard Unit of Measure
D-1 – D17 Daily Hospital Services	Patient Days
D18- Emergency Services	RVUs
D19- Clinic Services	RVUs
D20- Psychiatric Day & Night Care	Visits
D22- Same Day Surgery	Visits
D23 Labor or Delivery Services	RVUs
D24- Operating Room	Surgery Minutes
D24A- Operating Room Clinic	ORC Minutes
D25- Anesthesiology	Anesthesia Minutes
D26- Medical Supplies Sold	EIPA
D27- Drugs Sold	EIPA
D28- Laboratory	RVUs
D30- Electrocardiography	RVUs
D31- Interventional Rad/Cardio	IRC Minutes
D32- Radiology Diagnostic	RVUs
D33- Cat Scanner	RVUs
D34- Radiology Therapeutic	RVUs
D35- Nuclear Medicine	RVUs
D36- Respiratory Therapy	RVUs
D37- Pulmonary Function Testing	RVUs

Nomenclature	Standard Unit of Measure
D38- Electroencephalography	RVUs
D39- Physical Therapy	RVUs
D40- Occupational Therapy	RVUs
D41- Speech Therapy	RVUs
D42- Recreational Therapy	# of Treatments
D43- Audiology	RVUs
D44- Other Physical Medicine	# of Treatments
D45- Renal Dialysis	# of Treatments
D46- Organ Acquisition	Number Acquired
D48- Leukopheresis	RVUs
D49- Hyperbaric Chamber	Hours of Treatment
D50- Freestanding Emergency	Visits
D51- Magnetic Resonance Imaging	RVUs
D53- Lithotripsy	# of Procedures
D54- Rehabilitation	Patient Days
D55- Observation	Hours
D56- Ambulance Services Rebundled	RVUs
D57- Transurethral Microwave Thermo Therapy	# of Procedures
D58- Oncology Clinic	Visits
D59- Transurethral Needle Ablation	# of Procedures
D70- Psychiatric Adult	Patient Days
D71- Psychiatric child/Adolescent	Patient Days
D73- Psychiatric- Geriatric	Patient Days
D74- Individual Therapies	Hours
D75- Group Therapies	Hours
D76- Family Therapies	Hours
D77- Psychological Testing	Hours
D78- Education	Hours
D79- Other Therapies	Hours
D80-Electro-Convulsive Therapy	Treatments
D81- Activity Therapy	Hours
D82- Pediatric Step Down	Patient Days
D83- Clinic- 340	RVUs
D84- Radiology Therapeutic- 340	RVUs
D85- Operating Room Clinic- 340	ORC Minutes
D86- Laboratory- 340	RVUs
D87- Drugs Sold- 340	EIPA

Detailed Instructions .172

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital located in Appendix B. the assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g 0099.

Fiscal Year

Enter on this line the year for which the fiscal year is reported, e.g. 0610.

Sch. D Col.1- Units

Enter in this column, for each applicable patient care center line, the reporting hospital's fiscal year units. e.g. Medical Surgical Acute-Number of Patient Days

Sch. D Col.2 -Wages Salary & Benefits

Enter in this column, for each applicable general service center, the expenses of the reporting hospital incurred in the fiscal year for the following major expense categories:

.10 Salaries and Wages
.20 Employee Benefits

Expenses which are normally reported as components of general service function for the above categories are:

.01 Management and Supervision
.02 Technician and Specialist
.11 Environment, Hotel and Food Service Employee
.12 Clerical and Other Administrative Employee
.21 FICA
.22 SUI and FUI (UIC)
.23 Group Health Insurance
.24 Group Life Insurance
.25 Pension and Retirement
.26 Workmen's Compensation Insurance
.27 Union Health and Welfare
.28 Other Payroll Related Employee Benefits
.29 Employee Benefits (Non-Payroll Related)

Include only those non-payroll related employee benefits which are not allocated from Schedule OADP.

Sch. D Col. 3- Physician Supervision Expenses

Enter in this column, on each applicable patient care center line, in the Physician Supervision Expenses Column, the physician supervision expenses for the fiscal year.

Include in this column, fees paid to physicians not on the hospital payroll, for supervision of a cost center, e.g. Emergency Services Physicians who are billing fee for service contract with the hospital to provide administration and supervision services for the Emergency Room.

Sch. D Col. 4 -Other Expenses

Enter in this column, in each applicable general service center line, the expenses of the reporting hospital incurred in the fiscal year for the following major expense categories:

.30 Professional Fees
.40 Medical and Surgical Supplies
.50 Non-Medical and Non-Surgical Supplies
.60 Utilities
.70 Purchased Services
.80 Other Direct Expenses

Expenses which are normally reported as components of general service functions for the above categories by schedule are:

.33 Consulting and Management Fees
.34 Legal Fees
.35 Audit Fees
.49 Other Medical Care Materials & Supplies
.51 Food- Meats, fish and Poultry
.52 Food- Other
.53 Tableware and Kitchen Utensils
.54 Linen and Bedding
.55 Cleaning Supplies
.56 Office and Administrative Supplies
.57 Employee Wearing Apparel
.58 Instruments and Minor Equipment
.59 Other Non-Medical and Non-Surgical Supplies
.61 Electricity
.62 Fuel
.63 Water
.64 Disposal Service
.65 Telephone/Telegraph
.66 Purchased Steam
.69 Utilities- Other
.70 Maintenance and Repairs
.74 Laundry and Linen

.76 Management and Contracted Services
.77 Collection Agency
.78 Transcription Services
.79 Other Purchased Services
.84 Dues, Books and Subscription
.85 Outside Training Sessions
.86 Travel- Other
.87 Postage
.88 Printing and Duplicating
.89 Other Expenses

Sch. D Col. 5- Total Expenses

Total expenses is the sum of Wages, Salary & Fringe Benefits (Col. 2), Physician Supervision expenses (Col. 3) and Other Expenses (Col. 4).

Sch. D Col.6 -Adjusted Expenses

Amounts for this column traces to Sch. OADP Col. 10 – Total Allocated Expense

Sch. D Col. 7 -Adjusted Total Expenses

Adjusted Total Expenses is the sum of Total Expenses (Col. 5) and Adjusted Expenses (Col. 6)

Sch. D Col. 8- Expense Per Unit

The Expense Per Unit is calculated by dividing the Adjusted Total Expense (Col. 6) by the Number of

Units (Col. 1)

Sch. D Col.9- FTEs

Enter on this line, on each applicable patient care center line, the result of dividing the worked Hours by 2080 (hours worked). e.g., 20,800/2080= 10

Worked hours are to be counted in accordance with Section 200.0371, Salaries and Wages. Include hours worked for donated services and data processing.

Sch. D Col.10 -Physician Supervision FTEs

Enter on this line, on each applicable patient care center line, the result of dividing the Physician Supervision Hours Worked by 2080 (hours worked). e.g., 20,800/2080= 10

SCHEDULES E1 TO E9 - AUXILIARY ENTERPRISES .18

Overview .181

Schedulers E1 thru E9 are provided to enable each hospital to report expenses, revenue and FTEs for the following auxiliary enterprise centers:

Nomenclature	Account Number	Code
E1 - Ambulance Services	6950	AMB
E2 - Parking	8440	PAR
E3 - Doctor's Private Office Rental	9210	DPO
E4 - Office and Other Rental	9220	OOR
E5 - Retail Operations	9230	REO
E6 - Patient Telephones	8615	PTE
E7 - Cafeteria	8320	CAF
E8 - Day Care Center, Recreation Areas, etc.	N/A	DEB
E9 - Housing	8360	HOU

Auxiliary Enterprises are defined as continuing revenue producing activities which, while not related directly to the care of patients, are businesslike activities commonly found in hospitals for the convenience of employees, physicians, patients and/or visitors.

Each auxiliary enterprise schedule must be completed by the reporting hospital in accordance with the functional descriptions contained in Section 200.076. Ambulatory Services Expenses, Section 200.0783, General Services, and Section 200.0789, Non-Operating Revenue and Expenses.

Schedule E8 should be used to calculate the loss for which the reporting hospital considers to be non-payroll related fringe benefits not specifically reportable elsewhere, e.g., the operation of a day care center for hospital employees.

If a hospital does not have the functions of a specific auxiliary enterprise center, the schedule must be submitted with the words "NOT APPLICABLE" printed near the top of the schedule.

The column entitled Source indicates computations to be made or the source of the data requested.

Round the revenue/expenses on Lines B, C, D, E, F, G, H, I, J, K, L, M, N, O, Q and R to 1 decimal place (nearest hundred), e.g., $66,428.93 is entered as 66.4.

Round the expense/revenue per unit calculations in Columns 4 to 5 decimal places, e.g., 99.6 ÷ 9500 = 01048.
Round the FTE data on Lines S and T to 1 decimal place, e.g., 22,612 hours ÷ 2080 = 10.9.

Refer to Section 200.037, Natural Classification of Expense, for descriptions of the expense categories and Section 300, Account Distribution Index, for the distribution of various expenses by natural classification of expenses to functional cost centers.

The following is a listing of the auxiliary enterprise functions standard units of measure to be utilized for volume data:

Nomenclature	Standard Units of Measure
E1 - Ambulance Service	Number of Occasions of Service
E2 - Parking	Number of Parking Spaces
E3 - Doctor's Private Office Rental	Number of Gross Square Feet
E4 - Office and Other Rental	Number of Gross Square Feet
E5 - Retail Operations	Number of Gross Square Feet
E6 - Patient Telephones	Number of Patient Telephones
E7 - Cafeteria	Equivalent Number of Meals Served
E8 - Day Care Center, Recreation Areas, etc.	Number of Gross Square Feet
E9 - Housing	Average Number of Persons Housed

The Volume Data Section, Base Year Data Section, Base Year Profit (Loss) Section and Line R of the FTE Data Section are required to be completed for the annual reporting requirements.

Detailed Instructions .182

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line the year for which the base year data is reported, e.g., 06-79.

Budget Year Line

Enter on this line the year for which the budgeted data is reported, e.g., 06-79.

Volume Data Section

Line A - Volume Data

Schedules E1 to E9 - Column 1

Enter on this line, on each applicable auxiliary enterprise center schedule, in the Base Year Units Column, the number of units of the reporting hospital for the base year.

Schedules E1 to E9 - Column 2

Enter on this line, on each applicable auxiliary enterprise center schedule, in the Budget Year Units Column, the number of units projected for the budget year.

Base Year Data Section

Line B - Base Year Expenses

Schedules E1 to E9 - Column 1

Enter on this line, on each applicable auxiliary enterprise center schedule, in the Wages, Salaries and Fringe Benefits Column, the expenses of the reporting hospital incurred in the base year for the following major natural classification of expense categories:

.00, .10 Salaries and Wages
.20 Employee Benefits

Expenses which are normally reported as components of auxiliary enterprise functions for the above categories, by schedule, are:

.01	Management and Supervision	E1, E2, E5, E7, E8, E9
.11	Environment, Hotel & Food Service Employees	E2, E5, E7
.12	Clerical & Other Administrative Employees	E6, E7, E8, E9
.21	FICA	E1, E2, E5, E6, E7, E8, E9
.22	SUI and FUI (UIC)	E1, E2, E5, E6, E7, E8, E9
.23	Group Health Insurance	E1, E2, E5, E6, E7, E8, E9
.24	Group Life Insurance	E1, E2, E5, E6, E7, E8, E9
.25	Pension and Retirement	E1, E2, E5, E6, E7, E8, E9
.26	Workmen's Compensation Insurance	E1, E2, E5, E6, E7, E8, E9
.27	Union Health and Welfare	E1, E2, E5, E6, E7, E8, E9
.28	Other Payroll Related Employee Benefits	E1, E2, E5, E6, E7, E8, E9
.29	Employee Benefits (Non-Payroll Related)	E1, E2, E5, E6, E7, E8, E9

Include only those non-payroll related employee benefits which are not allocated from Schedule OAC.

Schedules E1 to E9 - Column 2

Enter on this line, on each applicable auxiliary enterprise center schedule, in the Other Expenses Column, the expenses of the reporting hospital incurred in the base year for the following major natural classification of expense categories:

.40	Medical and Surgical Supplies
.50	Non-Medical and Non-Surgical Supplies
.60	Utilities
.70	Purchased Services
.80	Other Direct Expenses

Expenses which are normally reported as components of auxiliary enterprise functions for the above categories, by schedule are:

.49	Other Medical Care Materials and Supplies	E1
.51	Food - Meats, Fish and Poultry	E5, E7
.52	Food - Other	E5, E7
.53	Tableware and Kitchen Utensils	E5, E7
.55	Cleaning Supplies	E5, E7, E8, E9
.56	Office and Administrative Supplies	E1 to E9
.57	Employee Wearing Apparel	E1, E2, E7, E8, E9
.61	Electricity	E2, E3, E4, E5, E6, E7, E8, E9
.62	Fuel	E3, E4, E5, E8, E9
.63	Water	E3, E4, E5, E7, E8, E9
.64	Disposal Service	E3, E4, E5, E7, E8, E9
.65	Telephone/Telegraph	E1 to E9
.66	Purchased Steam	E3, E4, E5, E7, E8, E9
.71	Medical	E1
.72	Maintenance and Repairs	E1 to E9
.74	Laundry and Linen	E1, E2, E5, E7, E8, E9
.81	Insurance	E1 to E9
.82	Interest	E1 to E9
.84	Dues, Books and Subscriptions	E1 to E9
.85	Outside Training Sessions	E1 to E9
.86	Travel - Other	E1 to E9
.87	Postage	E1 to E9
.88	Printing and Duplicating	E1 to E9

Schedules E1 to E9 - Column 3

Enter on this line, on each auxiliary enterprise center schedule, in the Total Expenses, Revenue Column, the result of adding the base year expenses from Columns 1 and 2.

Transfer the total expenses from Column 3 of Schedule E1 to E9 to Schedule RC, Line H.

Line C - Allocation from Cafeteria, Parking, Etc.

Schedules E1, E2, E3, E4, E5, E6 - Columns 1, 3

Enter on this line, on each applicable auxiliary enterprise center schedule in the Wages, Salaries and Fringe Benefits Column and the Total Expenses, Revenue Column, the allocation of cafeteria, parking, etc. from Schedule OADP, Lines 81 to 85, Column 2.

Schedules E7, E8, E9 - Columns 1, 3

This line is left blank on these schedules.

Only allocate cafeteria, parking, etc. to Schedule E2 if Parking is not considered a fringe benefit and is not included on Schedule OADP, Column 2.

Lines D1 to D6 - Allocations from General Service Centers & Unassigned Expense Centers

Schedules E1 to E9 - Cost Center Column

Enter on these lines, on each applicable auxiliary enterprise center schedule, in the Cost Center Column, the nomenclature of the general service center or unassigned expense center from which costs are being allocated, e.g., Housekeeping.

Schedules E1 to E9 - Code Column

Enter on these lines, on each applicable auxiliary enterprise center schedule, in the Code Column, the code for the general service center or unassigned cost center expense located in Appendix C, e.g., HKP.

Schedules E1 to E9 - Source Column

Enter on these lines, on each applicable auxiliary enterprise center schedule, in the Source Column, the general service center schedule or unassigned expense center, e.g., C6.

Schedules E1 to E9 - Column 1

Enter on these lines, on each applicable auxiliary enterprise center schedule, in the Wages, Salaries and Fringe Benefits Column, the wages, salaries, and fringe benefits expenses from each applicable general service center line, Schedule C – Lines C1-C14, Column 5.

Schedules E1 to E9 - Column 2

Enter on these lines, on each applicable auxiliary enterprise center schedule, in the Other Expenses Column, the other expenses from each applicable general service center line, Schedule C – Lines C1-C14, Column 5 or unassigned expenses schedule, Schedule UA, Line B, Columns 1, 2, 4, 5, 6, 7, 8.

Schedules E1 to E9 - Column 3

Enter on these lines, on each applicable auxiliary enterprise center schedule, in the Total Expenses, Revenue Column, the total expenses from each applicable general service center line, Schedule C – Lines C1-C14, Column 5 or unassigned expense schedule, Schedule UA Line B, Column 9.

Line E - Capital Facilities Allowance

Schedules E1 to E9 - Column 3

Enter on this line, on each applicable auxiliary enterprise center schedule, in the Total Expenses, Revenue column, the amount of Capital Facilities Allowance from schedule H3, column 8.

Line F - Donated Services and Commodities

Schedules E1 to E9 - Column 1

Enter on this line, on each applicable auxiliary enterprise center schedule, in the Wages, Salaries and Fringe Benefits Column, the donated services expenses of the reporting hospital for the base year in accordance with Section 100.11, Basis of Valuation, and utilizing the major natural expense categories outlined in the instructions for Line B, Column 1, above.

Schedules E1 to E9 - Column 2

Enter on this line, on each applicable auxiliary enterprise center schedule, in the Other Expense Column, the donated commodities expenses of the reporting hospital for the base year in accordance with Section 100.11, Basis of Valuation, and utilizing the natural expense categories outlined in the instructions for Line B, Column 2, above.

Schedules E1 to E9 - Column 3

Enter on this line, on each auxiliary enterprise center schedule, in the Total Expenses, Revenue Column, the result of adding the donated services expenses from Columns 1 and the donated commodities expenses from Column 2.

Line G - Base Year Adjusted Expenses

Schedules E1 to E9 - Columns 1, 2, 3

Enter on this line, on each auxiliary enterprise center schedule, in each expense column and the Total Expenses/Revenue Column, the result of adding Line B, Base Year Expenses, Line C, Allocation from Cafeteria, Parking, Etc., Lines D1 to D6, Allocations from General Service Centers, Line E, Capital Facilities Allowance, and Line F, Donated Services and Commodities.

Verify that the addition of the base year adjusted expenses in Columns 1 and 2 equal the total expenses in Column 3 for each auxiliary enterprise center schedule.

Schedules E1 to E9 - Column 4

Enter on this line, on each auxiliary enterprise center schedule in the Expense, Revenue Per Unit Column, the result of dividing Line G, Column 3, by Line A, Column 1, e.g., 140.0 ÷ 10,000 = .01400.

Base Year Profit (Loss) Section

Line H - Base Year Revenue

Schedules E1 to E9 - Column 3

Enter on this line, on each applicable auxiliary enterprise center schedule, in the Total Expense, Revenue Column, the revenue of the reporting hospital generated from Line H, Base Year Revenue.

Enter a loss in brackets, e.g., 100.9 – 210.9 = (110.0).

Line I - Profit (Loss)

Schedules E1 to E9 Column 3

Enter on this line, on each applicable auxiliary enterprise center schedule, in the Total Expenses, Revenue column, the result of subtracting line G Base Year Adjusted Expenses from line H, Base Year Revenue.

Line J - Amount Treated as Fringe

Schedules E2 E7, E8, E9 - Column 3

Enter on this line on each applicable auxiliary enterprise center schedule, in the Total Expenses, Revenue Column, the amount of loss from Line I that is treated as a fringe benefit.

Enter the amount of loss treated as a fringe benefit in brackets, e.g., (100.9).

Transfer the amount of loss treated as a fringe benefit from Schedules E2, E7 and E8, Line J, Column 3 to Schedule OADP, Line A, Column 1, Total.

Transfer the amount of loss treated as a fringe benefit from Schedule E9, Line J, Column 3 to Schedule OADP, Line A, Column 1, Total.

Schedules E1, E3, E4, E5, E6 - Column 3

This line on these schedules is left blank.

Line K - Amount Treated as OFC

Schedules E1 to E9 - Column 3

Enter on this line, on each applicable auxiliary enterprise center schedule, in the Total Expenses, Revenue Column, the result of subtracting Line J, Amount Treated as Fringe, from Line I, Profit (Loss), e.g., (110.9) – (100.9) = (10.9) or 250.0 - 100.0 = 150.0.

Transfer the amount treated as other financial considerations (OFC) to schedule G.

Budget Year Data Section

Line L - Inflation

Schedules E1 to E9 - Columns 1, 2

Enter on this line, on each applicable auxiliary enterprise center schedule, in each expense column, the projected inflation for the budget year, utilizing Commission supplied inflation factors, price leveled for the appropriate time period, e.g., (101.9)(.07)(1.5) = 10.7.

Schedules E1 to E9 - Column 3

Enter on this line, on each auxiliary enterprise center schedule, in the Total Expenses, Revenue Column, the result of adding the inflation from Columns 1 and 2.

Line M - Miscellaneous Adjustments

Schedules E1 to E9 - Columns 1, 2

Enter on this line, on each applicable auxiliary enterprise center schedule, in each expense column, the projected miscellaneous adjustments for the budget year.

Miscellaneous adjustments are defined as planned increases in costs not accounted for on Line L, e.g., projected salary increases above the Commission supplied inflation factor.

Schedules E1 to E9 - Column 3

Enter on this line, on each auxiliary enterprise center schedule, in the Total Expenses, Revenue Column, the result of adding the miscellaneous adjustments from Columns 1 and 2.

Line N - Budget Year Expenses

Schedules E1 to E9 - Columns 1, 2, 3

Enter on this line, on each auxiliary enterprise center schedule, in each expense column and the Total Expenses, Revenue Column, the result of adding Line G, Base Year Adjusted Expenses, Line L, Inflation and Line M, Miscellaneous Adjustments.

Verify that the addition of the budget year expenses in Columns 1 and 2 equal the total expenses in Column 3 for each auxiliary enterprise center schedule.

Transfer the total expenses from Column 3 of Schedules E1 to E9 to Schedule RC, Line H, Column 2, Budget Year

Schedules E1 to E9 - Column 4

Enter on this line, on each auxiliary enterprise center schedule, in the Expense, Revenue Per Unit Column, the result of dividing Line N, Column 3, by Line A, Column 2, e.g., 160.0 ÷ 10,000 = .01600.

Budget Year Profit (Loss) Section

Line O - Base Year Revenue

Schedules E1 to E9 - Column 3

Enter on this line, on each applicable auxiliary enterprise center schedule, in the Total Expenses, Revenue Column, the revenue of the reporting hospital generated in the base year.

Line P - Adjustments

Schedules E1 to E9 - Column 3

Enter on this line, on each applicable auxiliary enterprise center schedule, in the Total Expenses, Revenue Column, adjustments to the base year revenue.

Line Q - Budget Year Revenue

Schedules E1 to E9 - Column 3

Enter on this line, on each applicable auxiliary enterprise center schedule, in the Total Expense, Revenue Column, the result of adding Line O, Base Year Revenue, and Line P, Adjustments.

Line R - Profit (Loss)

Schedules E1 to D9 - Column 3

Enter on this line, on each auxiliary enterprise center schedule, in the Total Expenses, Revenue Column, the result of subtracting Line N, Budget Year Expenses, from Line Q, Budget Year Revenue.

Enter a loss in brackets, e.g., 180.7 – 190.9 = (10.2).

FTE Data Section

Line R - Adj. Base Year Hours Worked ÷ 2080

Schedules E1 to E9 - Column 1

Enter on this line, on each applicable auxiliary enterprise center schedule, in the Wages, Salaries and Fringe Benefits Column, the result of dividing the adjusted base year hours worked by 2080, e.g., 10,912 ÷ 2080 = 5.2.

Worked hours are to be counted in accordance with Section 200.0371, Salaries and Wages. Include hours worked for allocations from general service centers and donated services.

Transfer the FTEs on Line S of each auxiliary enterprise center schedule, to Schedule OADP, on the appropriate Lines D81 to D85, Column 1, Number of FTEs.

Line T - Budget Year Hours Worked ÷ 2080

Schedules E1 to E9 - Column 1

Enter on this line, on each auxiliary enterprise center schedule, in the Wages, Salaries and Fringe Benefits Column, the result of dividing the budget year hours worked by 2080, e.g., 20,500 ÷ 2080 = 9.9.

SCHEDULES F1 TO F4 - OTHER INSTITUTIONAL PROGRAMS .19

Overview .191

Schedules F1 to F4 are provided to enable each hospital to report expenses, revenues and FTEs for the following other institutional program centers:

Nomenclature	Account Number	Code
F1 - Research	8010	REG
F2 - Nursing Education	8220	RNS
F3 - Other Health Professional Education	8260	OHE
F4 - Community Health Education	8270	CHE

Other Institutional Programs are defined as institutional objectives other than the care of today's patients, such as educating nurses, educating the public in preventive medicine and maintaining research facilities.

Each other institutional program schedule must be completed by the reporting hospital in accordance with the functional descriptions contained in Section 200.0781. Research Expenses, Section 200.0782, Nursing Education, and Section 200.0783. General Services.

If a hospital does not have the functions of a specific other institutional program center, the schedule must be submitted with the words "NOT APPLICABLE" printed near the top of the schedule.

The column entitled Source indicates computations to be made or the source of the data requested.

Round the revenue/expenses on Lines B, C, D, E, F, G, H, I, J, K, L, M, N and O to 1 decimal place (nearest hundred), e.g., $66,428.93 is entered as 66.4.

Round the expense/revenue per unit calculations in Column 4 to 5 decimal places, e.g., 99.6 ÷ 9500 = .01048.

Round the FTE data on Lines O and P to 1 decimal place, e.g., 22,612 hours ÷ 2080 = 10.9.

Refer to Section 200.037. Natural Classification of Expenses, for descriptions of the expenses categories and Section 300, Account Description Index, for the distribution of various expenses by natural classification of expenses to functional cost centers.

The following is a listing of other institutional programs. Standard units of measure to be utilized for volume data are:

Nomenclature	Standard Unit of Measure
F1 - Research	Number of Research Projects
F2 - Nursing Education	Number of Nursing Students
F3 - Other Health Profession Education	Number of Students
F4 - Community Health Education	Number of Participants

The Volume Data Section, Base Year Data Section, Base Year Profit (Loss) Section and Line P of the FTE Data Section are required to be completed for the annual reporting requirements.

Detailed Instructions .192

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line the year for which the base year data is reported, e.g., 06-79.

Budget Year Line

Enter on this line the year for which the budgeted data is reported, e.g., 06-80.

Volume Data Section

Line A - Volume Data

Schedules F1 to F4 - Column 1

Enter on this line, on each applicable other institutional program center schedule, in the Base Year Units Column, the number of units of the reporting hospital for the base year.

Schedulers F1 to F4 - Column 2

Enter on this line, on each other institutional program center schedule, in the Budget Year Units Column, the number of units projected for the budget year.

Base Year Data Section

Line B - Base Year Expenses

Schedules F1 to F4 - Column 1

Enter on this line, on each applicable other institutional program center schedule, in the Wages, Salaries and Fringe Benefits Column, the expenses of the reporting hospital incurred in the base year for the following major natural classifications of expense categories:

.00 .10 Salaries and Wages
.20 Employee Benefits

Expenses which are normally reported as components of other institutional programs function for the above categories, by schedule are:

.01	Management and Supervision	F1 to F4
.02	Technician and Specialist	F1, F2, F3
.06	Physicians	F1
.12	Clerical and Other Administrative Employees	F1 to F4
.21	FICA	F1 to F4
.22	SUI and FUI (UIC)	F1 to F4
.23	Group Health Insurance	F1 to F4
.24	Group Life Insurance	F1 to F4
.25	Pension and Retirement	F1 to F4
.26	Workmen's Compensation Insurance	F1 to F4
.27	Union Health and Welfare	F1 to F4
.28	Other Payroll Related Employee Benefits	F1 to F4
.29	Employee Benefits (Non-Payroll Related)	F1 to F4

Include only those non-payroll related employee benefits which are not allocated from Schedule OAC.

Schedules F1 to F4 - Column 2

Enter on this line, on each applicable other institutional program center schedule, in the Other Expenses Column, the expenses of the reporting hospital incurred in the base year for the following major natural classification of expense categories:

.30	Professional Fees
.40	Medical and Surgical Supplies
.50	Non-Medical and Non-Surgical Supplies
.60	Utilities
.70	Purchased Services
.80	Other Direct Expenses

Expenses which are normally reported as components of other institutional program functions for the above categories, by schedule are:

.31	Medical Physicians	F1
.49	Other Medical Care Materials and Supplies	F1
.56	Office and Administrative Supplies	F1 to F4
.57	Employee Wearing Apparel	F1 to F4
.61	Electricity	F1 to F4
.62	Fuel	F1 to F4
.63	Disposal Service	F1 to F4
.63	Water	F1 to F4
.64	Disposal Service	F1 to F4
.65	Telephone/Telegraph	F1 to F4
.66	Purchased Steam	F1 to F4
.72	Maintenance and Repairs	F1 to F4
.73	Medical School Contracts	F1 to F4
.74	Laundry and Linen	F1 to F4
.75	Data Processing	F1
.81	Insurance	F1 to F4
.82	Interest	F1 to F4
.83	Licenses and Taxes	F1 to F4
.84	Dues, Books and Subscriptions	F1 to F4
.85	Outside Training Sessions	F1 to F4
.86	Travel - Other	F1 to F4
.87	Postage	F1 to F4
.88	Printing and Duplicating	F1 to F4

Schedules F1 to F4 - Column 3

Enter on this line, on each other institutional program center schedule, in the Total Expenses, Revenue Column, the result of adding the base year expenses from Columns 1 and 2.

Transfer the total expenses from Column 3 of Schedules F1 to F4 to Schedule RC, Line I, Column 1, Base Year.

Line C - Allocation from Cafeteria Parking, etc.

Schedules F1 to F4 - Columns 1,3

Enter on this line on each applicable other institutional program center schedule, in the Wages, Salaries and Fringe Benefits Column, and the Total Expenses, Revenue Column, the allocation of cafeteria, parking, etc. from Schedule OADP, Lines D86 to D89, Column 2 and Column 4.

Lines D1 to D6 - Allocation from General Service Center Unassigned Expense Center

Schedules F1 to F4 - Cost Center Column

Enter on these lines, on each applicable other institutional program center schedule, in the Cost Center Column, the nomenclature of the general service center or unassigned expense center from which costs are allocated, e.g., Plant Operations.

Schedules F1 to F4 - Code Column

Enter on these lines, on each applicable other institutional program center schedule, in the Code Column, the code for the general service center or unassigned expense center located in Appendix C, e.g., POP.

Schedules F1 to F4 - Source Column

Enter on these lines, on each applicable other institutional program center schedule, in the Source Column, the general service center schedule or unassigned expense center, e.g., C5.

Schedules F1 to F4 - Column 1

Enter on these lines, on each applicable other institutional program center schedule, in the Wages, Salaries and Fringe Benefits column, the wages, salaries and fringe benefits from each applicable general service center line, Schedule C – Lines C1-C15, Column 5.

Schedules F1 to F4 - Column 2

Enter on these lines, on each applicable other institutional program center schedule, in the Other Expenses Column, the other expenses from each applicable general service center line, Schedule C – Lines C1-C15, Column 5; Column 2 or unassigned expense center schedule, Schedule UA, Line B. Columns 1, 2, 4, 5, 6, 7, 8.

Schedules F1 to F4 - Column 3

Enter on these lines, on each applicable other institutional program center schedule, in the Total Expenses, Revenue Column, the total expenses from each applicable general service center line, Schedule C – Lines C1-C15, Column 2 or unassigned expense schedules, Schedule UA, Line B, Column 9.

Line E - Capital Facilities Allowance

Schedules F1 to F4 - Column 3

Enter on this line, on each other institutional program center schedule, in the Total Expenses, Revenue column, the amount of Capital Facilities Allowance from schedule H3, column 8.

Line F - Base Year Adjusted Expenses

Schedules F1 to F4 - Columns 1, 2, 3

Enter on this line, on each other institutional program center schedule, in each expense column and the Total Expenses, Revenue Column, the result of adding Line B, Base Year Expenses, Line C, Allocation from Cafeteria, Parking, Etc., Lines D1 to D6, Allocations from General Service Centers, and Line E, Capital Facilities Allowance.

Verify that the addition of the base year adjusted expenses in Columns 1 and 2 equal the total expenses in Column 3 for each other institutional program center schedule.

Schedules F1 to F4 - Column 4

Enter on this line, on each other institutional program center schedule, in the Expense/Revenue Per Unit Column, the result of dividing Line E, Column 3, by Line A. Column 1, e.g., 140.0 ÷ 10,000 = .01400.

Base Year Profit (Loss) Section

Line G - Base Year Revenue

Schedules F1 to F4 - Column 3

Enter on this line, on each applicable other institutional program center schedule, in the Total Expenses, Revenue Column, the revenue of the reporting hospital generated in the base year.

Line H - Profit (Loss)

Schedules F1 to F4 - Column 3

Enter on this line, on each applicable other institutional program center schedule, in the Total Expenses, Revenue Column, the result of subtracting Line F, Base Year Adjusted Expenses, from Line G, Base Year Revenue.

Enter a loss in brackets, e.g., 100.9 – 210.9 = (110.9).

Budget Year Data Section

Line I - Inflation

Schedules F1 to F4 - Columns 1, 2

Enter on this line, on each applicable other institutional program center schedule, in each expense column, the projected inflation for the budget year, utilizing Commission supplies inflation factors, price leveled for the appropriate time period, e.g., (101.9)(.07)(1.5) = 10.7.

Schedules F1 to F4 - Column 3

Enter on this line, on each other institutional program center schedule, in the Total Expenses, Revenue Column, the result of adding the inflation expenses from Columns 1 and 2.

Line J - Miscellaneous Adjustments

Schedules F1 to F4 - Columns 1,2

Enter on this line, on each applicable other institutional program center schedule, in each expense column, the projected miscellaneous adjustments for the budget year.

Miscellaneous adjustments are defined as planned increases in costs not accounted for on Line I, e.g., projected salary increases above the Commission supplied inflation factor.

Schedules F1 to F4 - Column 3

Enter on this line, on each other institutional program center schedule, in the Total Expenses, Revenue Column, the result of adding the miscellaneous adjustments from Columns 1 and 2.

Line K - Budget Year Expenses

Schedules F1 to F4 - Columns 1, 2, 3

Enter on this line, on each other institutional program center schedule, in each expense column and the Total Expenses, Revenue Column, the result of adding Line F, Base Year Adjusted Expenses, Line I, Inflation and Line J, Miscellaneous Adjustments.

Verify that the addition of the budget year expenses in Columns 1 and 2 equal the total expenses in Column 3 for each other institutional program center schedule.

Transfer the total expenses from Column 3 of Schedules F1 to F4 to Schedule RC, Line I, Column 2, Budget Year.

Schedule F1 to F4 - Column 4

Enter on this line, on each other institutional program center schedule, in the Expense, Revenue Per Unit Column, the result of dividing Line K, Column 3, by Line A, Column 2, e.g., 160.0 ÷ 10,000 = .01600.

Budget Year Profit (Loss) Section

Line L - Base Year Revenue

Schedules F1 to F4 - Column 3

Enter on this line, on each applicable other institutional program center schedule, in the Total Expenses, Revenue Column, the revenue of the reporting hospital generated in the base year.

Line M - Adjustments

Schedules F1 to F4 - Column 3

Enter on this line, on each applicable other institutional program center schedule, in the Total Expenses, Revenue Column, adjustments to the base year revenues.

Line N - Budget Year Revenue

Schedules F1 to F4 - Column 3

Enter on this line, on each applicable other institutional program center schedule, in the Total Expenses, Revenue Column, the result of adding Line L, Base Year Revenue, and Line M, Adjustments.

Line O- Profit (Loss)

Schedules F1 to F4 - Column 3

Enter on this line, on each other institutional program center schedule, in the Total Expenses, Revenue Column, the result of subtracting Line K, Budget Year Expenses, from Line N, Budget Year Revenue.

Enter a loss in brackets, e.g., 180.7 – 190.9 = (10.2).

FTE Data Section

Line P- Adj. Base Year Hours Worked ÷ 2080

Schedules F1 to F4 - Column I

Enter on this line, on each other institutional program center schedule, in the Wages, Salaries and Fringe Benefits Column, the result of dividing the adjusted base year hours worked by 2080, e.g., 10,912 ÷ 2080 = 5.2.

Worked hours are to be counted in accordance with Section 200.0371, Salaries and Wages. Include hours worked for allocations from general service centers.

Transfer the FTEs, on Line P of each other institutional program center schedule to Schedule OADP, on the appropriate Lines D86 to D893, Column I.

Line Q - Budget Year Hours Worked ÷ 2080

Schedules F1 to F4 1- Column 1

Enter on this line, on each other institutional program center schedule, in the Wages, Salaries and Fringe Benefits Column, the result of dividing the budget year hours worked by 2080, e.g., 20,500 ÷ 2080 = 9.9.

SCHEDULE RC - RECONCILIATION OF BASE YEAR REGULATED AND UNREGULATED TO SCHEDULE R .21

Overview .211

Schedule RC is provided to enable each hospital to reconcile the base year expenses submitted in Schedules UA, C, D, E1 to E9, F1 to F4, P2A to P2I, P3A to P3I, P4A to P4I, P5A to P5I and UR1 to UR8 to Schedule RE, Statement of Revenue and Expenses.

The Column entitled Source indicates computations to be made or the source of data requested.

Detailed Instructions .212

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line, the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line, the year for which the base year data are reported, e.g., 06–04.

Line A - Unassigned Expenses

Column 1

Enter on this line, in the Regulated Column, the regulated expenses transferred from Schedule UA, Line C, Column 10.

Column 2

Enter on this line, in the Unregulated Column, the unregulated expenses transferred from Schedule UA, Line B, Column 10 reversing the sign.

Column 3

Enter on this line, in the Total Column, the sum of Column 1 and 2.

Line B - Physicians Part B Services

Column 1

Enter on this line, in the Regulated Column, the expenses transferred from Schedule P2I, Line A. Column 7.

Column 2

Enter on this line, in the Unregulated Column, the expenses transferred from Schedule UR6, Line B, Column3.

Column 3

Enter on this line, in the Total Column, the sum of Columns 1 and 2.

Line C - Physician Support Services

Column 1

Enter on this line, in the Regulated Column, the base year expenses transferred from Schedule P31, Line A, Column 7.

Column 2

Enter on this line, in the Unregulated Column, the base year expenses transferred from the applicable UR Schedule, Line B, Column 3.

Column 3

Enter on this line, in the Total Column, the sum of Columns 1 and 2.

Line D - Resident Intern Services

Column 1

Enter on this line, in the Regulated Column, the expenses transferred from Schedule P4I, Line D, Column 7.

Column 2

Enter on this line, in the Unregulated Column, the expenses transferred from Schedule P5I. Line D. Column 7.

Column 3

Enter on this line in the Total Column the sum of Columns 1 and 2.

Line E - Overhead Expenses Summary

Column 1

Enter on this line, in the Regulated column, the expenses transferred from Schedule OES: Line P, Column 1. Exclude overhead expenses allocated to E, F, and UR schedules less overhead for E schedules treated as a fringe benefit.

Column 2

Enter on this line, in the Unregulated column, the overhead expenses allocated to E, F and UR schedules not treated as a fringe benefit.

Column 3

Enter on this line, in the Total Column the sum of Column 1 and 2.

Line F - Patient Care Centers

Column 1

Enter on this line, in the Regulated Column, the expenses transferred from Schedule D - Lines D1 to D81, Column 5.

Column 3

Enter on this line in the Total Column the entry in Column 1.

Line G - Auxiliary Enterprise

Column 1

Enter on this line, in the Regulated column, the losses treated as a fringe benefit.

Column 2

Enter on this line, in the Unregulated Expenses Column, the expenses transferred from Schedules E1 to E9. Line B. Column 3, the difference between total E schedule expenses and the losses treated as a fringe benefit.

Column 3

Enter on this line, in the Total Column, the entry in Column 2.

Line H - Other Institutional Programs

Column 2

Enter on this line, in the Unregulated Column, the expenses transferred from Schedules F1 to F4, Line B, Column 3.

Column 3

Enter on this line, in the Total Column, the entry in Column 2.

Line I - Unregulated Services

Column 2

Enter on this line, in the Unregulated Column, the expenses transferred from Line B, Column 3 of the UR Schedules (excluding the expenses reported on Lines B and C above).

Column 3

Enter on this line, in the Total Column, the entry in Column 2.

Line J - Total Operating Expenses

Columns 1, 2 and 3

Enter on this line, in each column, the result of adding the expenses from Lines A to I.

Line K - Non-Operating Expenses

Column 2

Enter on this line, in the Unregulated Column, the non-operating expenses.

Line L - Total Expenses

Columns 1, 2 and 3

Enter on this line, in each column, the result of adding the operating expenses from Line J and the non-operating expenses from Line K.

Line M - Total Operating Expenses - RE Schedule

Columns 1 and 2

Enter on this line, in the applicable column, the regulated and unregulated operating expenses transferred from Schedule RE, Line S, Column 1 and 2.

Column 3

Enter on this line, in the Total Column, the sum of Columns 1 and 2.

Line N - Non-Operating Expenses - RE Schedule

Column 2

Enter on this line, in the Unregulated Column, the non-operating expenses transferred from Scheduled RE, Line V, Column 2.

Column 3

Enter on this line, in the Total Column, the entry in Column 2.

Line O - Total Expenses - RE Schedule

Column 1 and 2

Enter on this line, in each column, the result of adding the operating expenses from Line M and non-operating expenses from Line N.

Column 3

Enter on this line, in the Total Column, the sum of Columns 1 and 2.

Line P - Reconciliation Amount

Columns 1 and 2

Enter on this line, in each column, the result of subtracting the total expenses on Line L from the total expenses, from the RE Schedule, on Line O. (Auxiliary Enterprises losses treated as employee fringe benefits should be a reconciling item between RC and RE expenses regulated and unregulated expenses.)

Column 3

Enter on this line, in the Total Column, the sum of Columns 1 and 2.

Lines Q1 to Q5 - Nomenclature Column

Enter on these lines in the Nomenclature Column the type of expenses included on Line P.

Columns 1 and 2

Enter on these lines, in the applicable column, the regulated and unregulated expenses corresponding to the nomenclature listed in the Nomenclature Column.

Column 3

Enter on this line, in the Total Column, the sum of Columns 1 and 2.

SCHEDULE RE - STATEMENT OF REVENUES AND EXPENSES .22

Overview .221

Schedule RE is provided to enable each hospital to report a statement of revenues and expenses in a uniform format.

Supplemental Schedule RE-R must be submitted reconciling Schedule RE to the hospital's audited revenue and expense statement.

Definitions:

Other Operating Revenue and Expenses - Includes services provided to patients other than health care services, as well as sales and services to non-patients (Auxiliary Enterprises - E Schedules and Research Education - Nursing, Other Health Profession and Community Health (Other Institutional Programs - F Schedules).

Non-Operating Revenue and Expense - Includes donations, investment income, other non-operating gains, plus revenue and expenses resulting from hospital's peripheral or incidental transactions and from other events stemming from the environment that may be largely beyond the hospital management's control. In addition, detailed information applicable to non-operating revenue and expenses, plus other significant financial information is to be submitted on Schedule SFI.

Submit detailed listings for Other Operating Revenues, Line L and Other Expenses, Line R. Additional detailed information for Non-Operating Revenues, Line U. and Non-Operating Expenses, are to be submitted on Supplemental Schedule SFI.

Round all entries on lines A through W to 1 decimal place (the nearest hundred).

Round the calculations on lines X and Y to 5 decimal places.

Round the calculation on line Z to 2 decimal places.

Detailed Instructions .222

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line, the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line, the year for which the fiscal year data is reported, e.g., 0610.

Line A - Gross Revenues from Daily Hospital Services

Column 1

Enter on this line, in the Regulated Column, the regulated fiscal year revenue for Daily Hospital Services and Admission Services, as reported on the monthly data submissions. (Includes Ambulatory Services associated with Fiscal inpatient admissions.)

Column 2

Enter on this line, in the Unregulated Column, the unregulated fiscal year revenue for Daily Hospital Services and Admission Services.

Column 3

Enter on this line, in the Total Column, the sum of entries in Columns 1 and 2.

Line B - Gross Revenues from Ambulatory Services

Column 1

Enter on this line, in the Regulated Column, the regulated fiscal year revenue for Ambulatory Services as reported on the monthly submissions. (Excluding those Ambulatory Services associated with inpatient admissions.)

Column 2

Enter on this line, in the Unregulated Column, the unregulated fiscal year revenue for Ambulatory Services.

Column 3

Enter on this line, in the Total Column, the sum of the entries in Columns 1 and 2.

Line C - Gross Revenues From Inpatient Ancillary Services

Column 1

Enter on this line, in the Regulated Column, the regulated fiscal year revenues for inpatient ancillary services, as reported on the monthly submissions.

Column 2

Enter on this line, in the Unregulated Column, the unregulated fiscal year revenues for inpatient ancillary services.

Column 3

Enter on this line, in the Total Column, the sum of the entries in Columns 1 and 2.

Line D - Gross Revenues from Outpatient Ancillary Services

Column 1

Enter on this line, in the Regulated Column, the regulated fiscal year revenue for outpatient ancillary services, as reported on the monthly submissions.

Column 2

Enter on this line, in the Unregulated Column, the unregulated fiscal year revenue for outpatient ancillary services.

Column 3

Enter on this line, in the Total Column, the sum of the entries in Columns 1 and 2.

Line E - Gross Patient Revenue

Column 1

Enter on this line, in the Regulated Column, the result of adding the gross regulated fiscal year patient revenues from lines A, B, C, and D.

Verify that the gross regulated patient revenues for the fiscal year equals the sum of the gross regulated inpatient revenue. Line A, and gross regulated outpatient revenue. Line F of Schedule V5.

Verify that the gross regulated patient revenues for the fiscal year agree with the gross patient revenues reported on Schedules RSA, RSB, RSC for the base year.

Column 2

Enter on this line, in the Unregulated Column, the result of adding the gross unregulated fiscal year patient revenues from lines A, B, C, and D

Column 3

Enter on this line, in the Total Column, the sum of the entries in Columns 1 and 2.

Line F - Provision for Bad Debts

Column 1

Enter on this line, in the Regulated Column, the provision for Bad Debts associated with fiscal year regulated patient services.

Column 2

Enter on this line, in the Unregulated Column, the provision for Bad Debts associated with fiscal year unregulated patient services.

Column 3

Enter on this line, in the Total Column sum of the entries in Columns 1 and 2

Line G - Charity/Uncompensated Care

Column 1

Enter on this line, in the Regulated Column, the Charity/Uncompensated Care associated with the regulated fiscal year patient services.

Column 2

Enter on this line, in the Unregulated Column, the Charity/Uncompensated Care associated with the unregulated fiscal year patient services.

Column 3

Enter on this line, in the Total Column, the sum of the entries in Columns 1 and 2.

Line H - Contractual Adjustments

Column 1

Enter on this line, in the Regulated Column, the Contractual Adjustments associated with regulated fiscal year patient services.

Column 2

Enter on this line, in the Unregulated Column, the Contractual Adjustments associated with unregulated fiscal year patient services.

Column 3

Enter on this line, in the Total Column, the sum of the entries in Columns 1 and 2.

Line H 1 - Uncompensated Care Fund Payments

Column 1

Enter on this line, in the Regulated Column, the payments made to the HSCRC Uncompensated Care Fund in the fiscal year.

Column 3

Enter on this line, in the Total Column, the entry in Column 1.

Line H2 – Denials

Column 1

Enter on this line, in the regulated column, denials written off from the hospital's revenue, Denials are defined as the difference between the amounts billed by the hospital in conformance with HSCRC approved charges and the portion of the patient bill denied payment by third party payers for administrative or medical necessity reasons, section 100.58 and 200.056.

Column 2

Enter on this line, in the unregulated column denial written off from the hospital's revenue. Denials are defined as the difference between the amounts billed by the hospital in conformance with HSCRC approved charges and the portion of the patient bill denied payment by third party payers for administrative or medical necessity reasons, sections 100.58 and 200.056.

Column 3

Enter on this line, in the total column, the sum of the entries in column 1 and 2.

Line I - Other Deductions from Revenue

Column 1

Enter on this line, in the Regulated Column, the Other Deductions from Revenue associated with fiscal year regulated patient services. This line may recognize Revenue Accruals/Adjustments related to regulatory adjustments, i.e., Charge per Case Price Compliance.

Column 2

Enter on this line, in the Unregulated Column, the Other Deductions from Revenue associated with unregulated fiscal year patient services.

Column 3

Enter on this line, in the Total Column, the sum of the entries in Columns 1 and 2.

Line J - Total Deductions from Revenue

Column 1

Enter on this line, in the Regulated Column, the sum of the deductions from revenue associated with regulated fiscal year patient services. Lines F, G, H, H1, and I.

Column 2

Enter on this line, in the Unregulated Column, the sum of the deductions from revenue associated with unregulated fiscal year services, Lines F, G, H, and I.

Column 3

Enter on this line, in the Total Column, the sum of the entries in Columns 1 and 2.

Line J1 - Uncompensated Care Fund Receipts

Column 1

Enter on this line, in the regulated Column, the payments from the HSCRC Uncompensated Care Fund in the fiscal year.

Column 3

Enter on this line, in the Total Column, the entry in Column 1.

Line K - Net Patient Revenues

Column 1

Enter on this line, in Regulated Column, the result of subtracting Line J, Total Deductions from Line E, Gross Patient Revenues, plus Line J1, Uncompensated Care Fund Receipts.

Column 2

Enter on this line, in the Unregulated Column, the result of subtracting Line J, Total Deductions, from Line E, Gross Patient Revenues.

Column 3

Enter on this line, in the total Column the sum of the entries in Columns 1 and 2.

Line L - Other Operating Revenues

Column 1

Other Operating Revenue and Expenses - Includes services provided to patients other than health care services, as well as sales and services to non-patients (Auxiliary Enterprises - E Schedules), and Research, Education - Nursing. Other Health Profession and Community Health (Other Institutional Programs - F Schedules).

Enter on this line, in the Regulated Column, the regulated fiscal year Other Operating Revenues. Supply a summary of the components of Regulated Other Operating Revenue.

Column 2

Enter on this line, in the Unregulated Column, the unregulated fiscal year Other Operating Revenues. This line should include: the gross fiscal year revenue from Line G, Column 3 of: all Auxiliary Enterprises (E) Schedules*, and all Other Institutional Programs (F) Schedules.

***See Other Expenses for treatment of Auxiliary Enterprise losses treated as employee fringe benefits.**

Column 3

Enter on this line, in the Total Column, the sum of entry Columns 1 and 2.

Line M - Net Operating Revenues

Column 1

Enter on this line the result of adding Regulated Net Patient revenues, Line K, and Regulated Other Operating Revenues, Line L.

Column 2

Enter on this line the entry on Line L. Unregulated Other Operating Revenue.

Column 3

Enter on this line, in the Total Column, the sum of Columns 1 and 2.

Line N - Salaries, Wages and Employee Benefits

Column 1

Enter on this line in the Regulated Column, the wages, salaries, and employee fringe benefit expenses associated with regulated fiscal year services.

Column 2

Enter on this line in the Unregulated Column, the base year wages, salaries, and fringe benefit expenses associated with unregulated fiscal year services.

Column 3

Enter on this line, in the Total Column, the sum of Columns 1 and 2.

Line O - Professional Fees

Column 1

Enter on this line, in the Regulated Column, the professional fees expenses associated with regulated fiscal year services.

Column 2

Enter on this line, in the Unregulated Column, the professional fees expenses associated with unregulated fiscal year services.

Column 3

Enter on this line, in the Total Column, the sum of Columns 1 and 2.

Lines P – Supplies

Column 1

Enter on this line, in the Regulated Column, the Supplies expenses associated with regulated fiscal year services.

Column 2

Enter on this line, in the Unregulated Column, the Supplies expenses associated with unregulated fiscal year services.

Column 3

Enter on this line, in the Total Column, the sum of Columns 1 and 2.

Line Q - Depreciation/Amortization, Leases/Rentals

Column 1

Enter on this line, in the Regulated Column, the depreciation/amortization and leases/rentals expenses associated with regulated fiscal year services.

Column 2

Enter on this line, in the Unregulated Column, the depreciation/amortization and leases/rentals associated with unregulated fiscal year services.

Column 3

Enter on this line, in the Total Column, the sum of Columns 1 and 2.

Line R - Other Expenses

Column 1

Enter on this line, in the Regulated Column, the Other expenses associated with regulated fiscal year services. **(The losses associated with auxiliary Enterprises provided as employee fringe benefits, i.e., cafeteria, parking, housing, child care center, Schedules E2, E7, E8, and E9, line I, Column 3, should be reported on this line.)**

Column 2

Enter on this line, in the Unregulated Column, the Other expenses associated with unregulated fiscal year services. (Expenses from E Schedules should be reduced by the amount of the losses treated as employee fringe benefits.)

Column 3

Enter on this line, in the Total Column, the sum of Columns 1 and 2.

Line S - Total Operating Expenses

Column 1

Enter on this line, in the Regulated Column, the sum of Regulated fiscal year Operating Expenses lines N, O, P, Q, and R.

Column 2

Enter on this line, in the Unregulated Column, the sum of Unregulated fiscal year Operating Expenses lines N, O, P, Q, and R.

Column 3

Enter on this line, in the Total Column, the sum of Columns 1 and 2.

Line T - Operating Margin, Excess (Deficit) Operating Revenue Over Operating Expenses

Column 1

Enter on this line, in the Regulated Column, the result of subtracting Line S, Regulated Total Operating Expenses from Line M, Regulated Total Operating Revenue. Enter a deficit in brackets.

Column 2

Enter on this line, in the Unregulated Column, the result of subtracting Line S, Unregulated Total Operating Expenses from Line M, Unregulated Total Operating Revenue. Enter a deficit in brackets.

Column 3

Enter on this line, in the Total Column, the sum of Columns 1 and 2. Enter a deficit in brackets.

Line U - Non-Operating Revenues

Column 2

Non-Operating Revenue and Expense - Includes donations, investment income, other non-operating gains, plus revenue and expenses resulting from hospital's peripheral or incidental transactions and from other events stemming from the environment that may be largely beyond the hospital management's control.

Enter on this line, in the Unregulated Column, the Non-Operating Revenues.

Column 3

Enter on this line, in the Total Column, the Non-Operating Revenues from column 2.

Line V - Non-Operating Expenses

Column 2

Enter on this line, in the Unregulated Column, the Non-Operating Expenses.

Column 3

Enter on this line, in the Total Column, the Non-Operating Expenses from column 2.

Line W - Total Margin, Excess (Deficit) Total Revenues Over Total Expenses

Column 1

Enter on this line, in the Regulated column, the Excess Operating Income Over Operating Expenses from line T. Enter a deficit in brackets.

Column 2

Enter on this line, in the Unregulated Column, the result of adding Line T, Operating Margin and Line U, Non-Operating Revenue, less Line V Non-Operating Expenses. Enter a deficit in brackets.

Column 3

Enter on this line, in the Total Column, the result of adding Line T, Operating Margin and Line U, Non-Operating Revenue, less Line V, Non-Operating Expenses. Enter a deficit in brackets.

Line X - Regulated Operating Expenses Per EIPD

Column 1

Enter on this line, in the Regulated Column, the result of dividing Line S, Total Regulated Operating Expenses by the EIPDs from Schedule V5, Line M, Column 2.

Line Y - Regulated Operating Expenses per EIPA

Column 1

Enter on this line, in the Regulated Column, the result of dividing Line S, Total Operating Expenses by the EIPAs from Schedule V5, Line S, Column 2.

Line Z - Working Capital Ratio

Column 1

Enter on this line, in the Regulated Column, the Working Capital ratio utilizing the formula. Current Assets divided by Current Liabilities.

Line AA - Admissions

Column 1

Enter on this line in the Regulated Column, the number of Admissions. Total Admissions should equal the total admissions from the admissions revenue center on the monthly reports plus the Neo Natal Infants Not Charged an Admission Charge, Line H on the Supplemental Births Schedule (SB).

Column 2

Enter on this line in the Unregulated Column, the number of Admissions for unregulated Inpatient Services.

Column 3

Enter on this line, in the Total Column, the sum of Column 1, Regulated admissions and Column 2, Unregulated Admissions.

Line BB - EIPAs

Column 1

Enter on this line the result of multiplying Line AA Regulated Admissions times Line E Regulated Gross Revenue divided by Regulated Inpatient Revenue (Column 1 line A plus column 1, line C).

Column 2

Enter on this line the result of multiplying Line AA Unregulated Admissions times Line E Unregulated Gross Revenue divided by Unregulated Inpatient Revenue (Column 2 Line A plus Column 2 Line C).

Column 3

Enter on this line, in the Total Column, the result of multiplying Line AA Total Admissions times Line E Total Gross Revenue divided by Total Inpatient Revenue (Column 3 Line A plus Column 3 Line C).

Schedule RE-R - Reconciliation of the Audited Financial Statements to Schedule RE .30

Overview .301

Schedules RE-R1 and RE-R2 are provided to enable each hospital to reconcile the reporting hospital's audited financial statements to Schedule RE in a uniform format.

Round all entries to 1 decimal place (nearest hundred).

Detailed Instructions .302

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number. e.g., 0099.

Column 1 - Audited Financial Statements

Enter on each line in this column the revenues and expenses as detailed in the audited financial statements of the reporting hospital. Certain revenues and expenses may be detailed in the notes to the financial statements.

Column 2 - Miscellaneous Adjustments

Enter on each line in this column the revenue and expense items that require different presentation to comply with HSCRC accounting and budget regulations, i.e., provision for bad debts as a deduction from revenue vs. operating expense, uncompensated care fund payments, etc.

Columns 3 through 11 - Auxiliary Enterprises

Enter on each line in these columns the revenue and expense items from each applicable schedule E - Auxiliary Enterprises

Columns 12 through 15 - Other Institutional Programs

Enter on each line in these columns the revenue and expense items from each applicable schedule F - Other Institutional Programs

Columns 16 through 23 - Unregulated Services

Enter on each line in these columns the revenue and expense items from each applicable schedule UR - Unregulated Services

Column 24 - Total Auxiliary Enterprises, Other Institutional Programs & Unregulated Services

Enter on each line in this column the result of adding the amounts in columns 3 through 23.

Column 25 - Unregulated Adjustments

Enter in this column the adjustments necessary to present unregulated operations in the format prescribed for the RE schedule.

Column 26 - Schedule RE

Enter in this column the result of adjusting column 1, audited financial statements, for entries in column 24, total auxiliary enterprises, other institutional programs and unregulated services, and column 25 unregulated adjustments.

Column 27 - Schedule RE Line

Enter in this column the line reference for the data element on schedule RE.

SCHEDULES FSA AND FSB - FINANCIAL STATEMENT SUMMARY .32

Overview .321

Schedule FSA and FSB are provided to enable each hospital to report certain unaudited financial data in a uniform and consistent format. In this way, the Commission may readily monitor the financial condition of each hospital under its jurisdiction. Hospitals should separate, as accurately as possible, regulated from unregulated financial data. The Commission recognizes that allocation or classification of some of the data may have to be estimated or extrapolated from prior period data. Schedules FSA and FSB must be submitted utilizing Section 200, Chart of Accounts, as basis for categorizing revenues and expenses.

Round all entries on Lines A to TT to the nearest whole dollar.

Definitions

Other Operating Revenue and Expenses - Includes services provided to patients other than health care services, as well as sales and services to non-patients (Auxiliary Enterprises - E Schedules and Research Education - Nursing, Other Health Profession and Community Health) (Other Institutional Programs - F Schedules).

Non-Operating Revenue and Expense - Includes donations, investment income, other non-operating gains, plus revenue and expenses resulting from hospital's peripheral or incidental transactions and from other events stemming from the environment that may be largely beyond the hospital management's control. In addition, detailed information applicable to non-operating revenue and expenses, plus other significant financial information is to be submitted on Schedule SFI with Schedules FSA and FSB.

Detailed Instructions .322

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Month Ending Line

Enter on this line the month for which the data is reported, e.g., 09-88.

Base Year Line

Enter on this line the year for which the data is reported, e.g., 06-88.

Revenue and Expense Summary Section - Schedule FSA

Column 1 - Regulated

Line A - Inpatient Revenue - HSCRC Regulated

Enter on this line, in this column, the Gross HSCRC Regulated Inpatient Revenues of the reporting hospital for the month consisting of Daily Hospital Services. Section 200.051. Ancillary Services, Section 200.053, and Admissions Services, Section 200.054.

Line B - Outpatient Revenues - HSCRC Regulated

Enter on this line, in this column, the Gross HSCRC Regulated Outpatient Revenues of the reporting hospital for the month consisting of Ambulatory Services. Section 200.052, and Ancillary Services, Section 200.054.

Line C - Gross Patient Revenues - HSCRC Regulated

Enter on this line, in this column, the result of adding line A, HSCRC Regulated Inpatient Revenues, plus line B, HSCRC Regulated Outpatient Revenues.

Line D - Inpatient Charity Care - HSCRC Regulated

Enter on this line, in this column, the HSCRC Regulated Inpatient Charity Care deduction from the reporting hospital's revenue for the month. Charity Care is defined as the difference between what the hospital bills a Charity Care patient for hospital services rendered (based on HSCRC approved rates) and the amount paid by the patient, if any, for those services, Sections 100.58 and 200.056.

Line D1 - Inpatient Bad Debts - HSCRC Regulated

Enter on this line, in this column, the HSCRC Regulated Inpatient Bad Debts deduction from the reporting hospital's revenues for the month. Bad Debts are defined as the amount of revenue written off by the hospital from HSCRC approved rates after the provisions of

the hospital's collection and write-off policy are followed, less bad debt recoveries, Section 100.58 and 200.056.

Line E - Outpatient Charity Care - HSCRC Regulated

Enter on this line, in this column, the HSCRC Regulated Outpatient Charity Care deduction from the reporting hospital's revenue for the month. Charity Care is defined as the difference between what the hospital bills a Charity Care patient for hospital services rendered (based on HSCRC approved rates) and the amount paid by the patient, if any, for those services, Sections 100.58 and 200.056.

Line E1-Outpatient Bad Debts - HSCRC Regulated

Enter on this line, in this column, the HSCRC Regulated Outpatient Bad Debts deduction from the reporting hospital's revenues for the month. Bad Debts are defined as the amount of revenue written off by the hospital from HSCRC approved rates after the provisions of the hospital's collection and write-off policy are followed, less bad debt recoveries, Section 100.58 and 200.056.

Line F - Inpatient HSCRC Approved Discounts & Differentials - HSCRC Regulated

Enter on this line, in this column, the HSCRC Regulated Inpatient Discounts and Differentials associated with approved discounts and differentials, i.e., prompt payment, SAAC, the differential granted to Medicare and Medicaid, and the differential granted to third party payers who subcontract with Medicare and Medicaid deducted from the hospital's revenue for the month, Sections 100.58 and 200.056.

Line F1 - Inpatient Denials - HSCRC Regulated

Enter on this line, in this column, the HSCRC Regulated Inpatient Denials written off from the hospital's revenue for the month. Denials are defined as the difference between the amounts billed by the hospital in conformance with HSCRC approved charges and the portion of the patient bill denied payment by third party payers for administrative or medical necessity reasons, Sections 100.58 and 200.056.

Line F2 - Inpatient Administrative, Courtesy, Policy, and Other Discounts and Adjustments - HSCRC Regulated

Enter on this Line, in this column, the HSCRC Regulated Inpatient Administrative, Courtesy, Policy, and Other Discounts and Adjustments deducted from the hospital's revenue for the month. These include but are not limited to reductions from established rates for: courtesy discounts; employee discounts; administrative decision discounts; and charges written off, for whatever reason,

that are not the result of a patient's ability to pay or where the hospital has not expended a reasonable collection effort, Sections 100.58 and 200.056.

Line F3 - Outpatient HSCRC Approved Discounts & Differentials - HSCRC Regulated

Enter on this line, in this column, the HSCRC regulated Outpatient HSCRC Approved Discounts & Differentials associated with approved discounts and differentials, i.e., prompt payment, SAAC, the differential granted to Medicare and Medicaid, and the differential granted to third party payers who subcontract with Medicare and Medicaid deducted from the hospital's revenue for the month, Sections 100.58 and 200.056.

Line F4 - Outpatient Denials - HSCRC Regulated

Enter on this line, in this column, the HSCRC regulated Outpatient Denials written off from the hospital's revenue for the month. Denials are defined as the difference between the amounts by the hospital in conformance with HSCRC approved charges and that portion of the patient bill denied payment by the third party payers for administrative or medical necessity reasons, Sections 100.58 and 200.056.

Line F5 - Outpatient Administrative, Courtesy, Policy, and Other Discounts and Adjustments - HSCRC Regulated

Enter on this Line, in this column, the HSCRC Regulated Outpatient Administrative, Courtesy, Policy, and Other Discounts and Adjustments for the hospital for the month. These include but are not limited to reductions from established rates for: courtesy discounts; employee discounts; administrative decision discounts; and charges written off, for whatever reason, that are not the result of a patient's ability to pay or where the hospital has not expended a reasonable collection effort, Sections 100.58 and 200.056.

Line F6 - Total Discounts, Differentials, Denials and Adjustments - HSCRC Regulated

Enter on this line, in this column, the result of adding Lines F1+F2+F3+F4+F5.

Line G - Deductions from Revenues - HSCRC Regulated

Enter on this line, in this column, the result of adding Lines D+D1+E+E1+F6.

Line H - Net Patient Revenues - HSCRC Regulated

Enter on this line, in this column, the result of subtracting Line G, Deductions from Revenues, HSCRC Regulated from Line C, Gross Patient Revenues HSCRC Regulated.

Line I - Other Operating Revenues - HSCRC Regulated

Definitions:

Other Operating Revenue and Expenses - Includes services provided to patients other than health care services, as well as sales and services to non-patients (Auxiliary Enterprises - E Schedules and Research Education - Nursing, Other Health Profession and Community Health) (Other Institutional Programs - F Schedules).

Enter on this line, in this column, the Other Operating Revenues of the reporting hospital for the month, to include Other Institutional Programs and Auxiliary Enterprises see Section 200.055. (These revenues should not include revenue from HSCRC unregulated services)

Line J - Net Operating Revenues - HSCRC Regulated

Enter on this line, in this column, the result of adding Line H, Net Patient Revenues, HSCRC Regulated and line I, Other Operating Revenues HSCRC Regulated.

Line K - Salaries and Wages - HSCRC Regulated

Enter on this line, in this column, the Salaries and Wages of the reporting hospital for the month, associated with HSCRC Regulated Services Section 200.037.

Line L - Employee Benefits - HSCRC Regulated

Enter on this line, in this column, the Employee Benefits of the reporting hospital for the month, associated with HSCRC Regulated Services.

Line M - Other Operating Expenses - HSCRC Regulated

Enter on this line, in this column, the Other Operating Expenses of the reporting hospital for the month, associated with HSCRC Regulated Services Section 200.057.

Line N - Operating Expenses (Excl. Depreciation and Interest)

Enter on this line, in this column, the result of adding Line K, Salaries and Wages, HSCRC Regulated Line L, Employee Benefits HSCRC Regulated, and Line M, Other Operating Expenses, HSCRC Regulated.

Line O - Interest - HSCRC Regulated

Enter on this line, in this column, the Interest expense of the reporting hospital for the month, associated with HSCRC Regulated Services Section 200.037, Natural Classification of Expense Category .82.

Line P - Depreciation/Amortization - HSCRC Regulated

Enter on this line, in this column, Depreciation/Amortization expense of the reporting hospital for the month associated with HSCRC regulated services Section 200.037, Natural Classification of Expense Categories .91, .92, .93 and .94.

Line Q - Total Operating Expenses - HSCRC Regulated

Enter on this line, in this column, the result of adding Line N, Operating Expenses (Excluding Depreciation and Interest), Line O, Interest and Line P, Depreciation/Amortization.

Line R - Excess (Deficit) Operating Revenue over Operating Expenses - HSCRC Regulated

Enter on this line, in this column, the result of subtracting Line Q, Total Operating Expenses from Line J, Net Operating Revenues. Enter a deficit in brackets, e.g. 22, 610, 9901 – 23,002,801 = (391,900).

Column 2 - Unregulated

Line A - Inpatient Revenue - Unregulated

Enter on this line, in this column, the Gross Unregulated Inpatient Revenues of the reporting hospital for the month consisting of Daily Hospital Services. Section 200.051. Ancillary Services, Section 200.053, and Admissions Services, Section 200.054.

Line B - Outpatient Revenues - Unregulated

Enter on this line, in this column, the Gross Unregulated Outpatient Revenues of the reporting hospital for the Month consisting of Ambulatory Services, Section 200.052, and Ancillary Services, Section 200.054.

Line C - Gross Patient Revenues - Unregulated

Enter on this line, in this column, the result of adding line A, column 2, Unregulated Inpatient Revenues, plus line B, column 2, Unregulated Outpatient Revenues.

Line D - Inpatient Charity Care - Unregulated

Enter on this line, in this column, the HSCRC Unregulated Inpatient Charity Care deduction from the reporting hospital's revenue month. Charity Care is defined as the difference between what the hospital bills a Charity Care patient for services rendered and the amount paid by the patient, if any, for those services.

Line D1 - Inpatient Bad Debts - Unregulated

Enter on this line, in this column, the HSCRC Unregulated Inpatient Bad Debts deduction from the reporting hospital's revenues for the month. Bad Debts are defined as the amount of revenue written off by the hospital after the provisions of the hospital's collection and write-off policy are followed, less bad debt recoveries.

Line E - Outpatient Charity Care - Unregulated

Enter on this line, in this column, the HSCRC Unregulated Outpatient Charity Care deduction from the reporting hospital's revenue month. Charity Care is defined as the difference between what the hospital bills a Charity Care patient for hospital services rendered and the amount paid by the patient, if any, for those services.

Line E1 - Outpatient Bad Debts - Unregulated

Enter on this line, in this column, the Outpatient Unregulated Bad Debts deduction from the reporting hospital's revenues for the month. Bad Debts are defined as the amount of revenue written off by the hospital after the provisions of the hospital's collection and write-off policy are followed, less bad debt recoveries.

Line F1 - Inpatient Denials - Unregulated

Enter on this line, in this column, the HSCRC Unregulated Inpatient Denials written off from the hospital's revenue for the month. Denials are defined as the difference between the amount billed by the hospital and the portion of the patient bill denied payment by third party payers for administrative or medical necessity reasons, Sections 100.58 and 200.056.

Line F2 - Inpatient Contractual, Administrative, Courtesy, Policy, and Other Discounts and Adjustments - Unregulated

Enter on this Line, in this column, the HSCRC Unregulated Inpatient Contractual, Administrative, Courtesy, Policy, and Other Discounts and Adjustments deducted from the hospital's revenue for the month. These include but are not limited to reductions from established rates for: contractual allowances; courtesy discounts; employee discounts; administrative decision discounts; and charges

written off, for whatever reason, that are not the result of a patient's ability to pay or where the hospital has not expended a reasonable collection effort.

Line F4 - Outpatient Denials - Unregulated

Enter on this Line, in this column, the HSCRC Unregulated Outpatient Denials written off from the hospital's revenue for the month. Denials are defined as the difference between the amount billed by the hospital and that portion of the patient bill denied payment by third party payers for administrative or medical necessity reasons.

Line F5 - Outpatient, Contractual, Administrative, Courtesy, Policy, and Other Discounts and Adjustments - Unregulated

Enter on this Line, in this column, the HSCRC Unregulated Outpatient Administrative, Courtesy, Policy, and Other Discounts and Adjustments deducted from the hospital's revenue for the month. These include but are not limited to reductions from established rates for: contractual allowances; courtesy discounts; employee discounts; administrative decision discounts; and charges written off, for whatever reason, that are not the result of a patient's ability to pay or where the hospital has not expended a reasonable collection effort.

Line F6 - Total Discounts, Differentials, Denials, and Adjustments - Unregulated

Enter on this line, in this column, the result of adding Lines F1+F2+F4+F5

Line G - Deductions from Revenues - Unregulated

Enter on this line, in this column, the result of adding Lines D+D1+E+E1+F6

Line H - Net Patient Revenues - Unregulated

Enter on this line, in this column, the result of subtracting Line G, column 2, Deductions from Unregulated Revenues, from Line C, column 2, Unregulated Gross Patient Revenues.

Line I - Other Operating Revenues - Unregulated

Enter on this line, in this column, the Other Operating Revenues of the reporting hospital for the month, Section 200.055. (Should not include revenue from HSCRC regulated services)

Definitions:

Other Operating Revenue and Expenses - Includes services provided to patients other than health care services, as well as sales and services to non-patient (Auxiliary Enterprises - E Schedules and Research Education - Nursing, Other Health Profession and Community Health) (Other Institutional Programs - F Schedules).

Line J - Net Operating Revenues - Unregulated

Enter on this line, in this column, the result of adding Line H, column 2, Net Unregulated Patient Revenues, and line I, column 2, Other Unregulated Operating Revenues.

Line K - Salaries and Wages - Unregulated

Enter on this line, in this column, the Salaries and Wages of the reporting hospital for the month, associated with unregulated services Section 200.037.

Line L - Employee Benefits - Unregulated

Enter on this line, in this column, the Employee Benefits of the reporting hospital for the month, associated with unregulated services.

Line M - Other Operating Expenses - Unregulated

Enter on this line, in this column, the Other Operating Expenses of the reporting hospital for the month, associated with unregulated services.

Line N - Operating Expenses (Excl. Depreciation and Interest) - Unregulated

Enter on this line, in this column, the result of adding Line K, column 2, Unregulated Salaries and Wages, Line L, column 2, Unregulated Employee Benefits, and Line M, column 2, Other Unregulated Operating Expenses.

Line O - Interest - Unregulated

Enter on this line, in this column, the Interest expense of the reporting hospital for the month, associated with unregulated services, Section 200.037, Natural Classification of Expense Category .82.

Line P - Depreciation/Amortization - Unregulated

Enter on this line, in this column, Depreciation/Amortization expense of the reporting hospital for the month associated with unregulated services Section 200.037, Natural Classification of Expense Categories .91, .92, .93 and .94.

Line Q - Total Operating Expense - Unregulated

Enter on this line, in this column, the result of adding Line N, column 2, Unregulated Operating Expenses (Excluding Depreciation and Interest), Line O, column 2, Unregulated Interest and Line P, column 2, Unregulated Depreciation/Amortization.

Line R - Excess (Deficit) Operating Revenue over Operating Expenses - Unregulated

Definitions:

Non-Operating Revenue and Expense - Includes donations, investment income, other non-operating gains, plus revenue and expenses resulting from hospital's peripheral or incidental transactions and from other events stemming from the environment that may be largely beyond the hospital management's control.

Enter on this line, in this column, the result of subtracting Line Q, column 2, Total Unregulated Operating Expenses from Line J, column 2, Net Unregulated Operating Revenues. Enter a deficit in brackets, e.g. 22, 610, 9901 - 23,002,801 = (391,900).

Line S - Non-Operating Revenues

Enter on this line, in this column, Non-Operating Revenues, for the month.

Line T - Non-Operating Expenses

Enter on this line, in this column, the Non-operating Expenses, of the reporting hospital for the month.

Line U - Excess (Deficit) Revenues Over Expenses - Unregulated

Enter on this line, in this column, the result of adding Line R, Excess (Deficit) Unregulated Operating Revenues Over Expenses and Line S, Non-Operating Revenues and Net Unregulated Services Revenue and subtracting Line T, Non-operating expenses and unregulated services expenses. Enter a deficit in brackets.

Column 3 - Total

Line A - Inpatient Revenue - Total

Enter on this line, in this column, the result of adding line A, column1, Gross Inpatient Revenues HSCRC Regulated and line A, column 2, Gross Unregulated Inpatient Revenues of the reporting hospital for the month consisting of Daily Hospital Services.

Line B - Outpatient Revenues - Total

Enter on this line, in this column, the result of adding line B, column1, Gross Outpatient Revenues HSCRC Regulated and line B, column 2, the Gross Unregulated Outpatient Revenues of the reporting hospital for the Month consisting.

Line C - Gross Patient Revenues - Total

Enter on this line, in this column, the result of adding line A, column 3, Inpatient Revenues, plus line B, column 3, Outpatient Revenues.

Line D - Inpatient Charity Care - Total

Enter on this line, in this column, the result of adding line D, column1, Inpatient Charity Care HSCRC Regulated and line D, column 2, Unregulated Inpatient Charity Care deduction from revenues of the reporting hospital.

Line D1 - Inpatient Bad Debts - Total

Enter on this line, in this column, the result of adding line D1, column1, Inpatient Bad Debts HSCRC Regulated and line D1, column 2, Unregulated Inpatient Bad Debts deduction from revenues of the reporting hospital

Line E - Outpatient Charity Care - Total

Enter on this line, in this column, the result of adding line E, column 1, Outpatient Charity Care HSCRC Regulated and line E, column 2, Unregulated Outpatient Charity Care deduction from revenues of the reporting hospital.

Line E1 - Outpatient Bad Debts - Total

Enter on this line, in this column, the result of adding line E1, column 1, Outpatient Bad Debts HSCRC Regulated and line E1, column 2, Unregulated Outpatient Bad Debts deduction from revenues of the reporting hospital.

Line F - Inpatient HSCRC Approved Discounts & Differentials - Total

Enter on this line, in this column, the HSCRC Regulated Inpatient HSCRC Approved Discounts & Differentials for the reporting hospital, for the month consisting of Inpatient HSCRC Approved Prompt Payment Discounts and HSCRC Approved Differentials Section 200.056.

Line F1 - Inpatient Denials - Total

Enter on this line, in this column, the result of adding Line F1, column 1 HSCRC Regulated Inpatient Denials and Line F1, column 2 Unregulated Inpatient Denials.

Line F2 - Inpatient Contractual, Administrative, Courtesy, Policy, and Other Discounts and Allowances - Total

Enter on this Line, in this column, the result of adding Line F2, column 1 HSCRC Regulated Inpatient Administrative, Policy, and Other Discounts and Allowances and Line F2, column 2 Unregulated Inpatient Contractual, Administrative, Policy, and Other Discounts and Allowances.

Line F3 - Outpatient HSCRC Approved Discounts & Differentials - Total

Enter on this line, in this column, the HSCRC Regulated Outpatient HSCRC Approved Discounts & Differentials for the reporting hospital, for the month consisting of Outpatient HSCRC Approved Prompt Payment Discounts and HSCRC Approved Differentials Section 200.056.

Line F4 - Outpatient Denials - Total

Enter on this line, in this column, the result of adding Line F4, column 1 HSCRC Regulated Outpatient Denials and Line F4, column 2 Unregulated Outpatient Denials.

Line F5 - Outpatient Contractual, Administrative, Policy, and Other Discounts and Allowances - Total

Enter on this Line, in this column, the result of adding Line F5, column 1 HSCRC Regulated Outpatient, Administrative, Policy, and Other Discounts and Allowances and Line F5, column 2 Unregulated Outpatient Contractual, Administrative, Policy, and Other Discounts and Allowances

Line F6 - Total Discounts, Differentials, Denials, and Adjustments - Total

Enter on this line, in this column, the result of adding Lines F1+F2+F3+F4+F5

Line G - Deductions from Revenues - Total

Enter on this line, in this column, the result of adding Lines D+D1+E+E1+F6.

Line H - Net Patient Revenues - Total

Enter on this line, in this column, the result of subtracting Line G, column 3, Deductions from Revenues, from Line C, column 3, Gross Patient Revenues.

Line I - Other Operating Revenues - Total

Enter on this line, in this column, the result of adding Line I, column 1, and Line I, column 2, Other Operating Revenues of the reporting hospital for the month.

Line J - Net Operating Revenues - Total

Enter on this line, in this column, the result of adding Line H, column 3, Net Patient Revenues, and line I, column 3, Other Operating Revenues.

Line K - Salaries and Wages - Total

Enter on this line, in this column, the result of adding line K, column 1, and Line K, column 2, Salaries and Wages.

Line L - Employee Benefits - Total

Enter on this line, in this column, the result of adding Line L, column 1, and line L, column 2, Employee Benefits.

Line M - Other Operating Expenses - Total

Enter on this line, in this column, the result of adding line M, column 1, and line M, column 2, Other Operating Expenses.

Line N - Operating Expenses (Excl. Depreciation and Interest) - Total

Enter on this line, in this column, the result of adding Line K, column 3, Salaries and Wages, Line L, column 3, Employee Benefits, and Line M, column 3, Other Operating Expenses.

Line O - Interest - Total

Enter on this line, in this column, the result of adding Line O, column 1, and line O column 2, Interest expense of the reporting hospital for the month.

Line P - Depreciation/Amortization - Total

Enter on this line, in this column, the result of adding Line P, column1, and Line P, column 2, Depreciation/Amortization expense of the reporting hospital.

Line Q - Total Operating Expense - Total

Enter on this line, in this column, the result of adding Line N, column 3, Operating Expenses (Excluding Depreciation and Interest), Line O, column 3, Interest and Line P, column 3, Depreciation/Amortization.

Line R - Excess (Deficit) Operating Revenue over Operating Expenses - Total

Enter on this line, in this column, the result of subtracting Line Q, column 3, Total Operating Expenses from Line J, column 3, Net Operating Revenues.

Enter a deficit in brackets, e.g. 22, 610, 9901 – 23,002,801 = (391,900).

Line S - Non-Operating Revenues and Net Unregulated Services Revenue - Total

Enter on this line, in this column, Non-Operating Revenues, Auxiliary Enterprises Revenues and net unregulated services revenue of the reporting hospital for the month, from line S, column 2.

Line T - Non-Operating Expenses and Unregulated Services Expenses - Total

Enter on this line, in this column, the non-operating expenses, auxiliary enterprises expenses, and unregulated services expenses of the reporting hospital for the month from line T, column 2.

Line U - Excess (Deficit) Revenues Over Expenses - Total

Enter on this line, in this column, the result of adding Line R, column 3, Excess (Deficit) Revenues Over Expenses and Line S, column 3, Non-Operating Revenues and Net Unregulated Services Revenue and subtracting Line T, column 3, Non-operating expenses and unregulated services expenses. Enter a deficit in brackets.

Enter on this line, in the Month Column, the Interest expense of the reporting hospital for the month. Section 200.037, Natural Classification of Expense Category .82.

Column 2

Enter on the line, in the Year to Date Column, interest expense of the reporting hospital for the year.

Line P - Depreciation/Amortization

Column 1

Enter on this line, in the Month Column, Depreciation/Amortization expense of the reporting hospital for the month, Section 200.037, Natural Classification of Expense Categories .91, .92., .93 and .94.

Column 2

Enter on this line, in the Year to Date Column, the Depreciation/Amortization expense of the reporting hospital for the year.

Line O - Total Operating Expense

Columns 1 and 2

Enter on this line, in each column, the result of adding Line N,, Operating Expenses (Excluding Depreciation and Interest), Line O, Interest and Line P, Depreciation/Amortization.

Line R - Excess (Deficit) Operating Revenues over Operating Expenses

Columns 1 and 2

Enter on this line, in each column, the result of subtracting Line Q, Total Operating Expenses from Line J, Net Operating Revenues.

Enter a deficit in brackets, e.g. 22,610,901 – 23,002,801 = (391,900).

Line S - Net Non-Operating Revenues and (Expenses)

Column 1

Enter on this line, in the Month Column, the result of subtracting Non-Operating Expenses, of the reporting hospital for the month from Non-Operating Revenues, of the reporting hospital for the month, Section 200.058.

Enter a Deficit in Brackets

Column 2

Enter on this line, in the Year to Date Column, the Net Non-Operating Revenues and (Expenses) of the reporting hospital for the year.

Line T - Excess (Deficit) Revenues Over Expenses

Columns 1 and 2

Enter on this line, in each column, the result of adding Line R, Excess (Deficit) Revenues Over Expenses and Line S Net Non-Operating Revenues and (Expenses). Enter a deficit in brackets.

Line U - Patient Days (Excluding Nursery)

Column 1

Enter on this line, in the Month Column, the number of Patient Days (excluding Nursery) of the reporting hospital for the month. This number should agree with Schedule MS, Column 10, Line P for each month.

Column 2

Enter on this line, in the Year to Date Column, the number of Patient Days (excluding Nursery) of the reporting hospital for the year.

Line V - Admissions (Excluding Nursery)

Column 1

Enter on this line, in the Month Column, the number of admissions (excluding Nursery) of the reporting hospital for the month. This number should agree with Schedule NS, Column 7, Line I for each month.

Column 2

Enter on this line, in the Year to Date Column, the number of admissions (excluding Nursery) of the reporting hospital for the year.

Balance Sheet Data Section - Schedule FSB

Line AA - Cash and Investments

Column 1

Enter on this line the Unrestricted Fund Cash and Investments of the reporting hospital, as of the last day of the reporting period. Section 200.061.

Line BB - Accounts Receivable

Column 1

Enter on this line the Unrestricted Fund Accounts Receivable of the reporting hospital as of the last day of the reporting period, Section 200.061.

Line CC - Allowance for Doubtful Accounts

Column 1

Enter on this line the Unrestricted Fund Allowance for allowance for Doubt of Accounts of the reporting hospital as of the last day of the reporting period. Section 200.061.

Line DD - Net Accounts Receivable

Column 1

Enter on this line the result of subtracting Line CC, Allowance for Doubtful Accounts from Line BB, Accounts Receivable.

Line EE - Inventories

Column 1

Enter on this line the Unrestricted Fund Inventory of the reporting hospital as of the last day of the reporting period, Section 200.061.

Line FF - Prepaid Expenses and Other Current Assets

Column 1

Enter on this line the Unrestricted Fund Prepaid Expenses and Other Current Assets of the reporting hospital as of the last day of the reporting period. Section 200.061.

Line GG - Total Current Assets

Column 1

Enter on this line the result of adding Line AA, Cash and Investments, Line DD, Net Accounts Receivable, Line EE, Inventories, Line FF, Prepaid Expenses and Other Current Assets.

Line HH - Property, Plant and Equipment

Column 1

Enter on this line, the Unrestricted Fund Property, Plant and Equipment of the reporting hospital as of the last day of the reporting period, Section 200.061.

Line II - Accumulated Depreciation and Amortization

Column 1

Enter on this line the Unrestricted Fund Accumulated Depreciation and Amortization of the reporting hospital as of the last day of the reporting period Section 200.061.

Line JJ - Net Property, Plant and Equipment

Column 1

Enter on this line the result of subtracting Line II, accumulated depreciated from Line HH, Property, Plant and Equipment.

Line KK - Other Long Term Assets

Column 1

Enter on this line the Unrestricted Fund Other Long Term Assets of the reporting hospital as of the last day of the reporting period Section 200.061.

Line LL - Total Long Term Assets

Column 1

Enter on this line the result of adding Line JJ, Net Property, Plant and Equipment to Line KK. Other Long Term Assets.

Line MM - Total Assets

Column 1

Enter on this line the result of adding Line GG, Total Current Assets and Line LL, total Long Term Assets.

Line NN - Total Current Liabilities

Column 1

Enter on this line the total Unrestricted Fund Current Liabilities of the reporting hospital as of the last day of the reporting period, Section 200.063.

Line OO - Long Term Debts

Column 1

Enter on this line the Long Term Debts of the reporting hospital as of the last day of the reporting period, Section 200.063.

Line PP - Other Long Term Liabilities

Column 1

Enter on this line, the Other Long Term Liabilities of the reporting hospital as of the last day of the reporting period, Section 200.063.

Line OO - Total Long Term Liabilities

Column 1

Enter on this line, the result of adding Line OO, Long Term Debts and Line PP, Other Long Term Liabilities.

Line RR - Total Liabilities

Column 1

Enter on this line, the result of adding Line NN, Total Current Liabilities, and Line QQ, Total Long Term Liabilities.

Line SS - Fund Balances

Column 1

Enter on this line the Fund Balance of the reporting hospital as of the last day of the reporting period, Section 200.065.

Line TT - Total Liabilities

Column 1

Enter on this line the result of adding Line RR, Total Liabilities and Line SS, Fund Balance.

SCHEDULE CFA - STATEMENT OF CHANGE IN BUILDINGS AND EQUIPMENT FUND BALANCES .33

Overview .331

Schedule CFA is provided to enable each hospital to report additions and deletions to the Capital Facilities Allowance Fund generated through Commission approved rates and other changes to the fund in order that the Commission monitors the fund to ensure that sufficient funds are available for the hospital to replace properly utilized buildings and equipment.

Round all entries on Lines A to V to 1 decimal place (nearest hundred), e.g., 9.3.

Revisions of data for prior periods must be submitted on a Schedule CFA indicating only the revised data by period and printing the word "Revised" above the Base Year Line.

Detailed Instructions .332

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line, the year for which the base year data is reported, e.g., 06–80.

Statement Section

Line A - Fund Balance - Beginning

Column 1

Enter on this line, in the Building Column, the fund balance in the beginning of the base year for the building portion of the Capital Facilities Allowance Fund.

The fund balance includes all restricted and board restricted funds for plant replacement and expansion and all funds from related organizations whose funds are restricted to the hospital's plant replacement and expansion.

Column 2

Enter on this line, in the Equipment Column, the fund balance at the beginning of the Base Year for the equipment portion of the Capital Facilities Allowance Fund.

The fund balance includes all restricted and board restricted funds for replacement or acquisition of equipment and all funds from related organizations whose funds are restricted to the hospital's replacement or acquisition of equipment.

Column 3

Enter on this line, in the Total Column, the total Capital Facilities Allowance Fund Balance at the beginning of the Base Year.

Line B - Facility Allowance in Rates

Column 1

Enter on this line, in the Building Column, the amount of building allowance included in rates for the Base Year transferred from Worksheet E of the Inflation Adjustment System if the reporting hospital's inflation rate increase is granted on the first day of its fiscal year and there was no increase in rates for a Capital Expansion Project granted in the Base Year.

The following example indicates the calculations necessary for a Hospital whose inflation rate increase was on August 1 of its Base Year and a rate increase for a Capital Expansion Project granted in the Base Year.

Worksheet E - Line 4, Column 2, CFA-Buildings
(IAS of August 1, Base Year)
944.4
Worksheet G, CFA-Buildings (IAS of August 1, Base Year)
2327.9

Time Period July 1, Base Year to July 31, Base Year
944.4 × 1/12 =
78.7

Time Period August 1, Base Year to June 30, Base Year	
944.4 × 11/12 =	865.7
2327.9 × 11/12 =	2133.9
Total Building Allowance in Rates for Base Year	3078.3

Column 2

Enter on this line, in the Equipment Column, the amount of equipment allowance included in rates for the Base Year transferred from Worksheet E of the Inflation Adjustment System if the reporting hospital's inflation rate increase is granted on the first day of its fiscal year and there was no increase in rates for increased equipment purchases during the year.

The following example indicates the calculations necessary for a hospital whose inflation rate increase was on August 1 of its Base Year and a rate increase for excess equipment purchases was granted during the Base Year.

Worksheet E, Line 3, Col. 2, CFA-Equipment (IAS of August 1, Base Year:	348.2
Worksheet G, CFA-Equipment (IAS of August 1, Base Year)	83.1
Time Period July 1, Base Year to July 31, Base Year	
348.2 × 1/12 =	29.0
Time Period August 1, Base Year to June 30, Base Year	
(WS-E, Line 3, Col. 2) (1 + WS-E, Line 3, Col. 1) (11/12)	
(348.2) (1.1065) (11/12) =	353.2
(WS-G) (11/12)	
(83.1) (11/12) =	76.2
Total Equipment Allowance in rates for Base Year	429.4

Column 3

Enter on this line, in the Total Column, the result of adding the Facility Allowance in Rates from Column 1 and Column 2.

Line C - Interest Earned

Column 1

Enter on this line, in the Building Column, the interest earned during the Base Year on the Building portion of the Capital Facility Fund.

Column 2

Enter on this line, in the Equipment Column, the interest earned during the Base Year on the equipment portion of the Capital Facility Fund.

Column 3

Enter on this line, in the Total Column, the result of adding the interest earned from Column 1 and Column 2.

Line D - Net Realized Capital Gains

Column 1

Enter on this line, in the Building Column, the net realized capital gains on the sale of investments during the Base Year for the building portion of the Capital Facility Fund.

Column 2

Enter on this line, in the Equipment Column, the net realized capital gains on the sale of investments during the Base Year for the equipment portion of the Capital Facility Fund.

Column 3

Enter on this line, in the Total Column, the result of adding the net realized capital gains from Column 1 and Column 2.

Line E - Donations

Column 1

Enter on this line, in the Building Column, the donations during the Base Year to the Building portion of the Capital Facility Fund.

Column 2

Enter on this line, in the Equipment Column, the donations during the Base Year to the equipment portion of the Capital Facility Fund.

Column 3

Enter on this line, in the Total Column, the result of adding the donations from Column 1 and Column 2.

Line F - Unrealized Capital Gains - Net

Column 1

Enter on this line, in the Building Column, the net unrealized capital gains on investments during the Base Year to the Building portion of the Capital Facility Fund.

Column 2

Enter on this line, in the Equipment Column, the net unrealized capital gains on investments during the Base Year to the Equipment portion of the Capital Facility Fund.

Column 3

Enter on this Line, in the Total Column, the result of adding the net unrealized capital gains from Column 1 and Column 2.

Lines G, H, I - Other

Column 1

Enter on these lines, in the Building Column, other additions during the Base Year to the building portion of the Capital Facility Fund. Enter each type of addition on a separate line and specify the type next to the word "Other".

Column 2

Enter on these lines, in the Equipment Column, other additions during the Base Year to the equipment portion of the Capital Facility Fund. Enter each type of addition on a separate line and specify the type next to the word "Other".

Column 3

Enter on these lines, in the Total Column, the result of adding the other additions from Column 1 and Column 2.

Line J - Total Additions

Column 1

Enter on this line, in the Building Column, the result of adding the additions to the building portion of the Capital Facility Fund from Lines B to I.

Column 2

Enter on this line, in the Equipment Column, the result of adding the additions to the equipment portion of the Capital Facility Fund from Lines B to I.

Column 3

Enter on this line, in the Total Column, the result of adding the additions to the Capital Facility Fund from Lines B to I. Verify that the result of adding total additions from Column 1 and Column 2 equals the total additions in Column 3.

Line K - Debt Service

Column 1

Enter on this line, in the Building Column, the debt service incurred during the Base Year for the building portion of the Capital Facility Fund.

Column 2

Enter on this line, in the Equipment Column, the debt service incurred during the Base Year for the equipment portion of the Capital Facility Fund.

Column 3

Enter on this line, in the Total Column, the result of adding the debt service incurred from Column 1 and Column 2.

Line L - Leases, Rents

Column 1

Enter on this line, in the Building Column, the lease, rent expenses during the Base Year for the building portion of the Capital Facility Fund in accordance with Section 200.0787. Unassigned Expenses, Account 8810.

Column 2

Enter on this line, in the Equipment Column, the lease, rent expenses during the Base Year for the equipment portion of the Capital Facility Fund, in accordance with Section 200.0787, Unassigned Expenses, Account 8810.

Column 3

Enter on this line, in the Total Column, the result of adding the lease, rent expenses from Column 1 and Column 2.

Line M - Purchases, Renovations & Improvements

Column 1

Enter on this line, in the Building Column, the expenditures during the Base Year for the building portion of the Capital Facility Fund which were capitalized in accordance with Section 100.284, Capitalization Policy.

Column 2

Enter on this line, in the Equipment Column, the expenditures during the Base Year for the equipment portion of the Capital Facility Fund which were capitalized in accordance with Section 100.284, Capitalization policy.

Column 3

Enter on this line, in the Total Column, the result of adding the expenditures from Column 1 and 2.

Line N - Net Realized Capital Losses

Column 1

Enter on this line, in the Building Column, the net realized capital losses during the Base Year from the sale of investments for the building portion of the Capital Facility Fund.

Column 2

Enter on this line, in the Equipment Column, the net realized capital losses during the Base Year from the sale of investments for the equipment portion of the Capital Facility Fund.

Column 3

Enter on this line, in the Total Column, the result of adding the losses from Column 1 and Column 2.

Line O - Unrealized Capital Losses - Net

Column 1

Enter on this line, in the Building Column, the net unrealized capital losses on investments during the Base Year to the building portion of the Capital Facility Fund.

Column 2

Enter on this line, in the Equipment Column, the net unrealized capital losses on investments during the Base Year to the equipment portion of the Capital Facility Fund.

Column 3

Enter on this line, in the Total Column, the result of adding the net unrealized capital losses from Column 1 and Column 2.

Lines P, Q, R - Other

Column 1

Enter on these lines, in the Building Column, other deductions during the Base Year to the building portion of the Capital Facility Fund. Enter each type of deduction on a separate line and specify the type next to the word "Other".

Do not include transfers to other funds for uses other than building and equipment purchases, renovations and improvements.

Column 2

Enter on these lines, in the Equipment Column, other deductions during the Base Year to the equipment portion of the Capital Facility Fund. Enter each type of deduction on a separate line and specify the type next to the word "Other".

Do not include transfers to other funds for uses other than building and equipment purchases, renovations and improvements.

Column 3

Enter on these lines, in the Total Column, the result of adding the other additions from Column 1 and Column 2.

Line S - Total Deductions

Column 1

Enter on this line, in the Building Column, the result of adding the deductions from the building portion of the Capital Facility Fund from Lines K to R.

Column 2

Enter on this line, in the Equipment Column, the result of adding the deductions from the equipment portion of the Capital Facility Fund from Lines K to R.

Column 3

Enter on this line, in the Total Column, the result of adding the deductions from the Capital Facility Fund from Lines K to R. Verify that the result of adding the total deductions from Column 1 and Column 2 equals the total deductions in Column 3.

Line T - Fund Balance - Ending

Column 1

Enter on this line, in the Building Column, the result of adding line J, Total Additions - Building, and subtracting Line S, Total Deductions - Building to Line A, Fund Balance - Beginning - Building.

Column 2

Enter on this line, in the Equipment Column, the result of adding Line J, Total Additions - Equipment, and subtracting Line S, Total Deductions - Equipment, to Line A, Fund Balance - Beginning - Equipment.

Column 3

Enter on this line, in the Equipment Column, the result of adding Line J, Total Additions, and subtracting Line S, Total Deductions, to Line A, Fund Balance - Beginning. Verify that the result of adding Fund Balance - Ending from Column 1 and Column 2 equals the Fund Balance - Ending in Column 3.

Line U - Donor Restricted Funds

Column 1

Enter on this line, in the Building Column, all donor restricted funds which are not available for the use by the hospital, for example, the principal of a pure endowment fund (Section 100.224).

Submit explanations and a copy of the will, covenant, or appropriate legal document.

Column 2

Enter on this line, in the Equipment Column, all donor restricted funds which are not available for use by the Hospital, for example, the principal of a pure endowment fund (Section 100.244).

Submit explanations and a copy of the will, covenant, or appropriate legal document.

Column 3

Enter on this line, in the Total Column, the result of adding the donor restricted funds from Column 1 and Column 2.

Line V - Available Balance - Ending

Column 1

Enter on this line, in the Building Column, the result of adding Line T, Fund Balance - Ending, and Line U, Donor Restricted Funds.

Enter a negative result in brackets.

Column 2

Enter on this line, in the Equipment Column, the result of adding Line T, Fund Balance - Ending, and Line U, Donor Restricted Funds.

Enter a negative result in brackets.

Column 3

Enter on this line, in the Total Column, the result of adding Line T, Fund Balance - Ending, and Line U, Donor Restricted Funds.

Enter a negative result in brackets.

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SCHEDULE SB - SUPPLEMENTAL BIRTHS SCHEDULE .46

Overview .461

Schedule SB is provided to enable hospitals with Neo-Natal (NEO) units to report additional information on births and infants admitted to their NEO unit on a monthly and annual basis.

Detailed Instructions .462

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital located in appendix B. The assigned number corresponds to the last four digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Period Line

Enter on this line the data period being reported. To report monthly data, enter the month and year, e.g., 05/1999. To report data for the annual report, enter the fiscal year, e.g., FY1999.

Line A

Enter on this line the number of Neonates not charged an admission charge.

Line B

Enter on this line the number of admissions from the Admissions revenue center submitted on the monthly reports.

Line C

Enter on this line the result of adding Line A and Line B.

Line D

Enter on this line the number of Neonates not charged an admission charge.

Line E

Enter on this line births in your hospital including infants transferred to your hospital's Neo-Natal unit from your hospital's Newborn Nursery.

Line F – Sub-Total

Enter on this line the result of adding line D Line E.

Line G

Enter on this line the number of admissions from the Admissions revenue center submitted on the monthly reports.

Line H

Enter on this line the result of adding Line F and Line G.

PENSION, WAGE AND SALARY DATA SURVEY .60

Pension Survey

Overview .601

The Pension Survey schedule is provided to enable hospitals to develop a consistent pension cost not influenced by changes in market valuations.

Use the financial data from your hospital's most recent actuarial report to complete the pension data survey corresponding to the Wage and Salary Survey for the current year. Complete a separate column for each pension plan at the hospital. Enter data only in those cells that are highlighted in yellow. You may add columns to the worksheet, if necessary, to provide complete information. To preserve comparability of data across hospitals, please do not change the rows in the spreadsheet.

Detailed Instructions: .602

Hospital Name

Enter the complete name of the reporting hospital.

Hospital Number

Enter the reporting hospital's Medicare Provider Number, e.g., 210099.

Base Year

Enter the four digit base year, e.g., 2015.

Plan Columns:

Line 1 - Descriptive Title of Plan

Fill out a separate column for each plan at the hospital. Provide a brief title for each plan.

Line 2 - Type of Plan

Identify type of plan i.e. Defined Contribution, Defined Benefit, or other (if "other" describe).

Expenses Section:

Defined Contribution (DC)

Line 3 - Contribution Expense

Enter the hospital contribution to the Defined Contribution Plan i.e., 401K match.

Line 4 - Other Administrative Expense

Enter the administrative cost expense of the Defined Contribution Plan.

Line 5 - Total DC Expense – Calculated Field

Calculation: the sum of Line 3 and Line 4.

Defined Benefit (DB) Plans

Line 6 - Service Cost

Enter the service cost of the Defined Benefit Plan (per actuarial report).

Line 7 - Interest Cost

Enter the interest cost of the Defined Benefit Plan (per actuarial report).

Line 8 - Asset Return

Enter the expected return on plan assets of the Defined Benefit Plan (per actuarial report).

Line 9 - Amortizations

Enter Amortizations, i.e. prior service cost, net actuarial gain (per actuarial report).

Line 10 - Total FAS 87 Expense – Calculated Field

Calculation: the sum of Lines 6 through Line 9.

Line 11 - Other Administrative Expense

Enter other administrative expenses

Line 12 - Total DB Expense- Calculated Field

Calculation: the sum of Line 10 and Line 11.

Line 13 - Total Pension Expense – Calculated Field

Calculation: the sum of Line 5 and Line 12.

Line 14 - Other Adjustments

Enter adjustments to Total Pension Expense, i.e. adjustments from prior period, changes in actuarial assumptions, etc.

Line 15 - Adjusted Total Pension Expense – Calculated Field

Calculation: the sum of Line 13 and Line 14.

Actuarial Assumptions:

Line 16 - Interest Rate

Enter the actuarial assumptions for interest rate.

Line 17 - Return on Assets

Enter the actuarial assumptions for return on plan assets.

Line 18 - Rate of Compensation Increase

Enter the actuarial assumptions for the rate of compensation increase.

Line 19 - Amortization Period

Enter the amortization period.

Line 20 - Present Value of Benefits Discount Rate

Enter the present value of the benefits discount rate.

Characteristics:

Line 21 - Is This an ERISA Plan?

Enter Yes or No.

Line 22 - Is This a Church Plan?

Enter Yes or No.

Line 23 - Is the Plan Covered by the PBGC?

Enter Yes or No.

Line 24 - Description of Benefit

Describe each Defined Benefit Plan, i.e. the percent the hospital contributes, years until employee is vested.

Total Column – Calculated Field

Remove Executives and Unregulated Employee Costs Column

Enter the amount from each pension plan that is attributable to executives as previously defined.

Adjusted Pension Cost for FB Line J Column- Calculated Field

Calculation: subtract executive and unregulated employee pension costs from sum of Line 5 (Total DC Expense), Line 6 (Service Cost) and Line 11 (Other Administrative Expense).

W&S FBCALC CALCULATION .61

Overview .611

Schedule FB enables each hospital to report total employee benefits incurred in the base year and an adjustment for the fringe benefits that are included in the calculation of the cafeteria, parking, and etc. loss on Schedule OADP. The fringe benefit calculation derived from this schedule is utilized on the W&S Survey.

Round the entries on Lines A to P to the nearest whole dollar, e.g., $50,903.99 is entered as 50,904.

Round the hours in lines Q and S to the nearest hour, e.g., 1,458,377.8 hours is entered as 1,458,378.

Round the entry on Line R to 2 decimal places, e.g., 1,510,900 divided by 1,458,377 = 1.04.

Round the entry on Line T and W to 4 decimal places, e.g., 1,458,378 divided by 1,518,629 = .9603.

Revisions of data must be submitted on a Schedule FB indicating only the revised data and printing the word "Revised" above the Base Year Line.

Detailed Instructions .612

Heading Section

Hospital Name:

Enter on this line, the complete name of the reporting hospital.

Hospital Number Line:

Enter the hospital's Medicare Provider Number, e.g., 210099.

Base Year Line:

Enter the four digit base year, e.g., 2015.

Benefits Incurred Based on Hours Section

Line A - UIC (SUI and FUI)

Enter the UIC expenses, natural expense category .22, incurred in the Base Year and included on the Base Year Expenses Line of Schedules OADP, P2A to P2I, P3A to P3H, C, D, E1 to E9 and F1 to F6 of the most recent Annual Reports of Revenues, Expenses and Volumes.

Line B - Workman's Compensation

Enter the Workman's Compensation expenses, natural expense category .26, incurred in the Base Year and included on the Base Year Expenses Line of Schedules OADP, P2A to P2I, P3A to P3H, C, D, E1 to E9, and F1 to F6 of the most recent Annual Reports of Revenues, Expenses and Volumes.

Line C - Group Health and Life Insurance and Union Health and Welfare

Enter the Group Health and Life Insurance and Union Health and Welfare expenses, natural expense categories .23, .24 and .27, incurred in the Base Year and included on the Base Year Expenses Line of Schedules OADP, P2A to P2I, P3A to P3H, C, D, E1 to E9 and F1 to F6 of the most recent Annual Reports of Revenues, Expenses, and Volumes.

Line D - Other Employee Benefit

Enter the Other Payroll Related Employee Benefits, natural expense category .28 and Employee Benefits (Non-Payroll related), natural expense category .29, incurred in the Base Year and included on the Base Year Expenses Line of Schedules OADP, P2A to P2I, P3A to P3H, C, D, E1 to E9 and F1 to F6 on the most recent Annual Reports of Revenues, Expenses and Volumes (where the value of the benefit is per employee or per hour).

NOTE: Cafeteria, Parking, etc. loss treated as a fringe benefit is not included on this line but is to be included on Line F.

Line E – Subtotal – Calculated Field

Calculation: Addition of Lines A through D

Line F - Cafeteria, Parking, Etc. Loss as a Fringe Benefit

Enter the Cafeteria, Parking, Etc. operating loss as a fringe benefit incurred in the fiscal year transferred from schedules E2, E7 and E8, Line I, from the most recently required Annual Report of Revenues, Expenses and Volumes.

Line G - Employee Benefits Included in Cafeteria, Parking Etc. Loss Treated as a Fringe Benefit

Enter the employee benefits natural expense categories, .21 to .29, incurred in the Base year and included on the Base Year Expenses Line of Schedule E2, E7 and E8 when an amount treated as a fringe is computed on Line I and transferred to Schedule OADP, Line A, of the most recent Annual Report of Revenues, Expenses and Volumes

Line- H - Total Benefits Incurred Based on Hours- Calculated Field

Calculation: Addition of Lines E, F, and G, e.g.989,920 + 101,280 + (23,920) = 1,067,280.

Line I - FICA

Enter the FICA expenses natural expense category .21, incurred in the Base Year and included on the Base Year Expenses Line of Schedules OADP, P2A to P2I, P3A to P3H, C, D, E1 to E9 and F1 to F6 of the most recent Annual Reports of Revenues, Expenses and Volumes.

Line J - Pension and Retirements

Enter the Pension and Retirement expenses, from lines 5. Defined Contribution total cost, line 6 Service Cost, and line 11 Other Administrative Cost from the Pension Survey Schedule. The data source is the most recent Annual Report of Revenues, Expenses and Volumes.

Line K - Other Employee Benefits

Enter the Other Payroll Related Employee Benefits, natural expense category .28 and Employee Benefits (Non-Payroll Related), natural expense category .29 of the reporting hospital incurred in the Base Year and included on the Base Year Expenses Line of Schedules OADP, P2A to P2I, P3A to P3H, C, D, E1 to E9 and F1 to F6 on the most recent Annual Reports of Revenues, Expenses and Volumes where the value of the benefit is a function of the employee's pay.

NOTE: Cafeteria, Parking, etc. loss is excluded on this line but included on Line H.

Line L - Total Benefits incurred Based on Salaries –Calculated Field

Calculation: Addition of Lines I, J and K.

Line M - Holiday Pay

Enter the Holiday Pay expenses incurred in the Base Year and included on the Base Year Expenses Line of Schedules OADP, P2A to P2I, P3A to P3H, C1 to C14, D1 to D81, E1 to E9 (except E2, E7, E8 when used in calculating loss) and F1 to F6 of the most recent Annual Reports of Revenues, Expenses and Volumes.

Line N - Vacation Pay

Enter the Vacation Pay expenses incurred in the Base Year and included on the Base Year Expenses Line of Schedules OADP, P2A to P2I, P3A to P3H, C1, C14, D1 to D81, E1 to E9 (except E2, E7, ES when used in computing loss) and F1 to F6 of the most recent Annual Reports of Revenues, Expenses and Volumes.

Line O - Sick Pay

Enter the Sick Pay expenses incurred in the Base Year and included on the Base Year Expenses Line of Schedules OADP, P2A to P2I, P3A to P3H, C, D, E1 to E9 (except E2, E7, E8 when used in computing loss) and F1 to F6 of the most recent Annual Reports of Revenue Expensed and Volumes.

Line P - Total Fringe Benefits-Calculated Field

Calculation: Addition of Lines H, L, M, N and O.

Fringe Benefits Factors for Benefits Incurred Based on Hours/Salaries Section

Line Q - Worked Hours in Base Year

Enter the worked hours included in the Base Year and included on Schedule OADP, Line B of the most recent Annual Reports of Revenues, Expenses and Volumes.

NOTE: To convert the FTEs on Line B of Schedule OADP to worked hours, multiply by 2080. e.g., 989.7 × 2080 = 2,058,576.

Line R - Fringe Benefits Cost per Worked Hour- Calculated Field

Calculation: the result of dividing the Total Benefits Incurred Based on Hours on Line H by the worked hours of Line Q, e.g., 2,140,919 divided by 2,058,576 = 1.04. Round the result to 2 decimal places.

Line S - Paid Hours in Base Year

Enter the paid hours incurred in the Base Year, except the paid hours of Schedules E2, E7, and E8 when a loss is treated as a Fringe Benefit Line F, of the most recent Annual Reports of Revenues, Expenses and Volumes.

Line T - Ratio Worked Hours to Paid Hours – Calculated Field

Calculation: the result of dividing the worked hours on Line Q by the paid hours on Line S, e.g., 2,058,576 divided by 2,257,211 = .9120. Round the result to 4 decimal places

Line U - Fringe Benefits Cost Per Paid Hour – Calculated Field

Calculation: the result of dividing the Sub-Total on Line H by the paid hours on line S, e.g., $2,140,919 divided by 2,264,434 = .95. Round the result to 2 decimal places.

Line V - Total Salaries

Enter the total salaries incurred in the Base Year and included on the Base Year Expenses Line of Schedules OADP, P2A to P2I, P3A to P3H, C, D,E1 through E8 and F1 through F6 of the most recent Annual Reports of Revenues, Expenses and Volumes This amount should be the balance of the total reported on the schedules listed above less the fringe benefits reported on Schedule FB lines A, B, C, D, I, J, K, M, N and O.

Line W - Fringe Benefits Based on Salaries –Calculated Field

Calculation: the result of dividing line L, Total Benefits Based on Salaries, by line V Total Salaries e.g., 2,058,576 divided by 16,273,328 = 0.1265. Round the result to 4 decimal places.

WAGE AND SALARY SURVEY .62

Overview .621

The Wage and Salary (W&S) Survey is provided to enable each hospital to report certain wage, salary and fringe benefit data for a specific time period of each year for the purpose of comparing a hospital's departmental productivity unit costs to the hospital's "market" and to compare the reasonableness of a hospital's wage, salary and fringe benefit policy to the hospital's region.

A separate Zip code schedule within this survey is provided to report confidential individual employee payroll data along with the employee's zip code for enhanced analyses of the hospital's labor market. Although they are non-employees, a hospital should report Contract RNs and Contract LPNs payroll data.

Detailed Instructions .622

Heading Section

Institution Name Line

Enter the complete name of the reporting hospital.

Institution Number Line

Enter the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the hospital's Medicare Provider Number, e.g., 210099.

Referential Pay Period Line

Enter the referential payroll period, e.g., 01-20-2015 to 02-02-2015.

The referential pay period is the primary pay period which includes February 1. For example, if a hospital has January 28 to February 10 as its payroll period applicable to 70% of its employees, January 28 to February 3 as its payroll period applicable to 25% of its employees and February 1, to February 28 as its payroll period applicable to the remaining 5% of its employees, the referential pay period is January 28 to February 10. Therefore, the referential pay period of the employees paid weekly (January 28 to February 3) will include 2 weekly payroll periods (January 28 to February 3 and February 4 to February 10). Also the referential pay period for the employees paid monthly (February 1 to February 28) will be January 28 to February 10 using the following calculation:

Monthly Salary / 26 × 12 = 2 week period

JOB CLASSIFICATION SECTION

Column 1 - Hours Paid

This is the number of paid hours in the referential pay period. This total shall include paid hours associated with vacations, sick leave, holidays, personal leave and overtime. The total shall not include hours identifiable with retroactive pay, advance pay or severance pay; nor should it include unrestricted on call or call back hours. Hours paid for salaried or exempt employees should be the number of weeks in the primary period multiplied by 40 hours. Round the hours paid in Column 1 to the nearest hour, e.g., 545.6 is entered as 546.

Reference Section 200.371 for a more detailed discussion for computing paid hours.

Job Classification Lines 1 to 69, 75 and 76

Enter the number of hours paid to employees for the referential pay period in accordance with the job classification specifications contained in subsection .603. Frontline supervisors should be included in their job specific category.

Job Classification Line 70 - Other Hospital Specific

Enter the number of hours paid to employees for all hospital specific classifications not entered on Lines 1 to 69 during the referential pay period.

Positions that are included in other hospital specific include:

Department heads and other management personnel of clinical departments, e.g., radiology, occupational therapy, speech therapy, pharmacy, etc. whose primary function is administrative duty.

- Exclude hours for residents, interns, physicians and students. Exclude the President/Chief Executive Officer and Executives that report directly to the President/Chief Executive Officer.

Job Classification Line 71 - Other Non-Hospital Specific

Enter the number of hours paid to employees of all non-hospital specific classifications not entered on Lines 1 to 69 during the referential pay period.

Positions that are non-hospital specific include:

Department heads and other management personnel of non-clinical departments, e.g., plant operations, central supply, housekeeping, etc.

- Exclude hours for residents, interns, physicians and students. Exclude the President/Chief Executive Officer and Executives that report directly to the President/Chief Executive Officer.

-

Job Classification Line 77 – Total – Calculated Field

Calculation: the result of adding the paid hours from Lines 1 to 71.

Column 2 - Base Wages and Salaries Paid

This is the number of base wages/salaries in the referential pay period. Round all entries in Column 2 thru 5 to the nearest dollar, e.g., $2246.82 is reported as 2,247.

Job Classification Lines 1 to 69

Enter the amount of base wages and salaries paid to employees during the referential pay period in accordance with the job classification specifications contained in sub-section .603.

Exclude pay for shift differential, on-call/standby, bonus or other premium pay.

Job Classification Lines 70 and 71

Enter the amount of base wages and salaries paid to employees for all classifications, divided between hospital specific and non-hospital specific, not on Lines 1 thru 69 during the referential pay period.

Exclude pay for shift differential, on-call/standby, bonus or other premium pay.

Job Classification Lines 75 and 76

Enter the amounts paid to the agency for each category of nurses (RN or LPN).

Exclude wages and salaries paid to residents, interns, physicians and students.

Job Classification Line 77 –Calculated Field

Calculation: the result of adding the base wages and salaries paid from Lines 1 to 71.

Column 3 - Other Wages and Salaries Paid

This is the number of other wages and salaries in the referential pay period. Other wages and salaries include: shift differential, overtime premium, on-call/standby pay/call back, bonuses and holiday premium. Exclude advance pay, severance pay and retroactive pay. Exclude wages and salaries paid to residents, interns, physicians and students.

Round all entries in Column 2 thru 5 to the nearest dollar, e.g., $2246.82 is reported as 2,247.

Job Classification Lines 1 to 69

Enter the amount of other wages and salaries paid to employees during the referential pay period in accordance with the job classification specifications contained in sub-section .603.

Example:

Type of Pay	Column 1 Hours Paid	Column 2 Base Wages & Salaries Paid	Column 3 Other Wages & Salaries Paid
Base wages and Advance pay, severance pay, & Retroactive pay	Enter hours No entry	Enter base wages and Salaries No entry	No entry No entry

Type of Pay	Column 1 Hours Paid	Column 2 Base Wages & Salaries Paid	Column 3 Other Wages & Salaries Paid
Overtime	Enter hours (Not hours Times 1 1/2)	Enter wages paid for straight time (1 times base wage)	Enter premium paid (1/2 times base wage)
Shift premium	No entry	No entry	Enter shift premium paid
On-call pay	No entry	No entry	Enter all wages for on-call (restricted and unrestricted)
Other premium pay i.e. Weekend premium pay, Extra shift premium pay hiring/referral bonus certification pay incentive pay performance bonus, etc.	No entry	No entry	Enter all premium pay

Job Classification Line 70 and 71

Enter the amount of other wages and salaries paid to employees of all classifications, divided between hospital specific and non-hospital specific, not entered on Lines 1 to 69 during the referential pay period.

Job Classification Line 77- Calculated Field

Calculation: the result of adding the other wages and salaries paid from Lines 1 to 71.

Column 4 - Fringe Benefits Per Hour Calculation

Job Classification Lines 1 to 71 –Calculated Field

Calculation: the result of multiplying the paid hours in Column 1 by the fringe benefit per paid hour from Schedule FB, Line U, Column 1, e.g., 546 × .8756 = 478. Round each result to the nearest dollar.

Job Classification Line 77 –Calculated Field

Calculation: the result of adding the fringe benefits Per Hour calculations for Lines 1 to 71.

Column 4A - Fringe Benefits Based on Salary Calculation

Job Classification Lines 1 to 71 –Calculated Field

Calculation: the result of multiplying the Base Wages and Salaries paid in Column 2 plus the Other Wages and Salaries paid times the Fringe Benefit based on salaries from Schedule FB Line W, Column 1, e.g. [(1,017 + 102) × 0.1265] = 142. Round each result to the nearest dollar.

Job Classification Line 77 –Calculated Field

Calculation: the result of adding the fringe benefits based on salary calculations Lines 1 to 71.

Column 5 - Total Wages, Salaries and Fringe Benefits Calculation

Job Classification Lines 1 to 71 –Calculated Field

Calculation: the result of adding the wages, salaries and fringe benefits from Columns 2, 3, 4 and 4A.

Job Classification Line 77 –Calculated Field

Calculation: the sum of Lines 1 to 71.

Column 6 Average Wages Salaries and Fringe Benefits per Hour

Job Classification Lines 1 to 71-Calculated Field

Calculation: the result of dividing the total wages, salaries and fringe benefits in Column 5 by the hours paid in Column 1, e.g., 9298 divided by 1849 = 5.03. Round each result to 2 decimal places.

Job Classification Line 77 –Calculated Field

Calculation: the sum of Lines 1 to 71.

Column 7 - Range Minimum

Job Classification Lines 1 to 69

Enter on each applicable job classification line, the minimum base rate per hour that is normally paid to employees in each job classification. Exclude shift differentials and probationary rates.

Column 8 - Range Maximum

Job Classification Lines 1 to 69

Enter on each applicable job classification line, the maximum base rate per hour that is normally paid to employees in each job classification. Exclude shift differentials and red circled rates.

Column 9 - Number of Employees

Job Classification Lines 1 to 69Enter on each applicable job classification line, the number of employees paid for each job classification for the referential pay period.

Job Classification Line 70 and 71

Enter on this line the number of employees paid for all job classifications, divided between hospital specific and non-hospital specific not includable on Lines 1 to 69 for the referential pay period. Exclude residents, interns, physicians and students.

Job Classification Line 77 – Calculated Field

Calculation: the result of adding the number of employees included on Lines 1 to 71.

Schedule Zip code - Wage, Salary and Fringe Benefit Detail .63

Overview .631

Schedule Zip Code is provided to enable each hospital to report wage, salary, and fringe benefit data by employee by Zip Code for enhanced analysis of the hospital's labor market. Although they are non-employees, a hospital should report Contract RNs and Contract LPNs payroll data. This data will be kept confidential.

Detailed Instructions .632

Column1 - Hospital Number Line:

Enter the hospital's Medicare Provider Number, e.g., 210099. Do not enter hyphens, dashes or quotation marks.

Column 2 - Employee ID

Enter the employee ID number (not Social Security number) assigned by the hospital.

Column 3 - Employee Zip Code

Enter the 5-digit zip code of the employee's residence. For contractual nurses, use the zip code of the hospital. Do not use hyphenated 9-digit zip code.

Column 4 - Job Category

Enter job category that corresponds to job classification specifications contained in sub-section .603 of the wage and salary survey (W&S). As a reminder, use job category #75 for contractual R.N.s. and job category #76 for contractual LPNs.

Column 5 - Hours Paid

Enter the number of paid hours not to exceed 80 hours during the referential pay period. This total shall include paid hours associated with vacations, sick leave, holidays, personal leave and overtime. The total shall not include hours identifiable with retroactive pay, FMLA, advance pay or severance pay; nor should it include unrestricted on call or call back hours.

Column 6 - Base Wages & Salaries Paid

Enter the amount of base wages and salaries paid to employees for the referential pay period in accordance with the job classification specifications contained in sub-section .603 of the wage and salary survey. Categorical contractual nurse wages equal total dollar amount paid to the nurse agency. Exclude pay for shift differential, on-call/standby, bonus or other premium pay.

Column 7 - Other Wages & Salaries Paid

Enter the amount of other wages and salaries paid to employees for the referential pay period in accordance with the job classification specifications contained in sub-section .603. Other wages and

salaries include: shift differential, overtime premium, on-call/standby pay, bonuses and holiday premium. Exclude advance pay, severance pay, FMLA and retroactive pay.

Note: If you have hours paid, you should have base wages and vice versa.

Example

Type of Pay	Column 1 Hours Paid	Column 2 Base Wages & Salaries Paid	Column 3 Other Wages & Salaries Paid
Base wages and salaries	Enter hours paid	Enter base wages and salaries	No entry
Advance pay, severance pay, & Retroactive pay	No entry	No entry	No entry
Overtime	Enter hours (Not hours Times 1-1/2	Enter wages paid for straight time (1 time base wage)	Enter premium paid (1/2 times base wage)
Shift premium	No entry	No entry	Enter shift premium paid
On-call pay	No entry	No entry	Enter all wages for on-call (restricted and unrestricted)
Other premium pay i.e. Weekend premium pay, Extra shift premium pay hiring/referral bonus certification pay incentive pay performance bonus, etc.	No entry	No entry	Enter all premium pay

Column 8 - Fringe Benefit per Hour- Calculated Field

Calculation: Fringe benefit per hour from W&S Survey multiplied by hours paid. There is no fringe benefit calculation for contracted nurses.

Column 9 - Fringe Benefit per Salary –Calculated Field

Calculation: Fringe benefit per salary from W&S Survey multiplied by the sum of base and other wages. There is no fringe benefit calculation for contracted nurses.

Column 10 – Total- Calculated Field

Calculation: the sum of Column 6 (base wages & salaries), Column 7 (other wages & salaries), Column 8 (fringe benefit per hour), and column 9 (fringe benefit per salary).

Column 11 – Hourly Wages- Calculated Field

Calculation: Column 10 (Total) divided by Column 5 (hours paid).

JOB CLASSIFICATION SPECIFICATIONS .633

01 INPATIENT/OUTPATIENT, ADMITTING AND REGISTRATION CLERK

Admits, registers, and discharges patients, interviews patient or his representative to obtain information as required, inputs information and distributes to various departments; assigns patient to a room; explains hospital regulations to and answers questions of patient; prepares census; may collect payments, schedule appointments, verify insurance, and enter charges.

02 BILLING CLERK

Audits weekly and final patient bill and calculates amount due from insurers and from patient; types various billing or insurance claim forms; answers questions regarding bill; may receive payment; post amounts to patient records. Includes financial counselors and billers.

03 CASHIER-BUSINESS OFFICE

Receives notes and checks from payers of patient bills; processes cash received by mail; resolves minor problems regarding payment of bills; reconciles cash on hand.

04 GENERAL OFFICE CLERK

Types letters, forms, reports and records from rough drafts and corrected copies, files, checks, posts and performs miscellaneous clerical duties as sorting, filing, answering telephone calls, and maintaining records. Entry level.

05 N/A

06 DIETITIAN

A professionally educated person who has a baccalaureate degree with a major in foods, nutrition or institutional management or qualifying experience in nutrition and management of food preparation and service. Does at least one of the following: (a) organizes, plans, and directs food service program: (b) applies principles of nutrition and management to menu planning and food preparation and services; (c) instructs individuals and groups in application of principles of nutrition; (d) instructs patients and their families on the requirements and importance of their modified diet and how to plan and prepare the food; and (e) consults medical, nursing, and social service staffs concerning problems affecting patients' food habits and needs. Excludes food service' supervisors who are concerned with the day-to-day operations of preparing and serving meals but who do not apply principles of nutrition to meal planning. In those hospitals which employ staff dietitians, chief and assistant chief dietitians are excluded.

07 E.K.G./CARDIOLOGY TECHNICIAN

Conducts diagnostic examinations such as standard electrocardiograph, stress test and holler monitor of patient's heart. Conducts examinations on the wards and in the clinic. If the employee does not fit into this category or the higher-level category description of 42, Special Procedures Technologist, please also consider job category 49, Ultrasound Technologist.

08 EXECUTIVE ASSISTANT

Under a minimum of supervision; performs varied clerical and secretarial duties, often of a confidential nature, for a senior executive, chief of service, or administrator in order to relieve him of designated administrative details and to assist in the organization and administration of office procedures.

09 INFORMATION SYSTEMS, STAFF LEVEL

Includes Help Desk/Tech Support personnel, analysts who provide support for applications, software testers/ quality assurance personnel, and telecommunications personnel.

10 DIETARY AIDE

Routine food-service work. Involves serving food to patrons and employees from a counter or steam table; assembles and delivers food trays to patient areas; washes dishes and trays; cleans kitchen and cooking utensils.

11 GENERAL DUTY NURSE

A registered professional nurse who gives nursing care to patients within an organized nursing unit: Utilizes special skill, knowledge, and judgment in observing and reporting symptoms and conditions of patient. Administers highly specialized therapy with complicated equipment. Gives medication and notes reactions. Assists physicians with treatment. May set up equipment, prepare the patient, etc. May spend part of the time instructing, supervising, or assigning duties to practical nurses and nursing aides. May instruct patients and family. May bathe and feed acutely ill patients. May take and record temperatures, respiration, and pulse. Must be licensed in Maryland.

12 ENVIRONMENTAL SERVICE WORKER

Cleans, mops, and waxes floors. Dusts furniture and equipment. Cleans window sills, empties trash baskets, and arranges furniture and equipment in an orderly fashion. Scours and polishes bathtubs, sinks, mirrors, and similar equipment. Replenishes supplies of soap and towels. Keep utilities storage rooms in good order by cleaning lockers and equipment, arranging supplies, and sweeping and mopping floors. Performs a variety of related duties. May be assigned to specific areas such as patient units, offices, or surgery.

13 INFORMATION SYSTEMS, PROFESSIONAL LEVEL

Includes engineers, programmers, systems analysts, systems designers, database administrators, network administrators, and IT managers.

14 LABORATORY ASSISTANT

Assists medical technologists by performing supportive duties in clinical laboratory, such as cleaning, and sterilizing glassware and other equipment; prepares simple stains, solutions and culture media; may perform simple laboratory tests, collects specimens from patients. May keep records of specimens held in laboratory and may perform minor repairs to laboratory apparatus. High school and on-the-job-training. This is the lowest level laboratory position performing technical tasks. This is not a phlebotomist.

15 LABORATORY TECHNICIAN I

Performs routine tests in medical laboratory for use in diagnosis and treatment of disease, such as urinalysis and blood counts. May prepare tissue samples for study by medical technologist or pathologist; prepare chemical reagent stains and solutions; tends automatic equipment to prepare specimens and performs analytic tests; make preliminary identification of common types of bacterial cultures for confirmation by supervisor; and collect specimens from patients. Maintains laboratory stock of chemicals and glassware.

Requires high school education and on-the-job training or MLT certification.

16 LABORATORY TECHNICIAN II

Under more general supervision than received by Laboratory Technician I, performs both standardized and non-routine tests, usually in specialized function of a clinical laboratory. Usually requires three to four years college with major in chemistry or biology. May have A.S.C.P. categorical certification in cytotechnology, histology, hematology, etc. Not a medical technologist.

17 PHYSICIAN'S ASSISTANT

Under the direct supervision of a physician, performs professional duties and technical procedures to provide health care services, operative procedures, suturing, infections, etc. Makes initial diagnosis and orders appropriate tests and treatment. May assist in surgery. Licensed P.A. by Maryland Board of Medical Examiners.

18 LICENSED PRACTICAL NURSE

Under supervision of a professional nurse, performs selected and delegated nursing tasks in care of patients. Performs three or more of the following duties: Measures and administers simple medications as directed; applies simple dressings; administers enemas, douches, perineal care, and other treatments as directed; reports general observations of patients' conditions; sets up treatment trays; keeps under constant surveillance patients recovering from anesthesia or receiving prolonged intravenous or subcutaneous injections, notifying professional nurse of unusual reactions; takes and records temperature, pulse, and respiration. May also perform duties of a nursing aide. Those regularly supervising other practical or nursing aides. Those regularly supervising other practical or nursing aides and those supervising units to which no professional nurses are assigned are excluded.

19 MAIL CLERK

Receives, sorts and distributes incoming interoffice mail; messages, records, flowers, etc.; runs errands for patients or hospital staff; mails outgoing letters and packages, and forwards patients' mail.

20 MAINTENANCE MECHANIC I

Performs such preventive maintenance and minor repair tasks as replacing windows, repairing doors unstopping toilets, replacing lamps and replacing faulty electrical switches and receptacles. Calls senior mechanic on more serious problems. Assists mechanics on more complex jobs. Entry level position that may include painters and groundskeepers.

21 MAINTENANCE MECHANIC II

Performs alterations, repair maintenance duties and minor construction on hospital buildings. Installs, modifies, repairs and maintains a variety of electrical and mechanical equipment. May include carpenter, plumber and electrician.

22 MEDICAL RECORDS AND CODING CLERK

Duties involve most of the following: Reviews medical records for completeness and accuracy; codes diseases, operations, and other data for retrieval uses; compiles medical care and census data for statistical reports; transcribes medical reports; files or supervises filing of patient records; may assist medical staff in special studies or research; maintains and uses indexes such as patient, disease, operations, physician, etc.; takes medical records to court; maintains flow of medical records and reports to all departments of the hospital or health facility.

23 MEDICAL RECORDS AND CODING TECHNICIAN, ART OR CMRT

Duties involve most of the following: Reviews medical records for completeness and accuracy; codes diseases, operations, and other data for retrieval uses; compiles medical care and census data for statistical reports; transcribes medical reports; files or supervises filing of patient records; may assist medical staff in special studies or research; maintains and uses indexes such as patient, disease, operations, physician, etc.; supervises day-to-day operations within medical record department; takes medical records to court; maintains flow of medical records and reports to all departments of the hospital or health facility.

24 N/A

(Combined with 40, Administrative Assistant)

25 SOCIAL WORKER (M.S.W.)

Provides direct services to patients by helping them solve personal and environmental difficulties that interfere with obtaining maximum benefits from medical care or that predispose toward illness.

Performs a variety of services such as counseling on social problems and arranging for post-hospital care at home or in institutions, for placement of children in foster homes or adults in nursing homes, and for financial assistance during illness, utilizes resources such as family and community agencies to assist patient to resume life in community or to learn to live within disability. Prepares and keeps current social case record. Provides attending physician and others with pertinent information to add to understanding of patient. May supervise work students and beginning caseworkers. Must have Master of Social Work degree.

Excludes social workers assigned primarily to psychiatric wards and clinics; workers engaged primarily in financial screening of patients and rate setting; those workers classified as case aides; and in hospitals where more than one social worker is employed, the head of the social service department and other supervisors of medical social workers unless they spend at least 80 percent of their time in direct service to patients (including related clerical and other duties).

26 SOCIAL WORKER (B.S.)

Under Supervision, carries out plans agreed upon during supervision conferences in the treatment of less complex patient psychosocial problems arising from their illness, hospitalization and discharge. Assists with personal, familial, and social adjustment problems and assists with disposition (discharge) and financial planning. (Excludes RN's acting as case managers; see category 66)

27 MEDICAL TECHNOLOGIST (A.S.C.P.)

Performs various chemical, microscopic, and bacteriologic tests to obtain data for use in diagnosis and treatment of disease. May obtain specimens; may operate auto analyzer. BS degree required and registry as medical technologist with the A.S.C.P.

28 MEDICAL TRANSCRIPTIONIST

Transcribes from dictating machine medical information recorded by physicians, such as: case histories, diagnoses, treatments, X-ray, and laboratory findings. May perform related clerical work.

29 NUCLEAR MEDICINE TECHNOLOGIST (REGISTERED)

Conduce diagnostic studies and/or radiation (either radiomagnetic or gamma ray) therapy on patients. Also works with radioisotopes and radioactive materials. Includes PET Scan technologist.

30 N/A

31 NURSE PRACTITIONER/CLINICAL NURSE SPECIALIST

Works with physician to provide care based on patient's psychobiological needs. Plans, assesses, implements and evaluates total patient needs. Functions independently as a primary care provider for certain patients after proper consultation with the preceptor. Must be Registered Nurse, have completed recognized academic program with nine to twelve month approved practicum.

32 PATIENT CARE/NURSING AIDE I

Assists the clinical staff by performing routine duties in the care of hospital inpatients and out patients. Performs several of the following patient care services: Bathes bed patients or assists them in bathing. Cares for patients' hair and nails. Feeds or assists patients to eat and brings patients between-meal nourishment. Assists patients with bedpans and urinals. Keeps records of patients' food intake and output when ordered. Assists patients in undressing and provides hospitals clothing, storing patients' clothing and valuables. Assists patients in walking and transports patients to various hospital rooms by means of wheelchair or stretcher. May clean rooms or equipment upon discharge of patients. Makes occupied beds. May escort newly admitted patients from admitting office to hospital room or ward. Includes medical assistants; Emergency room, Rehabilitation, Anesthesia and EEG Technicians. Exclude employees who perform the above duties primarily for mental patients.

33 PATIENT CARE/NURSING AIDE II

Assists the clinical staff by performing routine duties in the care of hospital inpatients and out patients. Performs several of the following patient care services: Bathes bed patients or assists them in bathing. Cares for patients' hair and nails. Feeds or assists patients to eat and brings between meals nourishment. Assists patients with bedpans and urinals. Keeps records of patients' food intake when ordered. Assists patients in undressing and provides hospital clothing, storing patients' clothing and valuables. Assists patients in walking and transports patients to various hospital rooms by means of wheelchair or stretcher. May clean rooms or equipment upon discharge of patients. Makes occupied beds. May take and record temperature, pulse, and respiration rate. May escort newly admitted patients from admitting office to hospital room or ward. May be called orderly and may transport and arrange portable X-ray, oxygen, or heavy equipment. Prepares sterile dressings, administers enemas, assists with special treatments and procedures. Includes medical assistants; Emergency room, Rehabilitation, Anesthesia and EEG Technicians. Exclude employees who perform the above duties primarily for mental patients.

34 PHARMACY TECHNICIAN

Performs such restricted tasks as bulk compounding (including I.V's), restocking the pharmacy and nursing stations, placing pharmaceuticals into small containers and typing labels. Does not fill prescriptions.

35 PHYSICAL THERAPIST

Treats disabilities, injuries, and diseases through the use of massage, exercise, and effective properties of air, water, heat, cold radiant energy, and electricity, according to prescription off a physician. May instruct students, interns and nurses in methods and objectives of physical therapy and may supervise physical therapy aides. May consult with other therapists to coordinate therapeutic programs for individual patients. Normally requires training in approved school of physical therapy. Must be licensed in the State which practicing. In hospitals with more than one physical therapist, the chief physical therapist and those who spend more than 20 percent of their time supervising other physical therapists are excluded.

36 RADIOLOGIC TECHNOLOGIST (RRT REGISTERED)

Takes radiographs (X-ray) of various portions' of body to assist physician detection of foreign bodies and diagnosis of diseases and injuries, and/or assists in treating diseased or affected areas under supervision of radiologist. Prepares patient for roentgenographic examination, fluoroscopy or therapy requested by the physician, performing such duties as positioning patients, and administering chemical mixtures to increase opaqueness of organs. Sets up and operates stationary and mobile X-ray equipment. Develops exposed film or supervises its development by darkroom helper. Prepares and maintains records or supervises their preparation by clerical helpers. May maintain equipment in efficient operating condition, including correction of minor faults, and may clean apparatus. May under radiologists direction, instruct nurses, interns, and students in X-ray techniques. R.R.T. Registered. Does not include ultrasonographer, nuclear medicine and special procedures technicians. Includes mammography technologist.

37 MRI TECHNOLOGIST

Operates equipment to produce magnetic resonance images (MRI) of body for diagnostic purposes, as directed by Radiologist.

38 RESPIRATORY THERAPY TECHNICIAN (CERTIFIED)

Sets up and operates various types of oxygen and other therapeutic gas and mist inhalation equipment such as iron lungs, tents, masks catheters, and incubators, to administer prescribed doses of medicinal gases to patients. Confers with patient, explaining treatment and breathing procedures. Operates equipment controls to regulate pressure of inhalants, breathing cycles, and ratio of inhalant to air, according to prescription. Relays to attending nurse the physician's prognosis and instructions for procedures in the event of adverse symptoms. May instruct students, interns, and nurses in methods and procedures of inhalation therapy. May consult with other therapists to coordinate programs for individual patients. Normally requires extensive on-the-job training or completion of formal training program. Requires certification by the American Registry of Respiratory Therapists.

In hospitals with more than one respiratory technician, the chief technician and those who spend more than 20 percent of their time supervising other respiratory technicians are excluded.

39 RESPIRATORY THERAPIST (NBRT REGISTERED)

Administers respiratory therapy care-and life support to patients by prescription of a physician. Sets up and operates devices such as respirators, mechanical ventilators, therapeutic gas administration apparatus, environmental control systems and aerosol generators. Performs pulmonary drainage and assist patient in performing breathing exercises. Monitors patents response to therapy and consults with physician.

40 ADMINISTRATIVE ASSISTANT

Performs secretarial and general clerical work; transcribes dictation, types correspondence, forms, records, reports and medical case histories, clinical reports, and minutes of clinical committees; processes, maintains and files records; answers phones, refers callers, screens visitors, schedules appointments, etc.

This is the primary level of secretary and is usually assigned to one department or cost center. Does not include persons whose duties are better described under clerk/typist, executive secretary (24, Medical secretary added in)

41 SECURITY OFFICER

Guards hospital buildings and property, safeguards patients, staff and visitors, and controls vehicular traffic.

42 SPECIAL PROCEDURES TECHNOLOGIST

Performs, as assistant to a physician and with minimum technical super-vision, advance radiological procedures such as heart catheterizations and selective angiographic studies. Operates all types of related equipment and processors. Constructs catheters. Recognizes minor and dangerous cardiac arrhythmias. R.R.T. registered.

43 STAFF AND CLINICAL PHARMACIST

Graduate of an accredited school of pharmacy and licensed as a registered pharmacist by the Board of Pharmacy of the State in which practicing. Reviews for accuracy and safety the prescriptions and medication orders written by physicians, dentists, and other qualified prescribers; compounds, fills, and dispenses the prescribed drugs and other pharmaceutical supplies to the appropriate inpatients and outpatients; explains directions for use of dispensed drugs and related items to outpatients and/or family members. Is responsible for bulk compounding and packaging of various pharmaceutical products used in hospital. Consults with, and provides information to, other professional staffs in hospital concerning drugs, related pharmaceuticals, and other activities requiring Professional judgment of qualified Pharmacist. Maintains issue records of all prescriptions filled for inpatient and outpatient use, as well as of all controlled drugs as required by Federal and State laws. Clinical pharmacist must have Pharm D., and is able to write prescriptions, and adjust patients' medications.

In small hospitals or those with a small pharmacy staff, where there is no Director of Pharmacy Services, the staff pharmacist may perform some administrative and supervisory duties. Where more than one pharmacist is employed, exclude the Director of Pharmacy Services and those who spend more Than 20 percent of their time supervising other pharmacists.

44 STATIONARY ENGINEER LICENSED

Operates and maintains and may also supervise the operations of stationary engines and equipment mechanical or electrical) to supply the establishment in which employed with power, heat, refrigeration, or air conditioning. Work involves: operating and maintaining equipment such as steam engines, air

compressors, generators, motors, turbines, ventilating and refrigerating equipment, steam boilers and boiler-fed water pumps, making equipment repairs; keeping record of operation of machinery, temperature, and fuel consumption. May also supervise these operations. Head or chief engineers in establishments employing more than one engineer are excluded.

45 MATERIALS HANDLER, OPERATIONS LEVEL

Includes materials handler, and other personnel involved in the actual movement of supplies and equipment.

46 SURGICAL TECHNICIAN

Assists surgical team during operative procedure. Work involves-most of the following: arranging sterile setup for operation; assisting in the preparation of patient for surgery, by washing, shaving, and disinfecting parts of the body; passing instruments, sponges, and sutures to surgeon and surgical assistants; assisting circulation nurse recording number of sponges, needles, instruments, etc. used and accounting for them following operation; adjusting lights and other equipment as directed; assisting in cleanup of operating room following operation; disposing of used materials. May assist anesthesiologist during administration of anesthetic. May prepare operative specimens, place in preservative solution, and deliver to laboratory for analysis. Certification by C.O.R.T. not required.

47 MATERIALS HANDLER, PROFESSIONAL LEVEL

[Includes buyers, production managers and mid-level managers who oversee the movement or processing of supplies and equipment]

48 TELEPHONE OPERATOR

Operates multiple position telephone console to relay incoming, outgoing, and inter office calls; pages hospital staff and physicians; maintains files of patients.

49 ULTRASOUND TECHNOLOGIST

Conducts diagnostic tests utilizing ultrasound equipment. Sets equipment, positions patient and conducts scanning tests. Reviews tests for acceptable quality and refers to physician. May be responsible for equipment maintenance and calibration and ordering and maintaining necessary supplies.

50 UNIT CLERK/SECRETARY

Maintains nursing station, completes patient charts from worksheets; receives and completes admission, transfer and/or discharge forms. Must have unit secretary certification or on the job training.

51 N/A

52 N/A

53 ACCOUNTANT/FINANCIAL ANALYST

Prepares a wide variety of financial and operating reports, journal entries, financial statement and supporting schedules. Coordinates and maintains general ledgers and operating fund accounts, reconciles bank statements, prepares various insurance reports and other reports required by regulating agencies.

54 ACCOUNTING/ACCOUNTS PAYABLE/PAYROLL CLERK

Assists with posting and processing of accounting transactions, monthly financial statement and cost reports. Posts to accounts and general ledger, balance ledgers, and heads new sheets. Vouchers, invoices, and check requests for payments. Includes processing of payroll and accounts payable.

55 COLLECTION CLERK

Contacts and follows-up on individual with unpaid, past due hospital bills. Provides information on charges and explains amount which may be covered by insurance. Makes arrangements for payments received. Recommends transfer of delinquent accounts to attorney or collection agency for further action as necessary.

56 COOK

Plans, prepares, cooks, and carves foodstuffs in quantities according to menu, work orders, and number of persons to be served.

57 C.T. TECHNOLOGIST

This is a position for performing a variety of radiographic procedures under the direction of the supervisor. Skills are utilized for the performance of procedures following clearly defined directions. Decisions are repetitive in nature and minor in scope within prescribed guidelines. Registry as RRT.

58 NURSE EDUCATORS

Lectures and demonstrates improved and existing methods and procedures of nursing service. Participates in planning, organizing, coordinating, and evaluating in-service orientation and training programs. Includes patient and community education as well as in-service programs.

NURSING MANAGEMENT

59 NURSE MANAGER A

Supervises one unit—8 hour responsibility

60 NURSE MANAGER B

Supervises one unit-24 hour responsibility

61 NURSE MANAGER C

Supervises more than one unit—8 hour responsibility

62 NURSE MANAGER D

Supervises more than one unit—24 hour responsibility

63 OCCUPATIONAL THERAPIST

Plans, organizes and conducts occupational therapy program in a variety of sensorimotor, educational, recreational, and social activities designed to help patients regain physical or mental functioning, or adjust to their handicaps. Teaches patient skills and techniques required for participating in activities. Studies and evaluates patients' reactions to the program and prepares reports recording their progress.

64 PHLEBOTOMIST

Using venous and/or peripheral puncture techniques, draws blood from patients for laboratory test and from donors for blood blank. Applies aseptic techniques to blood drawing. May obtain medical history and screen donors subject to physician's approval. Maintains related records.

65 PHYSICAL AND OCCUPATIONAL THERAPIST ASSISTANT

Executes planned patient care programs under the direction and supervision of physical or occupational therapist. Administers physical or occupational therapy treatments. Have completed a two year college program accredited by the American Physical Therapy Association [or American Occupational Therapy Association] Licensed or certified in the state of Maryland.

66 UTILIZATION REVIEW/QUALITY ASSURANCE SPECIALIST/CASE MANAGER

Review patient charts to verify evidence of medical necessity for acute hospital care. Reviews charts to insure patient symptoms and diagnosis comply with PRO standards. Certifies length of stay data co government agencies for billing purposes. May compile statistics and reports relating to above data. Assists in discharge planning, and care coordination.

67 SPEECH LANGUAGE PATHOLOGIST OR AUDIOLOGIST

Specializes in diagnosis and treatment of speech and language problems, or audiology problems. Plans, directs, or conducts treatment programs to restore communicative efficiency of individuals with communication problems of organic and non-organic etiology.

68 HUMAN RESOURCES, ASSOCIATE LEVEL

Includes technical specialists

69 HUMAN RESOURCES, MANAGEMENT LEVEL

Includes managers of different functions within the department.

70 OTHER HOSPITAL SPECIFIC

Positions that are hospital specific include department heads and other managers of clinical departments, e.g., radiology, occupational therapy, speech therapy, pharmacy, whose primary function is administrative. Front line supervisors should be included in their specific job category.

71 OTHER NON-HOSPITAL SPECIFIC

Positions that are non-hospital specific include department heads and other managers of non-clinical departments, whose primary function is administrative. Front line supervisors should be included in their specific job category.

75 CONTRACTUAL RN'S

76 CONTRACTUAL LPN'S

SPECIAL AUDIT .70

Overview .701

An audit of various data submitted in the Annual Reports of Revenues, Expenses and Volumes, COMAR 10.37.01.03K, and the State of Changes in Building and Equipment Fund Balances, COMAR 10.37.01.031, is required to be performed by the independent certified public accounting firm of each hospital. This audit will enable the Commission to ensure that certain data is reported in a uniform and consistent format.

The audit report should be prepared in accordance with SAS 14 utilizing the specific instructions described in sub-section .702 and in the following format:

1. Reference each specific audit step.

2. State the procedures performed to accomplish each audit step.

3. Summarize the findings of each audit step.

Special Audit Procedures .702

I. Annual Reports of Revenues, Expenses and Volumes

A. Expenses

1. Review the reconciliation of the Base Year expenses reported on Schedule OADP, Line A; Schedule UA, Line A; Schedules P2A to P2G, Line A; Schedules P3A to P3G, Line A; Schedule P4A to P4I, Line D; Schedule P5A to P5I, Line D; Schedules D – Line D1 to D83, Line B; Schedules E1 to E8, Line B; and Schedules F1 to F4, Line B; Schedule UR1 to UR9, Line B of the Annual Reports of Revenues, Expenses and Volumes to the Base Year trial balance used in preparing the audited financial statements.

a. Prepare and submit a summary of items reconciling the Annual Reports of Revenues, Expenses and Volumes with the audit trial balance. This reconciliation must be included in your report.

b. List the amount and a description of all reclassifications made in the preparation of the Annual Rate Review System. This list is to be included in your report in journal entry form.

2. During cash disbursements and payroll compliance testing, perform attribute statistical sampling, using a 95% confidence and 5% maximum error rate, to test the departmental classifications of expenses. List results of testing, including the number of test items and number of error occurrences.

3. Other audit of expense, stipulated by the Executive Director of the Commission.

B. Revenues

1. Review the reconciliation of the Base Year Revenues by revenue center reported on Schedules RSA, RSB, RSC to the Base Year trial balance used in preparing the audited financial statements.

a. List the amount and a description of all reclassifications made in reconciling revenue between schedules RSA, RSB, and RSC of the quarterly reports and the year end trial balance. This list is to be included in your report in journal entry form.

2. Obtain and review all rate orders in effect during the Base Year.

a. Prepare and submit a listing of all revenue centers which had a Commission approved rate in the Base Year.

b. Compare the list of Commission approved revenue centers with the audit trial balance and note those revenue centers included in the audit trial balance which do not have a Commission approved rate. Also note those revenue centers that were combined on Schedules RSA, RSB, RSC for the Base Year which could have had separate rates approved by the Commission.

3. Other audit of revenues stipulated by the Executive Director of the Commission.

C. Standard Units of Measure

1. Review the statistical accumulation of service units for three cost centers stipulated by the Executive Director of the Commission.

a. Determine by inquiry of appropriate personnel and reference to departmental source data that the cost center (department) is utilizing properly

the standard units of measure prescribed in Section 200 of the Accounting and Budget Manual for Fiscal and Operating Management.

b. Prepare a summary of Base Year standard units of measure by month for inpatient, outpatient and total and submit a reconciliation to the units reported in the appropriate quarterly Schedules MS and NS for the Base Year and also to the appropriate Schedules V1A, V1B, V1C, V2A, V2B, V3A, V3B, V3C of the Annual Reports of Revenues, Expenses and Volumes for the Base Year.

c. Test two months accumulation of the standard units of measure by tracing to the source data, such as a summarized departmental log. Submit a report on variances discovered.

2. Other audit of standard units of measure stipulated by the Executive Director of the Commission.

II. Wage and Salary Survey

A. Hours

1. Compare the hours paid by job classification in the referential pay period from the hospital's source documents to the hours reported on each job classification line (01 to 50) of Schedules WSA and WSB.

a. Submit a listing of discrepancies found.

2. Verify that the hours included on Schedule WSB, Line 51, do not include hours paid to residents, interns, physicians and students.

a. Submit a listing of discrepancies found.

B. Expenses

1. Compare the base wages and salaries paid by job classification in the referential pay period from the hospital's source documents to the base wages and salaries reported on each job classification line of Schedule WSA and WSB.

a. Prepare and submit a listing of discrepancies.

2. Verify that the base wages and salaries included on Schedule WSB, Lines 51 and 52 do not include base wages paid to residents, interns, physicians and students.

a. Prepare and submit a listing of discrepancies.

3. Compare the other wages and salaries paid by job classification in the referential pay period from the hospital's source documents to the other wages and salaries reported on each job classification of Schedule WSA and WSB.

a. Prepare and submit a listing of discrepancies.

4. Compare the fringe benefits expenses for the Base Year from the hospital's source documents to the benefits expenses reported on Schedule FB, Lines A, B, C, D, E, F, K, L and M.

a. Prepare and submit a listing of discrepancies.

III. Inflation Adjustments

If the hospital has received an inflation adjustment from the HSCRC during the prior fiscal year, perform the following steps. (if applicable):

A. Unusual Cost Items

1. Trace the unusual operating costs reported on Worksheet U, line 4 to the hospital's supporting records.

2. In your report note the amount of each item, the supporting documentation of each item and any errors that you found in tracing the reported items.

B. Invoice Cost

1. Trace the cost of Medical/Surgical supplies. Pharmacy and IV Therapy (if applicable) reported on Worksheet J. Line 7 to the hospital's supporting accounting records.

2. Note in your report the source of the hospital's reported figures and any errors that you found in your work.

SCHEDULES J1, J2, J3, J4 - OVERHEAD EXPENSE APPORTIONMENT,
SCHEDULES JS1 AND JS2 JS3 and JS4 - OVERHEAD STATISTICAL

APPORTIONMENT .76

Overview .761

Schedules J1, J2, JS1, JS2 (Schedules J3, J4, JS3 and JS4 for Private Psychiatric Hospitals) are provided to enable each hospital to allocate the following overhead expense centers to the patient care revenue producing centers:

Center	Schedule
Dietary	C1
Laundry and Linen	C2
Social Services	C3
Purchasing and Stores	C4
Plant Operations	C5
Housekeeping	C6
Central Supply	C7
Pharmacy	C8
General Accounting	C9
Patient Accounting	C10
Hospital Administration	C11
Medical Records	C12
Medical Staff Administration	C13
Nursing Administration	C14
Organ Acquisition Overhead	C15
Malpractice Insurance	UA
Other Insurance	UA
Medical Care Review	UA

Schedules JS1 and JS2 are utilized in recording the statistical units required in allocating the overhead expenses to the patient care revenues producing centers.

The statistical allocation units on Schedule JS1, Line B, must not include units for auxiliary enterprises, other institutional programs or services rendered to outside concerns.

The statistical bases for allocating the overhead expenses are:

Center	Statistical Basis
Dietary	Number of Patient Meals
Laundry and Linen	Number of Dry and Clean Pounds Processed
Social Services	None
Purchasing and Stores	Other Expenses-Schedule D's
Plant Operations	Net Square Feet
Housekeeping	Number of Hours Assigned
Central Supply	None
Pharmacy	None
General Accounting	Direct Costs-Inpatient/Outpatient
Patient Accounting	Direct Costs-Inpatient/Outpatient
Hospital Administration	Direct Costs-Inpatient/Outpatient
Medical Records	Direct Costs-Inpatient/Outpatient
Medical Staff Administration	Equivalent Inpatient Admissions
Nursing Administration	Direct Costs-Inpatient/Outpatient
Malpractice Insurance	Accumulated Costs
Other Insurance	Accumulated Costs
Medical Care Review	Accumulated Costs

Submit Schedules J1, J2, JS1 and JS2 for the base year when the hospital's rates are being realigned.

Submit Schedules J1, J2, JS1 and JS2 for the budget year when the hospital submits a permanent rate application in accordance with COMAR 10.37.10.03, or when the Commission initiates a review of the hospital's rates in accordance with COMAR 10.37.10.04.

An Admissions Services Center is provided to enable each hospital to allocate that portion of Social Services, Medical Records and Medical Staff Administration which would be allocated to the daily hospital service centers.

Detailed Instruction .762

Schedules J1, J2, JS1, JS2

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line, the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Fiscal Year Line

Enter on this line, the year for which the fiscal year data is reported, e.g., 06–80.

Schedule J1

Allocated Centers Section

Line A - Overhead Expenses

Column 1 - Dietary

Enter on this line, in the Dietary Column, the total-fiscal year expenses adjusted from Schedule C, Line C1, Column 7, for the fiscal year.

Column 2 - Laundry and Linen

Enter on this line, in the Laundry and Linen Column, the total fiscal year expenses adjusted from Schedule C - Line C2, Column 7, for the fiscal year.

Column 3 - Purchasing & Stores

Enter on this line, in the Purchasing and Stores Column, the total fiscal year expenses adjusted from Schedule C - Line C4, Column 7, for the fiscal year.

Column 4 - Housekeeping

Enter on this line, in the Housekeeping Column, the total fiscal year expenses adjusted from Schedule C-Line C6, Column 7, for the fiscal year.

Column 5 - Central Supply; Pharmacy & Social Services

Enter on this line, in the Central Supply, Pharmacy and Social Services Column, the total fiscal year expenses adjusted from Schedules C- Line C3, C7 and C8, Column 7, for the fiscal year.

Column 6 - Plant Operation

Enter on this line, in the Plant Operations Column, the total fiscal year expenses adjusted from Schedule C-Line C5, Column 7, for the fiscal year.

Column 7 – Total Patient Care Overhead

Enter on this line, in the Total Patient Care Overhead Column, the result of adding the overhead expenses from Columns 1 to 6.

Column 8 - Inpatient/Patient Accounting, General Accounting, Hospital Administration, Nursing Administration

Enter on this line, in the Total Patient Care Overhead Column, the result to adding the overhead expenses from Columns 1 to 6.

Enter on this line, in the Patient Accounting, General Accounting, Patient Accounting, Hospital Administration and Nursing Administration Column the total fiscal year expenses adjusted from Schedule C - Line C10, Column 7; Schedule C- Line C13, Column 7; Schedule C- Line C9, Column 7; Schedule C- Line C11, Column 7; Schedule C- Line C14, Column 7; for the fiscal year times total Admissions; Schedule V1D, Line A, Column 4; plus births; total reported for fiscal year on Schedule MS, Lines Q and R, Column 11; plus 1/8 total inpatient ambulatory visits divided by total Admissions plus births plus 1/8 total inpatient/outpatient visits, excluding Referred Ambulatory visits, Schedule V2A, Line A, Columns 1, 2 and 4 and Schedule V2B, Line A, Column 3, plus 1/2 total Same Day Surgery units V2B, Line A, Column 1.

Column 8A - Ambulatory/Patient Accounting, General Accounting, Hospital Administration, Nursing Administration

Enter on this line in the Patient Accounting, General Accounting, Hospital Administration and Nursing Administration Column the result of multiplying the cost per unit of Inpatient/Patient Accounting, General Accounting, Hospital Administration, Nursing Administration Schedule JS1 Line C, Column 7 by the amount of Direct Costs for Ambulatory Services on Schedule JS1 Line B, Column 7A.

Column 9 - Outpatient/Patient Accounting, General Accounting, Hospital Administration, Nursing Administration

Enter on this line, in the Patient Accounting, General Accounting, Patient Accounting, Hospital Administration and Nursing Administration Column the total fiscal year expenses adjusted from Schedule C - Line C10, Column 7; Schedule C- Line C12, Column 7; Schedule C- Line C9, Column 7; Schedule C- Line C11, Column 7; Schedule C - Line C14, Column 7; for the fiscal year times 1/8 total outpatient visits, plus 1/2 total Same Day Surgery Visits divided by total Admissions, plus births plus 1/8 total inpatient/outpatient visits, plus 1/2 Same Day Surgery visits minus the amount calculated in Column 8A.

Column 10 – Medical Records and Medical Staff Administration

Enter on this line, in the Medical Staff Administration Column, the total fiscal year expenses adjusted from Schedule C 12 and C13, Line G, Column 7, for the fiscal year.

Column 11 - Unassigned Expenses

Enter on this line in the Unassigned Expenses Column, the total fiscal year expenses adjusted from Schedule UA, Line C, Column 4 for the fiscal year.

Column 12 - Total Other Overhead

Enter on this line, in the Total Overhead Column, the result of adding the overhead expenses from Columns 8 to 11.

Column 13 - Total Allocated Overhead

Enter on this line, in the Total Allocated Column, the result of adding the total patient care overhead from Column 7 and the total other overhead from Column 12.

Schedule JS1

Unit Cost Calculations Section

Line A - Overhead Expenses

Column 1 - Dietary

Enter on this line, in the Dietary Column, the dietary expenses transferred from Schedule J1, Line A, Column 1.

Column 2 - Laundry and Linen

Enter on this line, in the Laundry and Linen Column, the laundry and linen expenses transferred from Schedule J1, Line A, Column 2.

Column 3 - Purchasing and Stores

Enter on this line, in the Purchasing and Stores Column, the purchasing and stores expenses transferred from Schedule J1, Line A, Column 3.

Column 4 - Housekeeping

Enter on this line, in the Housekeeping Column, the housekeeping expenses transferred from Schedule J1, Line A, Column 4.

Column 5 - Central Supply, Pharmacy and Social Services

Enter on this line, in the Central Supply Pharmacy and Social Services Column, the central supply, pharmacy and social services expenses transferred from Schedule J1, Line A, Column 5.

Column 6 - Plant Operations

Enter on this line, in the Plant Operations Column, the plant operation expenses transferred from Schedule J1, Line A, Column 6.

Column 7 - Inpatient/Patient Accounting, General Accounting, Hospital Administration, Nursing Administration

Enter on this line, in the Inpatient Patient Accounting, General Accounting, Hospital Administration and Nursing Administration, the expenses transferred from Schedule J1, Line A, Column 8.

Column 7A - Ambulatory/Patient Accounting, General Accounting, Hospital Administration, Nursing Administration

Enter on this line, in the Ambulatory Patient Accounting, General Accounting, Hospital Administration and Nursing Administration, the expenses transferred from Schedule J1, Line A, Column 8A.

Column 8 - Outpatient/Patient Accounting, General Accounting, Hospital Administration, Nursing Administration

Enter on this line, in the Outpatient Patient Accounting, General Accounting, Hospital Administration and Nursing Administration, the expenses transferred from Schedule J1, Line A, Column 9.

Column 9 – Medical Records and Medical Staff Administration

Enter on this line, in the Medical Records and Medical Staff Administration Column, the medical records and medical staff administration expenses transferred from Schedule J1, Line A, Column 10.

Column 10 - Unassigned Expenses

Enter on this line, in this column, the "Unassigned" expenses transferred from Schedule J1, Line A, Column 11.

Line B - Units

Column 1 - Dietary

Enter on this line, in the Dietary Column, the number of patient meals from Schedule C- Line C, Column 1, for the fiscal year.

Column 2 - Laundry and Linen

Enter on this line, in the Laundry and Linen Column, the number of pounds of laundry from Schedule C- Line C2, Column 1, for the fiscal year.

Column 3 - Purchasing and Stores

Enter on this line, in the Purchasing and Stores Column, the result of adding the total fiscal year Other Expenses from Schedule D, excluding Lines D26 and D27, Column 4; for the fiscal year.

Column 4 - Housekeeping

Enter on this line, in the Housekeeping Column, the number of hours assigned by housekeeping for patient care centers for the fiscal year.

Column 6 - Plant Operations

Enter on this line, in the Plant Operations Column, from the hospital's records the total net square feet of the cost centers listed on lines D1 to D54.

Column 7 - Inpatient/Patient Accounting, General Accounting, Hospital Administration, Nursing Administration

Enter on this line, in this column, the result of adding the total fiscal year inpatient Direct Costs on Schedules D- Line D1 to D25, Central Supply Overhead department Schedule C7 (Do Not Use Schedule D, Line D26) and Pharmacy Overhead department C- Line C8 (Do Not Use Schedule D, Line D27), Lines D28 to D45, Organ Acquisition Overhead depart Schedule C, Line 15 (Do Not Use Schedule D, Line D46), Lines D47 to D81.

Column 7A - Ambulatory/Patient Accounting, General Accounting, Hospital Administration, Nursing Administration

Enter on this line, in this column, the result of adding the total fiscal year outpatient Direct Costs as reported on Schedules D, Line D18 to D22, and D50.

Column 8 - Outpatient/Patient Accounting, General Accounting, Hospital Administration, Nursing Administration

Enter on this line, in this column, the result of adding the total fiscal year outpatient Direct Costs, as reported to the Commission on Schedules D- Lines D23 to D49, D51 to D56.

Column 9 – Medical Records and Medical Staff Administration

Enter on this line, in the Medical Records and Medical Staff Administration Column, the number of equivalent inpatient admissions from Schedule V5, Line U, Column 1, for the fiscal year.

Column 10 - Unassigned Expenses

Enter on this line, in this column, the result of adding the total fiscal year expenses from all D Schedule, D Lines excluding Lines D26, and D27. Line F, Column 4, and from Schedule J1, Line A, Columns 7 to 10, with the exception on line D57 (Admissions) for the base.

Line C - Cost Per Unit

Columns 1 to 10

Enter on this line, in each applicable column, the result of dividing the overhead expenses on Line A by the Units on Line B. Round each result to 6 decimal places, e.g., 1101 – 55238 = .019932.

Schedules JS1, JS2

Statistical Apportionment Section

Column 1 - Dietary

Lines D1 to D59

Enter on these lines, in the Dietary Column, the number of patient meals served for each patient care center for the base year.

Line E

Enter on this line, in the Dietary Column, the result of adding the number of patient meals served from Lines D1 to D59.

Verify that the total units on Line E, Column 1 agree with the total units on Line B, Column 1.

Schedules J1, J2

Revenue Centers Section

Column 1 - Dietary

Lines B1 to B59

Enter on each applicable line, in the Dietary Column, the result of multiplying the cost per unit from Schedule JS1, Line C, Column 1, by the statistical apportionment from Schedule JS1, JS2, Lines D1 to D59, Column 1, e.g., (.001993)(332,233) = 662.1.

Round each result to 1 decimal place.

Line C - Total Allocated Expenses

Enter on this line, in the Dietary Column, the result of adding the allocated expenses from Lines B1 to B59.

Verify that the total allocated expenses equals the overhead expenses on Schedule J1, Line A, Column 1.

Schedules JS1, JS2

Statistical Apportionment Section

Column 2 - Laundry and Linen

Lines D1 to D59

Enter on these lines, in the Laundry and Linen Column, the number of pounds of laundry processed for each applicable patient care center for the base year.

Line E

Enter on this line, in the Laundry and Linen Column, the result of adding the number of pounds of laundry processed from Lines D1 to D59.

Verify that the total units on Line E, Column 2 agree with the units on Line B, Column 2.

Schedules J1, J2

Revenue Centers Section

Column 2 - Laundry and Linen

Lines B1 to B59

Enter on each applicable line, in the Laundry and Linen Column, the result of multiplying the cost per unit from Schedule JS1, Line C, Column 2, by the statistical apportionment from Schedules JS1, JS2, Lines D1 to D59 Column 2, e.g., (.000117)(328,128) = 38.4.

Round each result to 1 decimal place.

Line C - Total Allocated Expenses

Enter on this line, in the Laundry and Linen Column, the result of adding the allocated expenses from Lines B1 to B52.

Verify that the total allocated expenses equals the overhead expenses on Schedule J1, Line A, Column 2.

Schedules JS1, JS2

Statistical Apportionment Section

Column 3 - Purchasing and Stores

Lines D1 to D59

Enter on these lines, in the Purchasing and Stores Column, the Other Expense Costs from Schedule D for each applicable center for the base year.

Line E

Enter on this line, in the Purchasing and Stores Column, the result of adding the Other Expenses Costs from Lines D1 to D59.

Verify that the total units Line E, Column 3 agree with the units on Line B, Column 3.

Schedules J1, J2

Revenue Centers Section

Column 3 - Purchasing and Stores

Lines B1 to B59

Enter on each applicable line, in the Purchasing and Stores Column, the result of multiplying the cost per unit from Schedule JS1, Line C, Column 3, by the statistical apportionment from Schedules JS1, JS2, Lines D1 to D59, Column 3, e.g., (.001089)(29,123) = 31.7.

Round each result to 1 decimal place.

Line C - Total Allocated Expenses

Enter on this line, in the Purchasing and Stores Column, the result of adding the allocated expenses from Lines B1 to B59.

Verify that the total allocated expenses equals the overhead expenses on Schedule J1, Line A, Column 3.

Schedules JS1, JS2

Statistical Apportionment Section

Column 4 - Housekeeping

Lines D1 to D56, D58 and D59

Enter on these lines, in the Housekeeping Column, the hours of housekeeping assigned for each applicable patient care center for the base year.

Line E - Total Statistics

Enter on this line, in the Housekeeping Column, the result of adding the hours from Lines D1 to D56, D58 and D59.

Verify that the total units Line E, Column 4 agree with units on Line B, Column 4.

Schedules J1, J2

Revenue Centers Section

Column 4 - Housekeeping

Lines B1 to B56, B58 and B59

Enter on these lines, in the Housekeeping Column, the result of multiplying the cost per unit from Schedule JS1, Line C, Column 4, by the statistical apportionment from Schedules JS1, JS2, Lines D1 to D54, Column 4, e.g., (.007810)(2,511) = 19.6.

Round each result to 1 decimal place.

Line C - Total Allocated Expenses

Enter on this line, in the Housekeeping Column, the result of adding the allocated expenses from Lines B1 to B56, B58 and B59.

Verify that the total allocated expenses equals the overhead expenses on Schedule J1, Line A, Column 4.

Schedules JS1, JS2

Revenue Centers Section

Column 5 - Central Supply, Pharmacy and Social Services

Line D57 - Admissions Services

Enter on this line, in the Central Supply, Pharmacy and Social Services Column, the overhead expenses transferred from Schedule JS1, Line A, Column 5, applicable to Social Services. These expenses should agree with total expenses or Social Services Line C3.

Line D58 - Medical Supplies

Enter on this line, in the Central Supply, Pharmacy and Social Service Column, the overhead expenses transferred from Schedule JS1, Line A, Column 5, applicable to Central Supply, Schedule C-Line C7.

Line D59 - Drugs

Enter on this line, in the Central Supply, Pharmacy and Social Services Column, the overhead expenses transferred from JS1, Line A, Column 5 applicable to Pharmacy. These expenses should agree with the total expenses on Pharmacy Schedule C- Line C8.

Schedule J1, J2

Revenue Centers Section

Column 5 - Central Supply, Pharmacy and Social Services

Line B57 - Admissions Service

Enter on this line, in the Central Supply, Pharmacy and Social Services Column, the overhead expenses transferred from Schedule J1, Line A, Column 5, applicable to Social Services. These expenses should agree with total expenses on Social Services Schedule C- Line C3.

Line B58 - Medical Supplies

Enter on this line, in the Central Supply, Pharmacy and Social Services, the overhead expenses transferred from Schedule J1, Line A, Column 5, applicable to Central Supply. These expenses should agree with total expense on Central Supply Schedule C- Line C7.

Line B59 - Drugs

Enter on this line, in the Central Supply, Pharmacy and Social Services Column, the overhead expenses transferred from J1, Line A, Column 5 applicable to Pharmacy. These expenses should agree with the total expenses on Pharmacy Schedule C- Line C8.

Line C - Total Allocated Expenses

Enter on this line, in the Central Supply, Pharmacy and Social Services Column, the result of adding the allocated expenses from Line B57, B58 and B59, Column 5.

Verify that the total allocated expenses equal the overhead expenses on Schedule J1, Line A Column 5.

Schedules JS1, JS2

Statistical Apportionment Section

Column 6 - Plant Operations

Lines D1 to D59

Enter on these lines, in the Plant Operations Column, the net square feet for each applicable center for the base year.

Line E - Total Statistics

Enter on this line, in the Plant Operations Column, the result of adding the net square feet from Lines D1 to D59.

Verify that the total units on Line E, Column 6 agree with units on Line B, Column 6.

Schedule J1, J2

Revenue Centers Section

Column 6 - Plant Operations

Lines B1 to B59

Enter on these lines, in the Plant Operations Column, the result of multiplying the cost per unit from Schedule JS1, Line C, Column 6, by the statistical apportionment from Schedules JS1, JS2, Lines D1 to D54, Column 6, e.g., (.007810)(2,511) = 19.6.

Round each result to 1 decimal place.

Line C - Total Allocated Expenses

Enter on this line, in the Plant Operations Column, the result of adding the allocated expenses from Lines B1 to B59.

Verify that the total allocated expenses equals the overhead expenses on Schedule J1, Line A, Column 6.

Schedules J1, J2

Revenue Centers Section

Column 7 - Total Patient Care Overhead

Lines B1 to B59

Enter on these lines, in the Total Patient Care Overhead Column, the result of adding the allocated expenses from Columns 1 to 6 for each applicable revenue center.

Line C - Total Allocated Expenses

Enter on this line, in the Total Patient Care Overhead Column, the result of adding the allocated expenses from Lines B1 to B59 Column 7.

Verify that the total patient care overhead expenses equals the result of adding the allocated expenses from Line C, Columns 1 to 6.

Schedules JS1, JS2

Statistical Apportionment Section

Column 7 - Inpatient/Patient Accounting, General Accounting, Hospital Administration and Nursing Administration

Lines D1 to D59

Enter on these lines, in this Column, the inpatient direct costs for each applicable center for the base year.

Line E - Total Statistics

Enter on this line, in this Column, the result of adding the inpatient direct costs from Lines D1 to D59.

Verify that the total units Line E, Column 7 agree with units on Line B, Column 7.

Schedules J1, J2

Revenue Center Section

Column 8 - Inpatient/Patient Accounting, General Accounting, Hospital Administration, Nursing Administration

Lines B1 to B59

Enter on these lines, in this Column, the result of multiplying the cost per unit from Schedule JS1, Line C, Column 7, by the statistical apportionment from Schedules JS1, JS2, Lines D1 to D59, Column 7, e.g., (.007810)(2,511) = 19.6.

Round each result to 1 decimal place.

Line C - Total Allocated Expenses

Enter on this line, in this Column, the result of adding the allocated expenses from Lines B1 to B59.

Verify that the total allocated expenses equals the overhead expenses on Schedule J1, Line A, Column 8.

Schedules JS1, JS2

Statistical Apportionment Section

Column 7A - Ambulatory/Patient Accounting, General Accounting, Hospital Administration and Nursing Administration

Lines D1 to D59

Enter on these lines, in this Column, the outpatient direct costs for each applicable center for the base year.

Line E - Total Statistics

Enter on this line, in this Column, the result of adding the outpatient direct costs from Lines D1 to D59.

Verify that the total units Line E, Column 7A agree with units on Line B, Column 7A.

Schedules J1, J2

Revenue Center Section

Column 8A - Ambulatory/Patient Accounting, General Accounting, Hospital Administration, Nursing Administration

Lines B1 to B59

Enter on these lines, in this Column, the result of multiplying the cost per unit from Schedule JS1, Line C, Column 7A, by the statistical apportionment from Schedules JS1, JS2, Lines D1 to D54, Column 7A, e.g., (.007810)(2,511) = 19.6.

Round each result to 1 decimal place.

Schedules JS1, JS2

Statistical Apportionment Section

Column 8 - Outpatient/Patient Accounting, General Accounting, Hospital Administration, Nursing Administration

Lines D1 to D59

Enter on these lines, in this Column, the outpatient direct costs for each applicable center for the base year.

Line E - Total Statistics

Enter on this line, in this Column, the result of adding the outpatient direct costs from Lines D1 to D59.

Verify that the total units Line E, Column 8 agree with units on Line B, Column 8.

Schedules J1, J2

Revenue Centers Section

Column 9 - Outpatient/Patient Accounting, General Accounting, Hospital Administration, Nursing Administration

Lines B1 to B59

Enter on these lines, in this Column, the result of multiplying the cost per unit from Schedule JS1, Line C, Column 8, by the statistical apportionment from Schedules JS1, JS2, Lines D1 to D59, Column 8, e.g., (.007810)(2,511) = 19.6.

Round each result to 1 decimal place.

Line C - Total Allocated Expenses

Enter on this line, in this Column, the result of adding the allocated expenses from Lines B1 to B59.

Verify that the total allocated expenses equals the overhead expenses on Schedule J1, Line A, Column 9.

Schedules JS1, JS2

Statistical Apportionment Section

Column 9 – Medical Records and Medical Staff Administration

Lines D18, D19, D20, D21, D23, and D24

Enter on these lines, in the Medical Records and Medical Staff Administration Column, the equivalent inpatient admissions (EIPA) for each applicable ambulatory service center for the base year.

Line D57

Enter on this line, in the Medical Records and Medical Staff Administration Column, the total inpatient admissions (excl. Nursery) for all daily hospital expense centers, for the base year.

Line E - Total Statistics

Enter on this line, in the Medical Staff Administration Column, the result of adding the units from Lines D18, D19, D20, D21, D23, D24, and D52.

Verify that the total units Line E, Column 9 agree with the units on Line B, Column 9.

Schedule J1, J2

Revenue Centers Section

Column 10 – Medical Records and Medical Staff Administration

Enter on these lines, in the Medical Records and Medical Staff Administration Column, the result of multiplying the cost per unit from Schedule JS1, Line C, Column 9, by the statistical apportionment from Schedules JS1, JS2, Lines D1 to D54 Column 9, e.g., (.004016)(1,928) = 7.7.

Round each result to 1 decimal place.

Line C - Total Allocated Expenses

Enter on this line, in the Medical Staff Administration Column, the result of adding the allocated expenses from Lines B1 to B54.

Verify that the total allocated expenses equals the overhead expenses on Schedules J1, Line A, Column 10.

Schedules JS1, JS2

Statistical Apportionment Section

Column 10 - Unassigned Expenses

Lines D1 to D51

Enter on these lines in this column, the result of adding the overhead expense allocation from Schedules J1, J2, Lines B1 to B57, Columns 7 to 10, to the base year expenses adjusted.

Line D57

Leave this line Blank.

Lines D58 and D59

Enter on these lines, in this column, the result of adding the overhead expense allocation from Schedules J1, J2, Lines B58 to B59 Column 7 to 10 for each applicable revenue center

Line E - Total Statistics

Enter on this line, in this column, the result of adding the units from Lines D1 to D59.

Verify that the units agree with the units on Line B, Column 10.

Schedules J1, J2

Revenue Centers Section

Column 11 - Unassigned Expenses

Lines B1 to B54

Enter on these lines, in this column, the result of multiplying the cost per unit from Schedule JS1, Line C, Column 10, by the statistical apportionment from Schedules JS1, JS2, Lines D1 to D59, Column 10, e.g., (.065978)(110.1) = 7.3.

Round each result to 1 decimal place.

Line C - Total Allocated Expenses

Enter on this line, in this column, the result of adding the allocated expenses from Lines B1 to B59.

Verify that the total allocated expenses equals the overhead expenses on Schedule J1, Line A, Column 11.

Column 12 - Total Other Overhead

Lines B1 to B59

Enter on this line, in the Total Other Overhead Column, the result of adding the allocated expenses from Columns 8 to 11 for each applicable revenue center.

Line C - Total Allocated Expenses

Enter on this line, in the Total Other Overhead Column, the result of adding the allocated expenses from Lines B1 to B59, Column 12.

Verify that the total other overhead expenses equals the result of adding the allocated expenses from Line C, Columns 8 to 11.

Column 13 - Total Allocated Overhead

Lines B1 to B59

Enter on these lines, in the Total Allocated Overhead Column, the result of adding the allocated expenses from Columns 7 and 12 for each applicable revenue center.

Line C - Total Allocated

Enter on this line, in the Total Allocated Overhead Column, the result of adding the allocated expenses from Lines B1 to B54, Column 13.

Verify that the total allocated expenses equals the result of adding the allocated expenses from Line C, Columns 7 and 12.

Verify that the total allocated expenses on Line C, Column 13 equals the total allocated expenses on Line A, Column 13.

SCHEDULE H1 - BUILDING FACILITY ALLOWANCE .77

Overview .771

Schedule H1 is provided to enable each hospital to report certain data regarding the buildings of the hospital, including debt service requirements. Schedule H1 also enables each hospital to project the cash requirements for the budget year including principal, interest, rents/leases and renovation/replacements. Schedule H1 also enables hospitals to report their average age of plant.

The Column entitled Source indicates computations to be made or the source of the data requested.

Submit Schedule H1 for the base year when the hospital's rates are being realigned.

Round the entries on Lines A, e.g., 40.

Round the entries on Line B to G to 1 decimal place in thousands, e.g., 10.1.

Enter at the top of each column, the name or other identification of each building separated into patient care related and non-patient care related and by facility age. For example, a parking garage would be reported separately; or a hospital that uses a portion of its main building for a convent or gift shop, etc. would report the building as patient care related. Indicate primary use i.e. medical office building, power plant, laundry, etc.

If a hospital needs more columns to enter the building identification, use additional H1 schedules.

Detailed Instructions .772

Heading Section

Institution Name Line

Enter on this line, the complete name of the reporting hospital.

Institution Number Line

Enter on this line, the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line, the year for which the base year data is reported, e.g., 06–80.

Budget Year Line

Enter on this line, the year for which the budgeted data is reported, e.g., 06–81.

Building Life Data Section

Line A - Facility Age

Columns 1 to 9

Enter on this line, in each Building Nomenclature Column, the age of each building.

Round the age of each building to the nearest full year, e.g., 40.

Cash Requirements Section

Line B - Principal Payments

Columns 1 to 9

Enter on this line, in each Building Nomenclature Column, the principal payments for building related debt for the base year or projected principal payment for the budget year. If debt has been incurred in financing a project, which involved the acquisition of both buildings and moveable equipment, prorate the debt service between buildings and equipment.

Column 10

Enter on this line, in the Total Column, the result of adding the principal payments from Column 1 to Column 9.

Line C - Interest Payments

Columns 1 to 9

Enter on this line, in each Building Nomenclature Column, the interest payments for building related debt for the base year.

Column 10

Enter on this line, in the Total Column, the result of adding the interest payments from Column 1 to Column 9.

Line D - Rent and Lease Payments

Columns 1 to 9

Enter on this line, in each Building Nomenclature Column, the rents/leases payments for buildings for the base year or projected rents/leases payments for the budget year. The rents/leases payments on this line should not include operating expenses, such as utilities, or payments for equipment. These types of expenses/payments are to be entered on the appropriate schedules, such as Schedules C5 or Schedule H2. Submit appropriate details concerning the rent or lease payments.

Column 10

Enter on this line, in the Total Column, the result of adding the rents/leases from Column 1 to Column 9.

Line E - Purchases

Columns 1 to 9

Enter on this line, in each Building Nomenclature Column, the cash purchases for the buildings debt for the base year.

Column 10

Enter on this line, in the Total Column, the result of adding the purchases from Column 1 to Column 9.

Line F - Renovations & Repairs

Columns 1 to 9

Enter on this line, in each Building Nomenclature Column, the Renovation and Repair payments for building related debt for the base year.

Column 10

Enter on this line, in the Total Column, the result of adding the Renovation and Repair payments from Columns 1 to Column 9.

Line G - Total

Enter on this line in each column the sum of lines B through F.

Line H - Accumulated Depreciation

Enter on this line the Accumulated Depreciation from the audited financial statements for the fiscal year.

Line I - Depreciation

Enter on this line the current depreciation from the audited financial statements for the fiscal year.

Line J - Average Age of Plant

Enter on this line the result of dividing line H, accumulated depreciation, by line I, depreciation. Round the result to one decimal place, e.g., 7.1.

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SCHEDULE H2 - DEPARTMENTAL EQUIPMENT ALLOWANCE .78

Overview .781

Schedule H2 is provided to enable each hospital to compute an equipment allowance for the following capital intensive cost centers.

Nomenclature	Account Number	Code
H2A - Medical/Surgical Intensive Care	6310	MIS
H2B - Coronary Care	6330	CCU
H2C - Pediatric Intensive Care	6350	PIC
H2D - Neo-Natal Intensive Care	6370	NEO
H2E - Burn Care	6380	BUR
H2F - Shock Trauma	6411	TRM
H2G - Oncology	6412	ONC
H2H - Operating Room	7040	OR
H2Ha – Operating Room Clinic	7070	ORC
H2I - Observation	7050	OBV
H2J - Laboratory Services	7210	LAB
H2K - Interventional Radiology/Cardiovascular	7310	IRC
H2L - Radiology-Diagnostic	7320	RAD
H2M - CT Scanner	7340	CAT
H2N - Radiology-Therapeutic	7360	RAT
H2O - Nuclear Medicine	7380	NUC
H2P - Renal Dialysis	7710	RDL
H2Q - Hyperbaric Chamber	7912	HYP
H2R - Dietary Services	8310	DTY
H2S - Laundry and Linen	8330	LL
H2T - Communications	8615	MGT
H2U - Data Processing	8994	EDP
H2V - MRI Scanner	7350	MRI
H2W - Lithotripsy	7355	LIT
Private Psychiatric Hospitals Only		
H2X - Electroconvulsive Therapy	7676	ETH
H2Y - Patient Transportation	8480	TRP
H2Z - Transureathral Thermotherapy	7365	TMT

Descriptions and functions of the accounts are located in Section 200.075, Daily Hospital Service Expenses, Section 200.077, Ancillary Services Expenses, Section 200.0783, General Services, Section 200.0785, Administrative Services, and Section 200.0788, Holding Accounts.

The department equipment allowance for these centers is comprised of:

a. Average purchased equipment;

b. Average leased equipment.

The line entitled Source indicated computations to be made or the source of the data required.

Round all dollar amounts to 1 decimal place (nearest hundred), e.g., $99,632 is entered as 99.6.

Refer to Appendix A, Capital Leases and FASB No 13 for the proper treatment of leases which must be capitalized. In calculating the allowance, a standard life of 10 years is used except for CT Scanner which is 6.5 years, MRI Scanner which is 6 years and Electronic Data Processing, Lithotripter and Patient Transportation which are 5 years.

Detailed Instructions .782

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line the year for which the base year data is reported, e.g., 06–87.

Purchased Equipment Section

Column 1 - Cost of Base Year Purchases

Lines H2A to H2Z

Enter on these lines, on each applicable department equipment allowance line, in the cost of Base Year Purchases Column, the cost of current purchases of the reporting hospital.

Column 2 - Number of Years

Lines H2A to H2Y

The number of years listed in this column is the average useful life of equipment for each department.

Column 3 - Cumulative Purchase Total

Lines H2A to H2Y

Enter on these lines, in the Cumulative Purchase Total Column, the cumulative cost of purchases or donations of major movable equipment for the number of base years in column 2.

Column 4 - Depreciation

Lines H2A to H2Z

Enter on these lines, on each applicable line in the Depreciation Column, the result of dividing Column 3, Cumulative Purchase Total, by Column 2, Number of Years.

Round each result to 1 decimal place.

Leased Equipment Section

Column 5 - Market Value Base Year Leases

Lines H2A to H2Z

Enter on these lines, in the Market Value Base Year Leases Column, the market value of leased major movable equipment for the current fiscal year, e.g., equipment leased in fiscal year 2003 with market value of $75,000 at the date of leasing would be entered as 75.0.

Column 6 - Cumulative Leases Total

Lines H2A to H2Z

Enter on these lines for each applicable department, in the Cumulative Leases Total Column, the cumulative amount of leased equipment for the number of years in column 2.

Round each result to 1 decimal place.

Column 7 - Lease Amortization

Lines H2A to H2Z

Enter on these lines, in the Lease Amortization Column, the result of dividing Column 6, Cumulative Leases Total by Column 2 number of years.

Round each result to 1 decimal place.

Column 8 - Total Depreciation/Amortization

Lines H2A to H2Z

Enter on these lines, on each applicable department equipment allowance schedule, in the Total Allowance Column, the result of adding Column 4, Depreciation, and Column 7, Amortization.

Column 8 - Total

Enter on this line in this column the sum of Lines H2A to H2Z Column 8.

FOR FUTURE USE

FOR FUTURE USE

SCHEDULES H3A, H3B, H3C AND H3D - DISTRIBUTION OF CAPITAL FACILITIES

ALLOWANCE .79

Overview .791

Schedules H3A and H3B (Schedules H3C and H3D for Private Psychiatric Hospitals) are provided to enable each hospital to distribute the general equipment depreciation, the building depreciation and the department equipment depreciation calculated on Schedule H2 to the patient care centers, auxiliary enterprise centers, other institutional program centers and unregulated services.

The column entitled Source indicated computations to be made or the source of the data requested.

Submit Schedules H3A, H3B (Schedules H3C and H3D for Private Psychiatric Hospitals) for the base year when the hospital's rates are being realigned.

Detailed Instructions .792

Heading Section

Institution Name Line

Enter on this line, the complete name of the reporting hospital.

Institution Number Line

Enter on this line, the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line, the year for which the base year is reported, e.g., 06–80.

Allowance Section

Line A - Interest

Column 2

Enter on this line, in the General Column, the interest from Schedule UA Line A Column 9.

Round the result to the nearest whole unit.

Line B - Total Depreciation

Column 2 - Total

Enter on this line, in the General Column, the depreciation from Schedule UA Line A Columns 5 and 6.

Round the allowance to 3 decimal places, e.g., $557 is entered as .557.

Line C - Capital Intensive Equipment Depreciation

Column 2 - Total

Enter on this line in this column the total from Schedule H2 Column 8.

Column 3 - Dietary

Enter on this line, in the Dietary Column, the dietary services department equipment depreciation transferred from Schedule H2, Line H2R Column 8.

Column 4 - Laundry

Enter on this line, in the Laundry Column, the laundry and linen department equipment depreciation transferred from Schedule H2, Line H2S Column 8.

Column 5 - Communications

Enter on this line, in the Communication Column the communications department equipment a depreciation transferred from Schedule H2, Line H2T Column 8.

Column 6 - Data Processing and Patient Transportation (Private Psychiatric Hospitals)

Enter on this line, in the Data Processing Column, the data processing department equipment depreciation transferred from Schedule H2, Line H2U, Column 8, for the appropriate base year or budget year and Patient Transportation departmental equipment depreciation, for private psychiatric hospitals, transferred from Schedule H2, Line H2Y, Column 8, from the appropriate base year or budget year.

Column 7 - Department

Enter on this line, in the Department Column, the capital intensive department equipment depreciation transferred from Schedule H2 Lines H2A to H2Q and H2V to H2X and H2Z Column 8.

Column 8 - Total

Enter on this line, in the Total Column, the result of adding the equipment depreciation from Line C, Columns 1 to 7.

Proprietary hospitals verify that the total equipment depreciation equals the straight line depreciation for moveable equipment for the appropriate base year or budget year.

Line D - Building & General Equipment Depreciation

Column 2 - Total and Column 8 - Total

Enter on this line, in the General Column, the result of subtracting Column 2 Line C, Capital Intensive Equipment Depreciation from Line B, Total Depreciation.

Line E - Building & General Equipment Depreciation and Interest

Columns 2

Enter on this line, in each column, the result of adding the amount from Line A, Interest and Line D, Building & General Equipment Depreciation.

Column 8 - Total

Enter on this line, in the Total Column, the result of adding Line C, Capital Intensive Equipment Depreciation, and Line D, Building & General Equipment Depreciation.

Verify that the total allowance from Columns 2 to 7 equals the total allowance in Column 8.

Line F - Standard Units

Column 2 - General

Enter on this line, in the General Column, the total net square feet for the cost centers listed on Lines H1 to H73 if there are not non-patient care related buildings listed on Schedule H1.

If non-patient care related buildings are listed on Schedule H1 do not include the square feet for these buildings in the total square feet.

Column 3 - Dietary

Enter on this line, in the Dietary Column, the number of patient meals served from Schedule JS1, Line B, Column 1.

Column 4 - Laundry

Enter on this line, in the Laundry Column, the number of dry and clean pounds of laundry processed from Schedule JS1, Line B, Column 2.

Column 5 - Communications

Enter on this line, in the Communications Column, the total inpatient and outpatient expense and ambulatory expense from Schedule JS1, Line B, Columns 7, 7A and 8.

Column 6 - Data Processing

Enter on this line, in the Data Processing Column, the total inpatient and outpatient expense and ambulatory expense from Schedule JS1, Line B, Columns 7, 7A and 8.

Line G - Allowance Per Unit

Columns 2 to 6

Enter on this line, in each department column, the result of dividing Line E, Total Allowance by Line F, standard Units, e.g., 441.0 ÷ 122,234 = .003607.

Round each result to 6 decimal places.

Distribution Section

Column 1 - Adjusted Square Footage Basis

Lines H1 to H73

Enter on these lines, in the Net Square Footage Basis Column, the square feet of each department located in patient care related buildings, including other institutional programs, Auxiliary Enterprises and Unregulated Services.

Line I - Subtotal

Enter on this line, in the Adjusted Square Footage Basis Column, the result of adding the adjusted square feet from Lines H1 to H53.

Line II - Total

Enter on this line, in the Net Square Footage Basis Column, the result of adding the adjusted square feet from Lines I to H73.

Verify that the total square feet is equal to the square feet entered on Line F, Column 2.

Column 2 - General

Lines H1 to H73

Enter on these lines, in the General Column, the result of multiplying Line G, Column 2, Allowance Per Unit, by Lines H1 to H73, Column 1, Net Square Footage Basis, and adding the cash requirements (principal and interest) relating to non-patient care related buildings, e.g., (.00367)(39,808) + 11.2 +9.8 = 164.6.

Round each result to 1 decimal place.

Line I - Subtotal

Enter on this line, in the General Column, the result of adding the general equipment allowances from Lines H1 to H53.

Line II - Total

Enter on this line, in the General Column, the result of adding the general equipment allowances from Lines I to H73.

Column 3 - Dietary

Line H1 to H73

Enter on these lines, in the Dietary Column, the result of multiplying Line G, Column 3, Allowance Per Unit, by Schedule JS1, JS2, Lines D1 to D52, Column 1, Number of Meals served, e.g., (.000106)(28,928) = 3.1.

Round each result to 1 decimal place.

Line I - Subtotal

Enter on this line, in the Dietary Column, the result of adding the dietary allowances from Lines H1 to H53.

Line II - Total

Enter on this line, in the Dietary Column, the result of adding the dietary allowances from Lines I to H73.

Column 4 - Laundry

Lines H1 to H73

Enter on these lines, in the Laundry Column, the result of multiplying Line G, Column 4, Allowances Per Unit, by Schedule JS1, JS2, Lines D1 to D52, Column 2, pounds of laundry processed, e.g., (.000089)(36234) = 3.2.

Round each result to 1 decimal place.

Line I - Subtotal

Enter on this line, in the Laundry Column, the result of adding the laundry allowances from Lines H1 to H53.

Line II - Total

Enter on this line, in the Laundry Column, the result of adding the laundry allowances from Lines I to H73.

Column 5 - Communications

Lines H1 to H73

Enter on these lines, in the Communications Column, the result of multiplying Line G, Column 5, Allowance Per Unit, by Schedules JS1, JS2, Lines D1 to D52, total of Columns 7, 7A and 8, (.000061)(72,145) = 4.4.

Round each result to 1 decimal place.

Line I - Subtotal

Enter on this line, in the Communications Column, the result of adding the communications allowances from Line H1 to H53.

Line II - Total

Enter on this line, in the Communications Column, the result of adding the communications allowances from Line I to H73.

Column 6 - Data Processing

Lines H1 to H73

Enter on these lines, in the Data Processing Column, the result of multiplying Line G, Column 6, Allowance Per Unit, by Schedules JS1, JS2, Lines D1 to D52, total of Column 7, 7A and 8, e.g., (.000061)(72,145) = 4.4.

Line I - Subtotal

Enter on this line, in the Data Processing Column, the result of adding the data processing allowances from Lines H1 to H53.

Line II - Total

Enter on this line, in the Data Processing Column, the result of adding the data processing allowances from Lines I to H73.

Column 7 - Department

Lines H1 to H73

Enter on these lines, in the Department Column, the department equipment allowance transferred from Schedule H2 Lines H2A to H2Q, Line K, Column 8.

Line I - Subtotal

Enter on this line, in the Department Column, the result of adding the department equipment allowances from Lines H1 to H53.

Line II - Total

Enter on this line, in the Department Column, the result of adding the department equipment allowances from Lines I to H73.

Column 8 - Total

Lines H1 to H73

Enter on these lines, in the Total Column, the result of adding the allowances from Columns 2 to 7.

Line I - Subtotal

Enter on this line, in the Total Column, the result of adding the allowances from Lines H1 to H53. This should tie to Schedule ACS Column 1, Lines C, Depreciation and Amortization, plus Line D, Interest Expense. This should also tie to Schedule UA, Line C, Column 5, Depreciation & Amortization, plus Column 6, Leases & Rentals, plus Column 9, Long Term Interest.

Line II - Total

Enter on this line, in the Total Column, the result of adding the allowances from Lines I to H73. This should also tie to Schedule UA, Line A, Column 5, Depreciation & Amortization, plus Column 6, Leases & Rentals, plus Column 9, Long Term Interest.

SCHEDULE H4 - CAPITAL FACILITY ALLOWANCE SUMMARY .80

Overview .801

Schedule H4 is provided to enable each hospital to prorate debt service between buildings and equipment, to determine total cash requirements for buildings and equipment and to determine any amount of excess cash requirements for buildings and equipment.

The column entitled Source indicates computations to be made or the source of the data requested.

Complete the Base Year Columns when the hospital's rates are being realigned and complete the Base Year Columns and Budget Year Columns when submitting a permanent rate application.

Round the entries on Lines A, C, D, E, F, G, H, I, J, K, L to 1 decimal place.

Detailed Instructions .802

Proration of Debt Service Section

Line A - Cost of Project

Column 1

Enter on this line, in the Building Column, the cost of each building project which has debt service.

Column 2

Enter on this line, in the Moveable Equipment Column, the cost of each building project which has debt service for moveable equipment.

Column 3

Enter on this line, in the Total Column, the total cost of each building project (Column 1 + Column 2).

Column 4

Enter on this line, in the Building Column, the projection or actual cost of each building project which has debt service.

Column 5

Enter on this line, in the Moveable Equipment Column, the projection or actual cost of each building project which has debt service for moveable equipment.

Column 6

Enter on this line, in the Total Column, the total cost of each building project (Column 1 + Column 2).

The first 10 years of debt service for each project is to be prorated on the basis of the cost of the buildings and moveable equipment.

In the 11th to 20th years of debt service for each project the portion of costs applicable to moveable equipment should be reduced to 1/2 of the cost.

All debt service for the 21st year forward will be allocated to buildings.

Line B - Percent of Project

Columns 1, 2, 4, 5

Enter on this line, in each applicable column, the ratio of the building or equipment cost to the total cost, e.g., 5,000.0 + 10,000 = .500.

Round each result to 3 decimal places.

Line C - Proration of Debt Service

Columns 1, 2, 4, 5

Enter on this line, in each applicable column, the result of multiplying Line B, by the total debt service entered on Line D, Column 3 or Column 6.

Columns 3, 6

Enter on this line, in each applicable column, the result of adding the proration of debt service from Columns 1 and 2 or Columns 4 and 5, whichever is applicable.

Cash Requirements Section

Line D - Debt Service

Column 1

Enter on this line, in the Building Column, the cash requirements for buildings debt service for the-base year from Line C, Column 1.

Verify that the cash requirements equal the principal and interest payments on Schedule H1, Lines P and Q, for the base year.

Column 2

Enter on this line, in the Moveable Equipment Column, the cash requirements for moveable equipment debt service for the base year from Line C, Column 2. Include cash requirements for capitalized leased equipment debt service.

Column 3

Enter on this line, in the Total Column, the total cash requirements for debt service for the base year from Line C, Column 3.

Column 4

Enter on this line, in the Building Column, the cash requirements for buildings debt service for the budget year from Line C, Column 4.

Column 5

Enter on this line, in the Moveable Equipment Column, the cash requirements for moveable equipment debt service for the budget year from Line C, Column 5. Include cash requirements for capitalized leased equipment debt service.

Column 6

Enter on this line, in the Total Column, the total cash requirements for debt service for the budget year from Line C, Column 6.

Line E - Rents/Leases

Column 1

Enter on this line, in the Building Column, the cash requirements for rents/leases of buildings from Schedule H1, Line R, Column 10, for the base year.

Column 2

Enter on this line, in the Moveable Equipment column, the cash requirements for rents/leases of moveable equipment for the base year. Exclude cash requirements for capitalized leased equipment debt service.

Column 3

Enter on this line, in the Total Column, the result of adding the cash requirements from Column 1 and Column 2.

Column 4

Enter on this line, in the Building Column, the cash requirements for rents/leases of buildings from Schedule H1, Line R, Column 10, for the budget year.

Column 5

Enter on this line, in the Moveable Equipment Column, the cash requirements for rents/leases of moveable equipment for the budget year. Exclude cash requirements for capitalized leased equipment.

Column 6

Enter on this line, in the Total Column, the result of adding the cash requirements from Column 1 and Column 2.

Line F - Purchases

Column 1

Enter on this line, in the Building Column, the cash requirements for purchases of buildings and fixed equipment for the base year, e.g., the down payment for a building project.

Column 2

Enter on this line, in the Moveable Equipment Column, the cash requirement for purchases of moveable equipment and the fair market value of capitalized leased equipment for the base year.

Column 3

Enter on this line, in the Total Column, the result of adding the cash requirements from Column 1 and Column 2.

Column 4

Enter on this line, in the Building Column, the cash requirements for purchases of buildings and fixed equipment for the budget year.

Column 5

Enter on this line, in the Moveable Equipment Column, the cash requirements for purchases of moveable equipment and fair market value of capitalized leased equipment for the budget year.

Column 6

Enter on this line, in the Total Column, the result of adding the cash requirements from Column 4 and Column 5.

Line G - Renovations/Repairs - Capitalized

(Non-capitalized renovations and repairs are to be reported to Schedule C-Line C5 Plant Operations.)

Column 1

Enter on this line, in the Building Column, the capitalized renovations/repairs cash requirements for buildings for the base year not included in Column 1. Line D. Specify whether cash requirements are for debt service or for cash payments. Provide details.

Column 2

Enter on this line, in the Moveable Equipment Column, the capitalized renovations/repairs cash requirements for moveable equipment for the base year not included in Column 2, Line D.

Column 3

Enter on this line, in the Total Column, the result of adding the cash requirements from Column 1 and Column 2.

Column 4

Enter on this line, in the Building Column, the capitalized renovations/repairs cash requirements for buildings for the budget year not included in Column 4, Line D. Specify whether cash requirements are for debt service or for cash payments. Provide details.

Column 5

Enter on this line, in the Moveable Equipment Column the capitalized renovations/repairs cash requirements for moveable equipment for the budget year not included in Column 5, Line D.

Column 6

Enter on this line, in The Total Column, the result of adding the cash requirements from Column 4 and Column 5.

Line H - Investment Income

Column 1

Enter on this line, in the Building Column, the investment income on building funds for the base year.

Column 2

Enter on this line, in the Moveable Equipment Column, the investment income on equipment funds for the base year.

Column 3

Enter on this line, in the Total Column, the result of adding the investment income from Column 1 and Column 2.

Column 4

Enter on this line, in the Building Column, the investment income on building funds for the budget year.

Column 5

Enter on this line, in the Equipment Column, the investment income on equipment funds for the budget year.

Column 6

Enter on this line, in the Total Column, the result of adding the investment income from Column 4 and Column 5.

Line I - Net Cash Requirements

Columns 1 to 6

Enter on this line, in each applicable column, the result of adding the cash requirements from Lines D, E, F and G and subtracting the investment income from Line H.

Excess Cash Requirements

Line J - Formula Allowances

Column 1

Enter on this line, in the Building Column, the building facility allowance from Schedule H1, Line W, Column 10, for the base year.

Column 2

Enter on this line, in the Moveable Equipment Column, the equipment facility allowance from Schedule H3A, Line C, Column 8, for the base year.

Column 3

Enter on this line, in the Total Column, the result of adding the facility allowances from Column 1 and Column 2.

Column 4

Enter on this line, in the Building Column, the building facility allowance from Schedule H1, Line W, Column 10, for the budget year.

Column 5

Enter on this line, in the Moveable Equipment Column, the equipment facility allowance from Schedule H3A, Line C, Column 8, for the budget year.

Column 6

Enter on this line, in the Total Column, the result of adding the facility allowances from Column 1 and Column 2.

Line K - Cash Requirements in Excess of Formula

Columns 1 to 6

Enter on this line, in each applicable column, the result of subtracting Line J, Formula Allowances, from Line I, Net Cash Requirements, e.g., 1000.5 – 989.8 = 10.7. Enter a negative in brackets.

Line L - Total Requirements

Columns 1 to 6

Enter on this line, in each applicable column, the result of adding Line J, Formula Allowances, and Line K, Cash Requirements in Excess of Formula.

SCHEDULE H4A - EQUIPMENT PURCHASES AND LEASES .803

Overview .804

Schedule H4A is provided to enable each hospital to provide current detailed information on hospital equipment purchases and leases. This schedule discloses the amount of replacement and non-replacement moveable equipment that was purchased, as well as, the amount of replacement and non-replacement movable equipment that was leased in the base and budget Years, as reported on Schedule H4.

(Report only information associated with moveable equipment purchased in the base or budget year for which leases were executed in the base or budget year)

Complete budget year columns and addendums only when submitting a full rate application.

Round all entries to one decimal place. .805

Detailed Instructions

Purchases

Line A - General Equipment

Column 1

Enter on this line the cost of General Equipment purchases for the base year.

Column 2

Enter on this line the cost of General Equipment purchases for the budget year.

Column 3

N/A

Line B - Replacement Requirement - Capital Intense Departments

Column 1

Enter on this line the cost of Capital Intense Department Replacement Equipment purchases for the base year.

Column 2

Enter on this line the cost of Capital Intense Department Replacement Equipment purchases for the budget year.

Column 3

N/A

Line C - Non-replacement Equipment - Capital Intense Departments

Column 1

Enter on this line the cost of Capital Intense Department Non-replacement Equipment purchases for the base year.

Column 2

Enter on this line the cost of Capital Intense Department Non-replacement Equipment purchases for the Budget Year. **Provide as an addendum to this schedule a detailed description and the purchase price of each piece of non-replacement equipment included on this line.**

Column 3

N/A

Leases

Line D - General Equipment Leases

Column 1

Enter on this line the fair market value of General Equipment whose leases were initiated in the Base Year.

Column 2

Enter on this line the fair market value of General Equipment whose leases are to be initiated in the Budget Year.

Column 3

Enter on this line the annual cash requirements for General Equipment whose leases are to be initiated in the Budget Year.

Line E - Replacement Equipment - Capital Intense Departments

Column 1

Enter on this line the fair market value of Capital Intense Department Replacement Equipment whose leases were initiated in the Base Year.

Column 2

Enter on this line the fair market value of Capital Intense Department Replacement Equipment whose leases are to be initiated in the Budget Year.

Column 3

Enter on this line the annual cash requirements for Capital Intense Department Replacement Equipment whose leases are to be initiated in the Budget Year.

Line F - Non-replacement - Capital Intense Equipment

Column 1

Enter on this line the fair market value of Capital Intense Department Non-replacement Equipment whose leases were initiated in the Base Year.

Column 2

Enter on this line the fair market value of Capital Intense Department Non-replacement Equipment whose leases are to be initiated in the Budget Year. **Provide as an addendum to this schedule a detailed description and the fair market value of each piece of non-replacement equipment included on this line.**

Column 3

Enter on this line the annual cash requirements for Capital Intense Department Non-replacement Equipment whose leases are to be initiated in the Budget Year.

Line G - Totals

Column 1

Enter on this line the result of adding the Base Year purchasers and the fair market value of Base Year leases from Lines A, B, C, D, E, and F. **This amount should agree with the amount of Line F, Column 2 of Schedule H4.**

Column 2

Enter on this line the result of adding the Budget Year purchases and the fair market value of Budget Year leases from Lines A, B, C, D, E, and F. **This amount should agree with the amount on Line F, Column 5, of Schedule H4.**

Column 3

Enter on this line the result of adding the annual cash requirements for leases from lines A, B, and C.

SCHEDULE GR - CASH AND MARKETABLE ASSETS .81

Overview .811

Schedule GR is provided to enable each hospital to report cash and marketable assets for unrestricted funds, restricted funds and funds held by others for the benefit of a hospital.

Schedule GR is also provided to enable each hospital to report other operating revenue and non-operating revenue not reported on Schedules E1 to E9 (Auxiliary Enterprises) and Schedules F1 to F4 (Other institutional Programs).

The column entitled Source indicates computations to be made or the source of the requested data.

Round all entries on Lines A to R to 1 decimal place (nearest hundred), e.g., $99,632.99 is entered as 99.6.

Submit Schedule GR for the base year when realigning rates and submit Schedule GR for the budget year when submitting a permanent rate application in accordance with COMAR 10.37.10.03 or COMAR 10.37.10.04.

Refer to Section 100.241 for definitions of Unrestricted Funds, including Board Designated Funds.

Refer to Section 100.242 for definitions of Plant Replacement and Expansion Funds.

Refer to Section 100.243 for definitions of Specific Purpose Funds.

Refer to Section 100.244 for definitions of Endowment Funds, including Pure Endowments and Term Endowments.

Funds held by others for the benefit of a hospital are defined as funds held in trust by outside parties for distribution to the hospital whether or not it is a related organization as defined in Section 100.32. Submit a copy of the financial statements of the trust.

Detailed Instructions .812

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line the year for which the base year data is reported, e.g., 06–80.

Budget Year Line

Enter on this line the year for which the budgeted data is reported, e.g., 06-81.

Fund Balances - Base Year Section

Line A - Cash and Marketable Assets

Columns 1 to 7

Enter on this line, in each applicable fund column, the cash and marketable assets of each hospital fund category at the end of the base year from the hospital's financial statements.

Column 8

Enter on this line, in this column, the cash and marketable assets of the Funds Held By Others for the Benefit of the Hospital at the end of the base year from the financial statements of the trust.

Line B - Other Assets

Columns 1 to 7

Enter on this line, in each applicable fund column, the total other assets of each hospital fund category at the end of the base year from the hospital's financial statements.

Column 8

Enter on this line, in this column, the total other assets of the Funds Held By Others for the Benefit of the Hospital at the end of the base year from the financial statements of the trust.

Line C - Liabilities

Columns 1 to 7

Enter on this line, in each applicable fund column, the total liabilities of each hospital fund category at the end of the base year from the hospital's financial statements.

Column 8

Enter on this line, in this column, the total liabilities of the Funds Held By Others for the Benefit of the Hospital at the end of the base year from the financial statements of the trust.

Line D - Fund Balances

Columns 1 to 8

Enter on this line, in each column, the result of adding Line A, Cash and Marketable Assets, and Line B, Other Assets, and subtracting Line C, Liabilities.

Verify that the various fund balances agree with the fund balances on the applicable financial statements.

Fund Balances - Budget Year Section

Line E - Cash and Marketable Assets

Columns 1 to 7

Enter on this line, in each applicable fund column, the cash and marketable assets of each hospital fund category projected at the end of the budget year from the hospital's budget.

Column 8

Enter on this line, in this column, the cash and marketable assets of the Funds Held By Others for the Benefit of the Hospital projected at the end of the budget year from the budget of the trust.

Line F - Other Assets

Columns 1 to 7

Enter on this line, in each applicable fund column, the total other assets of each hospital fund category projected at the end of the budget year from the hospital's budget.

Column 8

Enter on this line, in this column, the total other assets of the Funds Held By Others for the Benefit of the Hospital projected at the end of the budget year from the budget of the trust.

Line G - Liabilities

Columns 1 to 7

Enter on this line, in each applicable fund column, the total liabilities of each hospital fund category projected at the end of the budget year from the hospital's budget.

Column 8

Enter on this line, in this column, the total liabilities of the Funds Held By Others for the Benefit of the Hospital projected at the end of the budget year from the budget of the trust.

Line H - Fund Balances

Columns 1 to 8

Enter on this line, in each column, the result of adding Line E, Cash and Marketable Assets, and Line F, Other Assets, and subtracting Line G, Liabilities.

Verify that the various fund balances agree with the fund balances on the applicable budgeted financial statements.

Income - Base Year Section

Line I - Donations, Pledges

Columns 1 to 7

Enter on this line, in each applicable fund column, the donations and pledges revenue for each hospital fund category for the base year from the hospital's financial statements.

Column 8

Enter on this line, in this column, the donations and pledges revenue for the Funds Held By Others for the Benefit of the Hospital for the base year from the Financial statements of the trust.

Line J - Grants

Columns 1 to 7

Enter on this line, in each applicable fund column, the grants revenue for each hospital fund category for the base year from the hospital's financial statements.

Column 8

Enter on this line, in this column, the grants revenue for the Funds Held By Others for the Benefit of the Hospital for the base year from the financial statements of the trust.

Line K - Investment Income (Interest and Dividends)

Columns 1 to 7

Enter on this line, in each applicable fund column, the interest and dividends revenue for each hospital fund category for the base year from the hospital's financial statements.

Column 8

Enter on this line, in this column, the interest and dividends revenue for the Funds Held by Others for the Benefit of the Hospital for the base year from the financial statements of the trust.

Line L - Other

Columns 1 to 7

Enter on this line, in each applicable fund column, the other revenue for each hospital fund category for the base year from the hospital's financial statements, e.g., sale of medical abstracts, donated commodities, donated blood, cash discounts on purchases, sale of scrap and waste, vending machine commissions, other commissions, non-patient room rentals, gains on sale of hospital property, donated services, unrestricted income from endowment funds, term endowment funds becoming unrestricted, transfers from restricted funds for non-operating revenue and other operating revenue and other non-operating revenue.

Column 8

Enter on this line, in this column, the other revenue for the Funds Held By Others for the Benefit of the Hospital for the base year from the financial statements of the trust.

Line M - Total Income

Columns 1 to 8

Enter on this line, in each column, the result of adding Line I, Donations and Pledges, with Line J, Grants, Line K, Investment Income, and Line L, Other.

Income - Budget Year Section

Line N - Donations, Pledges

Columns 1 to 7

Enter on this line, in each applicable fund column, the donations and pledges revenue of each hospital fund category projected for the budget year from the hospital's budget.

Column 8

Enter on this line, in this column, the donations and pledges revenue of the Funds Held By Others for the Benefit of the Hospital projected for the budget year from the budget of the trust.

Line O - Grants

Columns 1 to 7

Enter on this line, in each applicable fund column, the grants revenue of each hospital fund category projected for the budget year from the hospital's budget.

Column 8

Enter on this line in this column, the grants revenue of the Funds Held By Others for the Benefit of the Hospital projected for the budget year from the budget of the trust.

Line P - Investment Income (Interest and Dividends)

Columns 1 to 7

Enter on this line, in each applicable fund column, the interest and dividends revenue of each hospital fund category projected for the budget year from the hospital's budget.

Column 8

Enter on this line, in this column, the interest and dividends revenue of the Funds Held By Others for the Benefit of the Hospital projected for the budget year from the budget of the trust.

Line Q - Other

Columns 1 to 7

Enter on this line, in each applicable fund column, the other revenue of each hospital fund category projected for the budget year from the hospital's budget.

Column 8

Enter on this line, in this column, the other revenue of the Funds Held By Others for the Benefit of the Hospital projected for the budget year from the budget of the trust.

Line R - Total Income

Columns 1 to 8

Enter on this line, in each column, the result of adding Line N, Donations and Pledges, with Line O, Grants, Line P, Investments Income, and Line Q, Other.

SCHEDULE G - OTHER FINANCIAL CONSIDERATIONS .82

Overview .821

Schedule G is provided to enable each hospital to calculate the other financial considerations to be included in hospital rates. Other financial considerations include non-patient revenues used to offset rates, miscellaneous expenses not included in rates in Levels I and II and other adjustments to rates, such as excess cash requirements for buildings or equipment.

The column entitled Source indicates computations to be made or the source of the requested data.

Round all entries on Lines A to R to 1 decimal place (nearest hundred), e.g., $99,632.11 is entered as 99.6.

Submit Schedule G for the base year when aligning rates and submit Schedule G for the budget year when submitting a permanent rate application in accordance with COMAR 10.37.10.03 or COMAR 10.37.10.04.

Detailed Instructions .822

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line the year for which the base year data is reported, e.g., 06–80.

Budget Year Line

Enter on this line the year for which the budgeted data is reported, e.g., 06–81.

Revenue Section

Line A - Donations, Pledges

Column 1

Enter on this line, in the Total Column, the donations, pledges revenue for the base year from Schedule GR, Line I, applicable columns.

Column 4

Enter on this line, in the Total Column, the donations, pledges revenue for the budget year from Schedule GR, Line N, applicable columns.

Line B - Grants

Column 1

Enter on this line, in the Total Column, the grants revenue for the base year from Schedule GR, Line J, applicable columns.

Column 4

Enter on this line, in the Total Column, the grants revenue for the budget year from Schedule GR, Line O, applicable columns.

Line C - Investment Income (Interest, Dividends)

Column 1

Enter on this line, in the Total Column, the investment income for the base year from Schedule GR, Line K, applicable columns.

Column 4

Enter on this line, in the Total Column, the investment income for the budget year from Schedule GR, Line P, applicable columns.

Line D - Donated Commodities, Blood, Services

Column 1

Enter on this line, in the Total Column, the donated commodities, blood, services revenue for the base year to offset the inputted expenses entered on other schedules, e.g., donated services and commodities on Schedules C1 to C14, Line F.

Column 4

Enter on this line, in the Total Column, the donated commodities, blood, services revenue for the budget year to offset the inputted expenses entered on other schedules, e.g., donated services and commodities on Schedules C1 to C14, Line F, adjusted for budget year changes.

Line E - PSRO

Column 1

Enter on this line, in the Total Column, the revenues for the base year from the Medicare intermediary entered on Schedule GR, Line L, Column 1, for the recovery of PSRO related expenses entered on a Schedule UA.

Column 4

Enter on this line, in the Total Column, the revenues for the budget year from the Medicare intermediary entered on Schedule GR, Line Q, Column 1 for the recovery of PSRO related expenses entered on Schedule UA.

Line F - Other

Column 1

Enter on this line, in the Total Column, the applicable other revenue for the base year from Schedule GR, Line L.

Column 4

Enter on this line, in the Total Column, the applicable other revenue for the budget year from Schedule GR, Line Q.

Line G - Total Revenues

Columns 1 and 4

Enter on this line, in the Total Columns, the result of adding the revenues from Lines A to F.

Expenses Section

Line H - Licenses and Taxes

Column 1

Enter on this line, in the Total Column, the licenses and taxes expense for the base year from Schedule UA, Line C, Column 6.

Column 4

Enter on this line, in the Total Column, the licenses and taxes expense for the budget year from Schedule UA, Line H, Column 6.

Line I - Short Term Interest

Column 1

Enter on this line, in the Total Column, the short term interest for the base year from Schedule UA, Line C, Column 7.

Column 4

Enter on this line, in the Total Column, the short term interest for the budget year from Schedule UA, Line H, Column 7.

Line J - Other

Column 1

Enter on this line, in the Total Column, other expenses for the base year from the hospital's records not accounted for on other schedules, e.g., amortization of organizational expenses.

Column 4

Enter on this line, in the Total Column, other expenses for the budget year from the hospital's budget not accounted for on other schedules, e.g., amortization of organizational expenses.

Line K - Total Expenses

Columns 1 and 4

Enter on this line, in the Total Columns, the result of adding the expenses from Lines H to J.

Other Adjustments Section

Line L - Aux Ent & OIP Gains

Column 1

Enter on this line, in the Total Column, the base year profits from Schedules E1 to E9, Line J, Column 3 and from Schedules F1 to F4, Line G, Column 3.

Column 4

Enter on this line, in the Total Column, the portion of the budget year profits treated as OFC from Schedules E1 to E9, Line Q, Column 3 and the budget year profits from Schedules F1 to F4, Line N, Column 3.

Line M - Aux Ent & OIP Losses

Column 1

Enter on this line, in the Total Column, the base year losses from Schedules E1 to E9, Line J, Column 3 and from Schedules F1 to F4, Line G, Column 3.

Column 4

Enter on this line, in the Total Column, the portion of the budget year losses treated as OFC from Schedules E1 to E9, Line Q, Column 3, and the budget year losses from Schedules F1 to F4, Line N, Column 3.

Line N - Excess Cash Requirements - Bldg & Equip

Column 1

Enter on this line, in the Total Column, the excess cash requirements for the base year from Schedule H4, Line K, Column 3.

Column 4

Enter on this line, in the Total Column, the excess cash requirements for the budget year from Schedule H4, Line K, Column 6.

Line O - Gain on Disposal of Assets

Column 1

Enter on this line, in the Total Column, the gain on disposal of capital intensive center assets (Schedules H2A to H2U) using Commission approved lives for the base year.

Column 4

Enter on this line, in the Total Column, the gain on disposal of capital intensive center assets (Schedules H2A to H2U) using Commission approved lives for the budget year.

Line P - Loss on Disposal of Assets

Column 1

Enter on this line, in the Total Column, the loss of disposal of capital intensive center assets (Schedules H2A to H2Y) using Commission approved lives for the base year.

Column 4

Enter on this line, in the Total Column, the loss on Disposal of capital intensive center assets (Schedules H2A to H2Y) using Commission approved lives for the budget year.

Line Q - Total Other Adjustments

Columns 1 and 4

Enter on this line, in the Total Column, the result of adding the other adjustments Lines L to P. Enter a negative in brackets.

Other Financial Consideration Section

Line R - Net Other Financial Considerations

Columns 1 and 4

Enter on this line, in the Total Column, the result of adding the total revenues from Line G, the total expenses from Line K, and the total other adjustments from Line Q. Enter a negative in brackets.

Revenues Section

Lines A to F

Columns 2,3,5,6

Enter on these lines, in each applicable column, the distribution of other financial considerations revenue between direct offsets to rates and uniform offsets to rates. For example, a grant to fund a free standing clinic would be entered on Column 2 and/or 5, Line B.

Except when filed as part of a full rate application, total direct offsets to rates are limited to the amount of direct offsets to rates approved, by the Commission, in the hospital's most recent full rate setting. (See Commission Policy #12)

Line G

Columns 2,3,5,6

Enter on this line, in each column, the result of adding the revenues from Lines A to F.

Expenses Section

Lines H to J

Columns 2,3,5,6

Enter on these lines, in each applicable column, the distribution of other financial considerations expenses between direct increases to rates and uniform offset to rates.

Except when filed as part of a full rate application, total direct offsets to rates are limited to the amount of direct offsets to rates approved, by the Commission, in the hospital's most recent full rate setting. (See Commission Policy #12.)

Line K

Columns 2,3,5,6

Enter on this line, in each column, the result of adding the expenses from Lines H to J

Other Adjustments Section

Lines L to P

Columns 2,3,5,6

Enter on these lines, in each applicable column, the distribution of other financial considerations other adjustments between direct adjustments to rates and uniform adjustments to rates. For example, a gain on disposal of assets would be entered on Column 2 and/or Column 5, Line O.

Except when filed as part of a full rate application, total direct offsets to rates are limited to the amount of direct offsets to rates approved, by the Commission, in the hospital's most recent full rate setting. (See Commission Policy #12.)

Line Q

Columns 2, 3, 5, 6

Enter on these lines, in each column, the result of adding the other adjustments from Lines L to P.

Percentage Calculation

Line R

Columns 2, 3, 5, 6

Enter on this line, in each column, the result of adding Line G, Total Revenues, Line K, Total Expenses, and Line Q, Total Other Adjustments.

Line S

Columns 3 and 6

Enter on this line, in each column, the result of dividing Line R, Columns 3 and/or 6 by the Total Level II costs from Schedule M, Line, Column, e.g., 100.0 + 10,000.0 = .100.

Round each result to 3 decimal places.

SCHEDULE CT - CHARITY AND BAD DEBTS .83

Schedule Reporting Waived.

RESERVED FOR FUTURE USE.

SCHEDULE PDA - PAYOR DIFFERENTIAL .84

Overview .841

Schedule PDA is provided to enable each hospital to develop HSCRC regulated gross revenue (rates) after allowing purchaser differentials, working capital (prompt payment) differentials and a provision for charity and bad debts.

Regulated gross patient revenue, by payer category, should be adjusted for uncompensated care cases and for cases where the expected payer changes after admission.

Round all entries on Lines A, B, C, D, E, F, G, G1, N and O to 1 decimal place (nearest hundred), e.g., $99,632 is entered at 99.6.

Round all entries on Lines H, I, J, K, L, M, M1 and P to 4 decimal places.

Submit Schedule PDA for the base year when realigning rates and submit Schedule PDA for the budget year when submitting a permanent rate application in accordance with COMAR 10.37.10.03 or COMAR 10.37.10.04.

Detailed Instructions .842

Heading Section

Instruction Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line the year for which the base year data is reported, e.g., 06-80.

Budget Year Line

Enter on this line the year for which the budget data is reported, e.g., 06-81.

Charges, Deductibles, CBA Section

Line A - Gross Patient Revenue - HSCRC Regulated

Column 1 - Inpatient

Enter on this line, in Column 1, the reporting hospital's gross inpatient HSCRC regulated patient revenues.

Column 2 - Outpatient

Enter on this line, in Column 2, the reporting hospital's gross outpatient HSCRC regulated patient revenues.

Column 3 - Total

Enter on this line, in Column 3, the result of adding Column 1, gross inpatient regulated revenues, and Column 2, gross outpatient regulated revenues.

Verify that the HSCRC regulated total gross patient revenues agree with the HSCRC regulated gross patient revenue on Line E, Schedule RE and Line C on Schedule UCS.

Line B - Medicare Revenue - HSCRC Regulated

Column 1 - Inpatient

Enter on this line, in Column 1, the reporting hospital's gross inpatient HSCRC regulated charges for Medicare patients reduced by charges written off to bad debt.

Column 2 - Outpatient

Enter on this line, in Column 2, the reporting hospital's gross outpatient HSCRC regulated charges for Medicare patients minus charges written off to bad debt.

Column 3 - Total

Enter on this line, in Column 3, the result of adding Column 1, inpatient Medicare revenue, and Column 2, outpatient Medicare revenue.

Line C - Medicaid Revenue - HSCRC Regulated

Column 1 - Inpatient

Enter on this line in Column 1, the reporting hospital's gross inpatient HSCRC regulated charges for Medicaid patients reduced by charges written off to bad debt.

Column 2 - Outpatient

Enter on this line, in Column 2, the reporting hospital's gross outpatient HSCRC regulated charges for Medicaid patients minus charges written off to bad debt.

Column 3 - Total

Enter on this line, in Column 3, the result of adding Column 1, inpatient Medicaid revenue and Column 2, outpatient Medicaid revenue.

Line D - Blue Cross Revenue - HSCRC Regulated

Column 1 - Inpatient

Enter on this line, in Column 1, the reporting hospital's gross inpatient HSCRC regulated charges for Blue Cross patients reduced by charges written off to bad debt.

Column 2 - Outpatient

Enter on this line, in Column 2, the reporting hospital's gross outpatient HSCRC regulated charges for Blue Cross patients minus charges written off to bad debt.

Column 3 - Total

Enter on this line, in Column 3, the result of adding Column 1, inpatient Blue Cross revenue and Column 2, outpatient Blue Cross.

Line E - MCO subcontracted Medicare, Medicaid Revenue - HSCRC Regulated

Column 1 - Inpatient

Blank

Column 2 - Outpatient

Blank

Column 3 - Total

Enter on this line, in column 3, the total gross HSCRC regulated revenues of the reporting hospital for HSCRC regulated revenues for managed care organizations (MCO) subcontracting with Medicare and Medicaid, inmates of penal facilities operated by the State of Maryland and Maryland counties, as well as entities that contract with the State of Maryland and/or counties for hospital services provided to inmates only, and inpatients of hospitals operated by the State of Maryland reduced by charges written off to bad debt.

Note: Include the charges for HSCRC regulated revenues for managed care organizations (MCO) subcontracting with Medicare and Medicaid, inmates of penal facilities operated by the State of Maryland and Maryland counties, as well as entities that contract with the state of Maryland and/or counties for hospital services provided to inmates only, and inpatients of hospitals operated by the State of Maryland. (Including but not limited to Maryland Medicare Health Choice Program) Provide a supplemental schedule detailing charges by payer.

Line F - Medicare Deductible Paid by Medicaid - HSCRC Regulated

Column 1 - Inpatient

Blank

Column 2 - Outpatient

Blank

Column 3 - Total

Enter on this line, in Column 3, the total deductibles and coinsurance of the reporting hospital for all HSCRC regulated services to Medicare patients and paid by Medicaid.

Line G - Uncompensated Care - HSCRC regulated

Column 1 - Inpatient

Enter on this line, in Column 1, the reporting hospital's uncompensated care associated with HSCRC regulated inpatient services for all patients. This amount is the total charity care provided to patients who qualify for free care under existing hospital policy and the amounts of bad debt removed from Column 1, Lines B, C, D, and E.

Verify that the Inpatient uncompensated care on Line G, Column 1, agrees with Inpatient Uncompensated Care Schedule UCS, column, Line A.

Column 2 - Outpatient

Enter on this line, in Column 2, the reporting hospital's uncompensated care associated with HSCRC regulated outpatient services for all patients.

This amount is the total of charity care provided to patients who qualify for free care under existing hospital policy and the amounts of bad debts removed from Column 2, Lines B, C, D, and E.

Column 3 - Total

Enter on this line, in Column 3, the result of adding Column 1, inpatient, and column 2, outpatient.

Verify that the Total Uncompensated Care on Line G, Column 3, agrees with the Total Uncompensated Care on Schedule RE, Lines F plus G, Column 1.

Provide a supplemental schedule reconciling the amount of uncompensated care per the hospital's audited financial statements and trial balance.

The reconciliations should be provided in the following format:

Audited Financial Statement	
Bad debts	$
Charity Care	_____
Uncompensated Care per Statement	$_____
Trial Balance	
Bad Debt Write-offs	$
Charity Write-offs	
Change in Balance Sheet Reserve	
Bad Debt Recoveries	
* Other	_____
Uncompensated Care per Trial Balance	$_____

Annual Report of Revenues, Expenses and Volumes

Uncompensated Care-Schedule PDA $
Unregulated Charity & Bad Debts
Uncompensated Care Fund Payments

* Other _____
Uncompensated Care per Trial Balance $_____
* Explain in detail

Line GI - Other Payers

Column 1 - Inpatient

Blank

Column 2 - Outpatient

Blank

Column 3 - Total

Enter on this line, in Column 3, the result of subtracting the result of adding line B, Column 3, Line C, Column 3, Line D, Column 3, Line E, Column 3, and Line G, Column 3, from Line A Column 3. The total gross revenue of the reporting hospital for payers who are not eligible for the SAAC discount and not included in Uncompensated Care include, but is not limited to, Commercial insurers, HMO's not approved for SAAC, and self pay patients. e.g., $10,102.7 - ($3,289.1 + $532.8 + $4,103.4 + $428.9 + $489.8) = $1,258.7.

Line H - Ratio of HSCRC Regulated Medicare and Medicaid Charges

Column 1 - Inpatient

Blank

Column 2 - Outpatient

Blank

Column 3 - Inpatient

Enter on this line, in Column 3, the result of dividing the result of adding Line B, Column 3, total HSCRC regulated Medicaid revenue, by Line A, Column 3, gross HSCRC regulated patient revenue, e.g., (3,289.1 + 532.8) divided by 10,102.7 = .3783.

Round each number to 4 decimal places.

Line I - Ratio of HSCRC Regulated Blue Cross Charges

Column 1 - Inpatient

Enter on this line, in Column 1, the result of dividing Line D, Column 1, total HSCRC regulated Blue Cross Inpatient Revenue, by Line A, Column 3, total gross HSCRC regulated patient revenue, e.g., 3077.5 divided by 10,102.7 = .3046.

Round each result to 4 decimal places.

Column 2 - Outpatient

Enter on this line, in Column 2, the result of dividing Line D, Column 2, total HSCRC regulated Blue Cross Outpatient Revenue, by Line A, Column 3, total gross HSCRC regulated patient revenue, e.g., 1.025.9 divided by 10,102.7 = .1016.

Round each result to 4 decimal places.

Column 3 - Total

Blank

Line J - Ratio of HSCRC Regulated HMO Charges and MCO Medicare, Medicaid

Column 1 - Inpatient

Blank

Column 2 - Outpatient

Blank

Column 3 - Total

Enter on this line, in Column 3, the result of dividing Line E, Column 3, HSCRC regulated MCO Medicare, Medicaid revenue, by Line A, Column 3, gross HSCRC regulated patient revenues, e.g., 428.9 divided by 10,102.7 = .0425.

Round each result to 4 decimal places.

Line K - Ratio HSCRC Regulated of Deductibles Paid by Medicaid and Blue Cross

Column 1 - Inpatient

Blank

Column 2 - Outpatient

Blank

Column 3 - Total

Enter on this line, in Column 3, the result of dividing line F, Column 3, HSCRC regulated Medicare Deductibles paid by Medicaid and Blue Cross by Line A, Column 3, gross HSCRC regulated patient revenues, e.g. 50.9 divided by 10,102.7 = .0050.

Round each result to 4 decimal places.

Line L - Ratio of HSCRC Regulated Uncompensated Care

Column 1 - Inpatient

Blank

Column 2 - Outpatient

Blank

Column 3 - Total

Enter on this line, in column 3, the result of dividing Line G, Column 3 provision for HSCRC regulated Uncompensated Care, by Line A, Column 3, gross HSCRC regulated patient services, e.g., 489.8 divided by 10,102.7 = .0485.

Line M - Ratio of Other Payers

Column 1 - Inpatient

Blank

Column 2 - Outpatient

Blank

Column 3 - Total

Enter on this line, in Column 3, the result of dividing Line G1, Column 3, total gross revenues for other payers by Line A, Column 3, gross HSCRC regulated patient revenues, e.g., 1,258.7 divided by 10,102.7 = .1245.

Round each result to 4 decimal places.

Line N - Level III Costs

Column 1 - Inpatient

Blank

Column 2 - Outpatient

Blank

Column 3 - Total

Enter on this Line, Column 3, the total Level III Costs from Schedule MA, Column 3, Line B.

Differential Calculation Section

Line O - HSCRC Regulated Gross Revenue

Column 1 - Inpatient

Blank

Column 2 - Outpatient

Blank

Line O - Column 3 Total

Enter on this line in Column 3, the result of solving the following equation for 0:

0 = 0 (.06H + .025I + .02I1 + .06J + .02K + L + .02M) + N, e.g., 0 = 0 [.06(.3783) + .0225(.3046) + .02(.1016) + .06(.0425) + .02(.0050) + .0485 + .02(.1245)] + 19,938.1 = 22,189.7

Round each result to 1 decimal place (nearest hundred).

Note: The above formula is derived from the following calculation:

0 = 0[.06H + .0225(I) + .02(I1 + J + K + M) + L] + N where:

.06H = Medicare and Medicaid differential
.04 (+J) = MCO differential
.0225 (I) = Cash discount for inpatient Blue Cross working capital paid at admission
.02 (I1 + J + K + M) = Working capital provision or cash discount provision for Outpatient Blue Cross, HMO/MCO, self pay, commercial insurance patients.

L = Charity and Bad Debt provision
N = Level III Costs

Line P - Payor Differential

Column 1 - Inpatient

Blank

Column 2 - Outpatient

Blank

Column 3 - Total

Enter on this line, in Column 3, the result of subtracting the results of dividing Line O, HSCRC regulated gross revenue, by Line N, Level III Costs, from 1, e.g., 1 – (22,189.7 divided by 19,938.1) = .1129

Round each result to 4 decimal places.

SCHEDULES M, MA, MC AND MD - REVENUE CENTER RATE SUMMARY .85

Overview .851

Schedules M and MA (Schedules MC and MD for Private Psychiatric Hospitals) are provided to enable each hospital to develop rates for each D Schedule.

Schedules M and MA are divided into 5 levels:

Schedule M

Level I -	Col. 2	Direct Expenses from D Schedules.
	Col. 3	Patient Care Overhead Expenses from Schedule C -Lines C1, C2, C6, C7, C8, C14, via Schedules J1 and J2, Column 7.
	Col. 4	Other Overhead Expenses from Schedule C- Lines C3, C4, C5, C9, C10, C11, C12, C13 and UA via Schedules J1 and J2, Column 12.
	Col. 5	N/A
	Col. 6	Physician Support Services from Schedules P3A to P3H.
	Col. 7	Resident and Intern Services From Schedules P4A to P4I plus P5A to P5H.
Level II	Col. 9	Building and General Equipment allowance
	Col. 10	Departmental Equipment Allowance.

Schedule MA

Level III	Col. 1	Direct Other Financial Considerations.
	Col. 2	Allocated Other Financial Considerations.
Level IV	Col. 4	Payor Differential.
Level V	Col. 6	Cross Subsidy.
	Col. 7	Miscellaneous Adjustments.
	Col. 8	HSCRC Adjustments.

Submit Schedules M and MA for the base year when realigning rates and submit schedules M and MA for the budget year when submitting a permanent rate application in accordance with COMAR 10.37.10.03 or COMAR 10.37.10.04.

Detailed Instructions .852

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Fiscal Year Line

Enter on this line the year for which the base year data is reported, e.g., 06–84.

Schedule M

Column 1 - Units of Measure

Lines A1 to A17

Enter on these lines, in the Units of Measure Column, the units of service transferred from Schedule V1A, Line G, Columns 1 to 6, Schedule V1B, Line G, Columns 1 to 6, and Schedule V1C, Line G, Columns 1 to 6 for the fiscal year.

Lines A18 to A22 and A24

Enter on these lines, in the Units of Measure Column, the units of service transferred from Schedule V2A, Line A, Columns 1 to 4 and Schedule V2A, Line A, Columns 1 to 3, for the fiscal year.

Lines A23 and A25 to A51

Enter on these lines, in the Units of Measure Column, the units of service transferred from Schedule V3A, Line O, Columns 1 to 8, Schedule V3B, Line O, Column 1 to 8, Schedule V3C, Line O, Columns 1 to 9, and Schedule V3D, Line O, Columns 1 to 9 for the fiscal year.

Line A 52

Enter on this line, in the Units of Measure Column, the units of service transferred from Schedule V1C, Line A, Column 4, for the fiscal year.

Lines A53 and A54

Enter on these lines, in the Units of Measure Column, the units of service transferred from Schedule V5, Line U, Column 1 for the fiscal year.

Column 2 - Direct Expenses

Lines A1 to A54

Enter on these lines, in the Direct Expenses Column, the base year expenses adjusted from Schedule D, Line F, Column 4, for the fiscal year.

Line B - Totals

Enter on this line, in the Direct Expenses Column, the result of adding the direct expenses from Lines A1 to A54.

Column 3 - Patient Care Overhead Expenses

Lines A1 to A54

Enter on these lines, in the Patient Care Overhead Expenses Column, the patient care overhead expenses transferred from Schedule J1. Lines B1 to B25, Column 7, and Schedule J2, Lines B26 to B52, Column 7, for the fiscal year.

Line B - Totals

Enter on this line, in the Patient Care Overhead Expenses Column, the result of adding the patient care overhead expenses from Lines A1 to A54.

Column 4 - Other Overhead Expenses

Lines A1 to A54

Enter on these lines, in the Other Overhead Expenses Column, the other overhead expenses transferred from Schedule J1, Lines B1 to B25, Column 12, and Schedule J2, Lines B26 to B52, Column 12, for the fiscal year.

Line B - Totals

Enter on this line, in the Other Overhead Expenses Column, the result of adding other overhead expenses from Lines A1 to A54.

Column 5 - N/A

Column 6 - Physician Support Expenses

Lines A1 to A54

Enter on these lines, in the Physician Support Expenses Column, the fiscal year expenses adjusted transferred from Schedules P3A to P3F, Line D, Columns 1 to 7, for the fiscal.

Line B - Totals

Enter on this line, in the Physician Support Expenses Column, the total Physician support expenses from Schedule P3H, Line D, Column 7, for the fiscal year.

Verify that the result of adding the physician support expenses from Lines A1 to A54 equals the total physician support expenses on Line B, Column 6.

Column 7 - Resident, Intern Expenses

Lines A1 to A54

Enter on these lines, in the Resident, Intern Expenses Column, the base year expenses adjusted transferred from Schedules P4A to P4H and P5A to P5H, Line D, Columns 1 to 7, and Schedules P4I and P5I, Line D, Columns 1 to 6, for the fiscal.

Line B - Totals

Enter on this line, in the Resident, Intern Expenses Column, the total resident, intern expenses from Schedule P4I and P5I, Line I, Column.

Verify that the result of adding the resident, intern expenses from Lines A1 to A54 equals the total resident, intern expenses on Line B, Column 7.

Column 8 - Level I

Lines A1 to A54

Enter on these lines, in the Level I Column, the result of adding Column 2, Direct Expenses Column 3, Patient Care Overhead Expenses; Column 4, Other Overhead Expenses; Column 6, Physician Support Expenses; and Column 7, Resident, Intern Expenses.

Line B

Enter on this line, in the Level I Column, the result of adding Column 2, Direct Expenses; Column 3, Patient Care Overhead Expenses; Column 4, Other Overhead Expenses; Column 6, Physician Support Expenses; and Column 7, Resident, Intern Expenses.

Verify that the result of adding the Level I expenses from Lines A1 to A54 equals the Level I expenses on Line B, Column 8.

Column 9 - CFA, Building and General Equipment

Lines A1 to A54

Enter on these lines, in the CFA, Building and General Equipment Column, the CFA allowance transferred from Schedule H3A, Column 2, Column 5, and Column 6, Lines H1 to H31 and from Schedule H3B, Column 2, Column 5, and Column 6, Lines H32 to H51, for the fiscal year.

Line B

Enter on this line, in the CFA, Building and General Equipment Column, the result of adding the CFA allowance from Lines A1 to A54.

Column 10 - CFA, Departmental Equipment

Lines A1 to A54

Enter on these lines, in the CFA, Departmental Equipment Column, the CFA allowance transferred form Schedule H3A, Column 3, Column 4 and Column 7, Lines H1 to H31 and from Schedule H3B, Column 3, Column 4 and Column 7, Lines H32 to H51, for the fiscal year.

Line B

Enter on this line, in the CFA Departmental Equipment Column, the result of adding the CFA allowance from Lines A1 to A54.

Column 11 - Level II

Lines A1 to A54

Enter on these lines, in the Level II Column, the result of adding Column 8, Level I; Column 9, CFA, Building and General Equipment; and Column 10, CFA, Departmental Equipment.

Verify that the result of adding the Level II expenses from Lines A1 to A54 equals the Level II expenses in Line B, Column 11.

Schedule MA

Column 1 - OFC Direct

Lines A1 to A54

Enter on these lines, in the OFC direct Column, the OFC allocated from Schedule G, Line R, for the fiscal year.

In no case shall the total individual positive direct offset entries in this column exceed the total positive direct offset approved, by the commission, in the hospital's most recent full rate setting. In addition, in no case shall the total individual negative entries in this column exceed the total negative direct offset approved in the hospital's most recent full rate setting.

Except when filed as part of a full rate application, total direct offsets to rates are limited to the amount of direct offsets to rates approved, by the Commission, in the hospital's most recent full rate setting. (See Commission Policy #12)

Submit details for any direct offset.

Line B

Enter on this line, in the OFC, Direct columns, the result of adding the OFC, Direct from Lines A1 to A54.

Column 2 OFC. Percentage

Lines A21 to A54

Enter on these lines, in the OFC, Percentage Column, the result of multiplying the Other Financial Consideration Percentage from Schedule G, Line S, Column 3, by the Level II Costs from Schedule M, Column 11, Lines A1 to A54 for the fiscal year (.0589)(178.1) = 10.5.

Round each result to 1 decimal place.

Line B

Enter on this line, in the OFC, Percentage Column, the result of adding the OFC, from Lines A1 to A54.

Column 3 - Level III

Lines A1 to A54

Enter on these lines, in the Level III Column, the results of adding Schedule M, Column 11, Level II; Schedule MA, Column 1, OFC, Direct; and Column 2, OFC, Percentage.

Line B

Enter on this line, in the Level III Column, the result of adding Schedule M, Column 11, Level II; Schedule MA, Column 1, OFC, Direct, and Column 2, OFC, Percentage.

Verify that the result of adding the Level III expenses from Lines A1 to A54 equals the Level III Expenses on Line B, Column 3.

Column 4 - Payor Differential

Lines A1 to A54

Enter on these lines, in the payor Differential Column, the results of multiplying the Payor Differential from schedule PDA, Column 3, Line P by the Level III Costs from Schedule MA, column 3, Lines A1 to A54 for the fiscal year, e.g., 129.7 × 1189 = 15.4

Round each result to 1 decimal place.

Line B

Enter on this line, in the Payor Differential Column, the result of adding the Payor Differential from Lines A1 to A54.

Column 5 - Level IV

Lines A1 to A54

Enter on these lines, in the Level IV Column, the results of adding Column 3, Level III; and Column 4, Payor Differential.

Line B

Enter on this line, in the Level IV column, the result of adding Column 3, Level III; and Column 4, Payor Differential.

Verify that the result of adding the Level IV revenue from Lines A1 to A54 equals the Level IV revenue on Line B, Column 5.

Column 6 - Cross Subsidy

Lines A1 to A54

Enter on these lines, in the Cross Subsidy Column, the amount of cross subsidy currently in rates when submitting a rate realignment or the amount of cross subsidy requested when submitting a permanent rate application.

Line B

Enter on this line, in the Cross Subsidy Column, the result of adding the cross subsidy from Line A1 to A54.

Column 7 - Miscellaneous Adjustments

Lines A1 to A54

Enter on this line, in the Miscellaneous Adjustment Column, any miscellaneous adjustment to rates such as the retrospective adjustments for price and volume and unusual costs utilizing the IAS up to the date the requested rates are to be effective.

Note: This column should not be completed for realignment of rates.

Line B

Enter on this line, in the Miscellaneous Adjustment Column, the result of adding the miscellaneous adjustments from Lines A1 to A54.

Column 8 - HSCRC Adjustments

Lines A1 to A54

Line B

This column is reserved for HSCRC use for rate realignment and adjustments to individual rates via rate applications.

Column 9 - Adjusted Level IV

Lines A1 to A54

Enter on these Lines, in the Adjusted Level IV Column, the results of adding Column 5, Level III; Column 6, Cross Subsidy; and Column 7, Miscellaneous Adjustments when submitting permanent rate applications.

Note: This column should not be completed when submitting for rate realignment.

Line B

Enter on this line, in the Adjusted Level IV Column, the result of adding the adjusted Level IV revenue from Lines A1 to A54.

Column 10 - Average Rates

Lines A1 to A54

Enter on these lines, in the Average Rates Column, the result of dividing Column 9, Adjusted Level IV, by Schedule M, Column 1, Units of Measure, e.g., 99.6 ÷ 3.589 = 27.7515.

Round each result to 4 decimal places.

Note: This column should not be completed for realignment of rates.

Round each result to 4 decimal places.

Note: This column should not be completed for realignment of rates.

FOR FUTURE USE

SCHEDULE MB - PHYSICIANS PART B SERVICES (NON-MEDICARE) .88

Overview .881

Schedule MB is provided to enable each hospital to develop rates for Physicians Part B Services Revenue Center, Schedules P2A - P2H. Schedule MB is divided into 4 sections:

Schedule MB

Section 1	Col. 2	Direct expenses from Schedule P2A to P2H, Line A.
	Col. 3	Overhead expenses from Schedule OES, Line P
Section II	Col. 5	Other financial considerations.
Section III	Col. 7	Payor Differential
Section IV	Col. 9	Miscellaneous adjustments
	Col 10	HSCRC adjustments

Schedule MB must be completed for all hospitals with non-Medicare Part B Physicians costs in rates.

Submit Schedule MB for the budget year when submitting a permanent rate application in accordance with COMAR 10.37.10.03 or COMAR 10.37.10.04.

Detailed Instructions .882

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line the year for which the base year data is reported, e.g., 06–80.

Budget Year Line

Enter on this line the year for which the budgeted data is reported, e.g., 06–81.

Schedule MB

Column 1 - Units of Measure

Lines A1 to A54

Enter on these lines, in the Units of Measure Column, the units of service for the budget year.

Round each entry to 3 decimal places, e.g., 42,345 units is entered as 42.345.

Column 2 - Direct Expenses

Lines A1 to A54

Enter on these lines, in the Direct Expenses Column, the base year expenses adjusted from Schedules P2A to P2G, Line D, and schedule P2H, Columns 1 thru 6, for the base year or the budget year expenses from Schedules P2A to P2G, Line I, Columns 1 thru 7 and Schedule P2H Columns 1 thru 6, for the budget year.

Line B - Totals

Enter on this line, in the Direct Expenses Column the result of adding the direct expenses from Lines A1 to A54.

Column 3 - Overhead Expenses

Lines A1 to A54

Enter on these lines, in the Overhead Expenses Column, the overhead expenses transferred from Schedule OES, Line P, Column 2.

Line B - Totals

Enter on this line, in the Overhead Expenses Column, the result of adding the overhead expenses from Lines A1 to A54.

Column 4 - Section I

Lines A1 to A54

Enter on these lines, in the Section I Column, the results of adding Column 2, Direct Expenses; Column 3 and Overhead Expenses.

Line B

Enter on this line, in the Section I Column, the result of adding Column 2, Direct Expenses and Column 3, Overhead Expenses.

Verify that the result of adding the Sub-total expenses from Lines A1 to A54 equals the sub-total expenses on Line B, Column 4.

Column 5 - OFC

Lines A1 to A54

Enter on these lines, in the OFC Column, the OFC allocated from Schedule G, Line R, for the base year or from Schedule G, Column 5, Line R, for the budget year.

Submit details for any direct offset.

Line B

Enter on this line, in the OFC, Columns, the result of adding the OFC from Lines A1 to A54.

Column 6 - Section II

Lines A1 to A54

Enter on these lines, in the Section II Column, the results of adding Column 4, Section I and Column 5, OFC.

Line B

Enter on this line, in the Section II Column, the result of adding Column 4, Section I and Column 5, OFC.

Verify that the result of adding the Section II expenses from Lines A1 to A54 equals the expenses on Line B, Column 6.

Column 7 - Payor Differential

Lines A1 to A54

Enter on these lines, in the Payor Differential Column, the results of multiplying the Payor Differential from Schedule PDA, Column 1, Line P by the Section II Costs, Column 6, Lines A1 to A54 for the base year or multiplying the payor differential from Schedule PDA, Column 2, Line P by the Section II Costs, Column 6, Lines A1 to A54 for the budget year, e.g., 129.7 × .1189 = 15.4.

Round each result to 1 decimal place.

Line B

Enter on this line, in the Payor Differential Column, the result of adding the Payor Differential form Lines A1 to A54.

Column 8 - Total

Lines A1 to A54

Enter on these lines, in the Total Column, the results of adding Column 6, Section II; and Column 7, Payor Differential.

Line B

Enter on this line, in the Total Column, the result of adding Column 6, Section II; and Column 7, Payor Differential.

Verify that the result of adding the Total revenue from Lines A1 to A54 equals the total revenue on Line B, Column 8.

Column 9 - Adjustments

Lines A1 to A54

Enter on this line, in the Adjustment Column, any adjustment to Physicians Part B Services rates.

Line B

Enter on this line, in the Adjustment Column, the result of adding the adjustments from Lines A1 to A54.

Column 10 - Adjusted Total

Lines A1 to A54

Enter on these lines, in the Adjusted Total Column, the results of adding Column 8, Total and Column 9, Adjustments when submitting permanent rate applications.

Line B

Enter on this line, in the Adjusted Total Column, the result of adding the adjusted total revenue from Lines A1 to A54.

Column 11 - Average Rates

Lines A1 to A54

Enter on these lines, in the Average Rates Column, the result of dividing Column 10, Adjusted Total, by Column 1, Units of Measure, e.g., 99.6 divided by 3.589 = 27.7515.

Round each result to 4 decimal places.

SCHEDULE OES - ALLOCATION OF OVERHEAD EXPENSES .89

OVERVIEW .891

Schedule OES is provided to enable each hospital to distribute overhead expenses to benefiting cost centers.

Schedule OES must be completed for hospitals with approved Part B rates

Round expenses on Lines A to P to 1 decimal place (nearest hundred), e.g., $532,910.11 is entered 532.9.

Detailed Instructions .892

Heading Section

Institution Name Line

Enter on this line, the complete name of the reporting hospital.

Institution Number Line

Enter on this line, the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line, the year for which the base year data is reported, e.g., 06–84.

Base Year Data Section

Line A to O

Column 1

Enter on Lines A to O, in the Total Column, from the General Ledger, the total overhead expenses of the reporting hospitals incurred in the base year.

Distribution Section

Column 2 - Physicians Part B Services

Enter on lines A to O, in the Physicians Part B Services Column, the overhead expenses associated with non-Medicare Physicians Part B Services to be distributed to Physicians Part B Services, Revenue Center Rate summary, Schedule MB.

Column 3 - Data Processing

Enter on Line O, in the Data Processing Column, the data processing expenses not benefiting non-Medicare Physicians Part B Services. These expenses are to be distributed to a location of Data Processing, Schedule DP1, Line A.

Column 4

Enter on Lines A to N, in the General Service Center column, the general services expenses not benefiting non-Medicare Physicians Part B Services. These expenses are to be distributed to General Services Centers, Schedule C – Line C1 to C14.

Line P

Enter on this line in the Total Columns, Column 1; Physicians Part B Services, Column 2; Data Processing, Column 3; and General Services Centers, Column 4; the result of adding Lines A thru O.

Verify that the addition of the expenses in columns 2, 3 and 4 equal the expenses in Column 1. Total Expenses and that the sum of Column 1. Total Expenses equals the total overhead expenses on the hospital's general ledger excluding those associated with providing Physicians Part B Services to Medicare patients.

SCHEDULE UR TO UR8 - UNREGULATED ACTIVITIES .90

Overview .901

UR Schedules are provided to enable each hospital to report expenses, revenue and FTEs for unregulated patient care activities:

Nomenclature	Account Number	Code
UR1	Free Standing Clinic Services FSC	6970
UR2	Home Health Services HHC	6980
UR3	Outpatient Renal Dialysis ORD	7720
UR4	Skilled Nursing Care ECF	6610
UR5	Laboratory - Non Patient ULB	7720
UR6	Physicians Part B Services (Unregulated) UPB	8760
UR7	Certified Nurse Anesthetist CAN	7090
UR8	Physician Support Services (Unregulated)	8740

Unregulated activities are defined as all activities that are wholly owned by the hospital, including subsidiary corporations regardless of where the activity is physically located, by statute, not regulated by the Commission.

Report the applicable data for the operations of all unregulated activities that are wholly owned by the hospital, including subsidiary corporations regardless of where the activity is physically located. Do not report operations of distinct and separate divisions of the hospital's parent corporation not owned by the hospital.

Each unregulated activity schedule must be completed by the reporting hospital in accordance with the functional descriptions contained in Section 200.075, Daily Hospital Service Expenses and Section 200.076, Ambulatory Services Expenses.

If a hospital does not have the functions of a specific unregulated activity, the schedule must be submitted with the words "NOT APPLICABLE" printed on the top of the schedule. If additional UR schedules are needed report activities of other unregulated activities for which specific schedules have not been assigned, schedules designed UR with the next appropriate number should be submitted.

The column entitled Source indicates computations to be made or the source of the data requested.

Round the revenue/expenses on Lines B, C, D, E, F, G, H, I, J, K, L, M, N, and O to 1 decimal place (nearest hundred) e.g., $66,428.93 is entered as 66.4.

Round the expense/revenue per unit calculations in Column 4 to 5 decimal places, e.g., 99.6 divided by 9500 = .01048.

Round the FTE data on Lines P and Q to 1 decimal place, e.g., 22,612 hours divided by 2080 = 10.9.

Refer to Section 200.037, Natural Classification of Expense, for descriptions of the expense categories and Section 300, Account Distribution Index, for the distribution of various expenses by natural classification of expenses to functional cost centers.

The following is a listing of the unregulated service functions standard units of measure to be utilized for volume data:

Nomenclature	Standard Unit of Measure
UR1 Free Standing Clinic Services	Number of Visits
UR2 Home Health Services	Number of Visits
UR3 Outpatient Renal Dialysis	Number of Treatments
UR4 Skilled Nursing Care	Number of Patient Days
UR5 Laboratory - Non Patient	CAP, WMY, 1982 Edition
UR6 Physicians Part B Services	Number of FTE's
UR7 Certified Nurse Anesthetist	Number of CNA Minutes
UR8 Physician Support Services – Part B Services	Number of FTEs

The Volume Data Section, Base Year Section, Base Year Profit (Loss) Section and Line P of the FTE Data Section are required to be completed for the annual reporting requirements.

Detailed Instructions .902

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospitals Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line the year for which the base year data is reported, e.g., 06-86.

Budget Year Line

Enter on this line the year for which the budgeted data is reported, e.g., 06-86.

Volume Data Section

Line A - Volume Data

UR Schedules - Column 1

Enter on this line, on each applicable unregulated service schedule, in the Base Year Units column, the number of units of the reporting hospital for the base year.

UR Schedules - Column 2

Enter on this line, on each applicable unregulated service schedule, in the Budget Year Units Column, the number of units projected for the budget year.

Base Year Data Section

Line B - Base Year Expenses

UR Schedules - Column 1

Enter on this line, one each applicable unregulated service schedule, in the Wages, Salaries and Fringe Benefits Column; the expenses of the reporting hospital incurred in the base year for the following major natural classification of expense categories:

.10 Salaries and Wages
.20 Employee Benefits

Expenses which are normally reported as components of unregulated services functions for the above categories are:

.01 Management and Supervision
.02 Technician and Specialist
.03 Registered Nurses
.04 Licensed Vocational (Practical) Nurses
.05 Aides, Orderlies and Attendants
.06 Physicians
.07 Intern, Resident and Fellow
.08 Non-Physician Medical Practitioners
.11 Environment, Hotel, and Food Service Employees
.12 Clerical and Other Administrative Employees
.21 FICA
.22 SUI and FUI (UIC)
.23 Group Health Insurance
.24 Group Life Insurance
.25 Pension and Retirement
.26 Workmen's Compensation Insurance
.27 Union Health and Welfare
.28 Other Payroll Related Employee Benefits
.29 Employee Benefits (Non-Payroll Related)

Include only those non-payroll related employee benefits which are not allocated from Schedule OADP.

Schedule UR8 Physician Support Services – Part B

For Physician Support Services – Part B enter the salaries, compensation and fringe benefits expenses incurred for the direct patient care portion of the hospital's non-physician medical practitioners.

Non-Physician Medical Practitioners are:

Physician Assistants
Clinical Nurse Specialist
Nurse Practitioners
Clinical Psychologists
Other non-physician medical practitioners that can bill professionally

Please note the expenses in this column must be identical to the Medicare B expenses reported on W/S A-8-2 of the Medicare cost report. In addition hospitals must maintain time studies to support the expense reported on Schedule UR8. If no time studies are developed then the entire Physician Support Services expense per rate center should be reported on the hospital Schedule UR8.

UR Schedules - Column 2

Enter on this line, on each applicable unregulated service schedule, in the Other Expenses Column, the expenses of the reporting hospital incurred in the base year for the following major natural classification of expense categories:

.40 Medical and Surgical Supplies
.50 Non-Medical and Non-Surgical Supplies
.60 Utilities
.70 Purchased Services
.80 Other Direct Expenses

Expenses which are normally reported as components of unregulated service functions for the above categories are:

.49 Other Medical Care Materials and Supplies
.51 Food - Meats, Fish and Poultry
.52 Food - Other
.53 Tableware and Kitchen Utensils
.55 Cleaning Supplies
.56 Office and Administrative Supplies
.57 Employee Wearing Apparel
.66 Purchased Steam
.71 Medical
.72 Maintenance
.74 Laundry and Linen
.81 Insurance
.82 Interest
.84 Dues, Books and Subscriptions
.85 Outside Training Sessions
.86 Travel - Other
.87 Postage
.88 Printing and Duplicating

UR Schedules - Column 3

Enter on this line, on each unregulated service schedule, in the Total Expenses, Revenue Column, the result of adding the base year expenses from Columns 1 and 2.

Transfer the total expenses from Column 3 of Schedule UR1 to UR6 to Schedule RC, Line J.

Line C - Allocation from Cafeteria, Parking, Etc.

Columns 1, 3

Enter on this line, on each applicable unregulated service schedule in the Wage, Salaries and Fringe Benefits Column and the Total Expenses, Revenue Column, the allocation of cafeteria, parking, etc. from Schedule OADP, Column 2.

Lines D1 to D6 - Allocations from General Service Centers & Unassigned Expense Centers

Cost Center Column

Enter on these lines, on each applicable unregulated service schedule, in the Cost Center Column, the nomenclature of the general service center or unassigned expense center from which costs are being allocated, e.g., Housekeeping.

Code Column

Enter on these lines, on each applicable unregulated service schedule, in the Code Column, the code for the general service center or unassigned cost center expense located in Appendix C, e.g., HKP.

Source Column

Enter on these lines, on each applicable unregulated service schedule, in the Source Column, the general service center schedule or unassigned expense center, e.g., C6.

Column 1

Enter on these lines, on each applicable unregulated service schedule, in the Wages, Salaries and Fringe Benefits Column, the wages, salaries and fringe benefits expenses from each applicable general service center schedule, Schedules C1 to C4, Line B, Column 1.

Column 2

Enter on these lines, on each applicable unregulated service schedule, in the Other Expenses Column, the other expenses from each applicable general service center schedule, Schedules C – Line C1 to C14, Column 2 or unassigned expense schedule, Schedule UA, Line B, Columns 1, 2, 4, 5, 6, 7, 8.

Column 3

Enter on these lines, on each applicable unregulated service schedule, in the Total Expenses, Revenue Column, the total expenses from each applicable general service center schedule, Schedules C – Line C1 to C14, or unassigned expense schedule, Schedule UA, Line B, Column 9.

Line E - Capital Facilities Allowance

Column 2

Enter on this line, on each applicable unregulated service schedule, in the Other Expense Column. Capital Facilities Allowance from Schedule H3 Column 8.

Column 3

Enter on this line, on each unregulated service schedule, in the Total Expenses Revenue Column, the Capital Facilities allowance from Column 2.

Line F - Base Year Adjusted Expenses

Columns 1, 2, 3

Enter on this line, on each unregulated service schedule in each expense column and the Total Expenses/Revenue Column, the result of adding Line B, Base Year Expenses, Line C Allocation from Cafeteria, Parking, Etc. Lines D1 to D6. Allocations from General Service Centers and Line E, Capital Facilities Allowance.

Verify that the addition of the base year adjusted expenses in Columns 1 and 2 equal the total expenses in Column 3 for each unregulated service.

Column 4
Enter on this line, on each unregulated service in the Expense, Revenue Per Unit Column, the result of dividing Line F, Column 3, by Line A, Column 1, e.g., 140.0 divided by 10,000 = .01400.

Base Year Profit (Loss) Section

Line G - Base Year Revenue

Column 3

Enter on this line, on each applicable unregulated service schedule, in the Total Expense, Revenue Column, the revenue of the reporting hospital generated in the Base Year.

Line H - Profit (Loss)

Column 3

Enter on this line, on each applicable unregulated service schedule, in the Total Expense, Revenue Column, the result of subtracting Line F, Base Year Adjusted Expenses, from Line G, Base Year Revenue.

Enter a loss in brackets, e.g., 100.9 – 210.9 = (110.0).

Budget Year Data Section

Line I - Inflation

Columns 1, 2

Enter on this line, on each applicable unregulated service schedule, in each expense column, the projected inflation for the budget year, utilizing Commission supplied inflation factors, price leveled for the appropriate time period, e.g., (101.9)(.07)(1.5) = 10.7.

Column 3

Enter on this line, on each unregulated service schedule, in the Total Expenses, Revenue Column, the result of adding the inflation from Columns 1 and 2.

Line J - Miscellaneous Adjustments

Columns 1, 2

Enter on this line, on each applicable unregulated service schedule, in each expense column, the projected miscellaneous adjustments for the budget year.

Miscellaneous adjustments are defined as planned increases in costs not accounted for on Line K, e.g., projected salary increases above the Commission supplied inflation factor.

Column 3

Enter on this line, on each unregulated service schedule, in the Total Expenses, Revenue Column, the result of adding the miscellaneous adjustments from Columns 1 and 2.

Line K - Budget Year Expenses

Columns 1, 2, 3

Enter on this line, on each unregulated service schedule, in each expense column and the Total Expenses, Revenue Column, the result of adding Line F, Base Year Adjusted Expenses, Line I, Inflation and Line J, Miscellaneous Adjustments.

Verify that the addition of the budget year expenses in Columns 1 and 2 equal the total expenses in Column 3 for each unregulated service schedule.

Transfer the total expenses from Column 3 of Schedule UR1 to UR6 to Schedule RC, Line J, Column 2, Budget Year.

Column 4

Enter on this line, on each unregulated service schedule, in the Expenses, Revenue Per Unit Column, the result of dividing Line K, Column 3, by Line A, Column 2, e.g., 160.0 divided by 10,000 = .01600.

Budget Year Profit (Loss) Section

Line L - Base Year Revenue

Column 3

Enter on this line, on each applicable unregulated service schedule, in the Total Expenses, Revenue Column, the revenue of the reporting hospital generated in the base year.

Line M - Adjustments

Column 3

Enter on this line, on each applicable unregulated service schedule, in the Total Expenses, Revenue Column, adjustments to the base year revenue.

Line N - Budget Year Revenue

Column 3

Enter on this line, on each applicable unregulated service schedule, in the Total Expense, Revenue Column, the result of adding Line L, Base Year Revenue, and Line M, Adjustments.

Line O - Profit (Loss)

Column 3

Enter on this line, on each applicable unregulated service schedule, in the Total Expenses, Revenue Column, the result of subtracting Line K, Budget Year Expenses, from Line N, Budget Year Revenue.

Enter a loss in brackets, e.g., 180.7 – 190.9 = (10.2).

FTE Data Section

Line P - Adj. Base Year Hours Worked Divided by 2080

Enter on this line, on each applicable unregulated service schedule, in the Wage, Salaries and fringe Benefits Column, the result of dividing the adjusted base year hours worked by 2080, e.g., 10,912 divided by 2080 = 5.2.

Worked hours are to be counted in accordance with Section 200.0371, Salaries and Wages. Include hours worked for allocations from general service centers and donated services.

Transfer the FTEs on Line D of each auxiliary enterprise center schedule, to Schedule OAK, on the appropriate Lines, Column 1, Number of FTEs.

Line O - Budget Year Hours Worked Divided by 2080

Column 1

Enter on this line, on each unregulated service schedule, in the Wage, Salaries and fringe Benefits Column, the result of dividing the budget year hours worked by 2080, e.g., 20,500 divided by 2080 = 9.9.

SCHEDULE URS - UNREGULATED SERVICES SUMMARY .903

Overview

Schedule URS is provided to enable each hospital to report the name and location of each unregulated service provided by the hospital.

Detailed Instructions

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line the year for which the base year data is reported e.g., 06–01.

Budget Year Line

Enter on this line the year for which the budgeted data is reported e.g., 06–02.

Entity Name and Address column

On each line in the Entity Name and Address column enter the Legal Name and Address and the Trade Name and physical address. Attach additional sheets as necessary.

Nature of Service column

On each line in the Nature of Service column enter the sub-specialty, e.g., Home Infusion, DME. etc. Attach additional sheets as necessary

Schedule ACS - Annual Cost Survey .92

Overview .921

Schedule ACS is provided to enable each hospital to report the breakdown of their HSCRC regulated costs and to calculate the percentage of the hospital's total costs.

Schedule ACS must be reported for all hospitals.

Round all entries in Column 1 to one (1) decimal place (nearest hundred), e.g., $123,456.78 is entered as $123.5.

Round the calculation in Column 2, Lines A through U to one (1) decimal place, e.g., 12.3 / 900.1 = .0137 is entered as 1.4.

Detailed Instructions .922

Heading Section

Institution Name Line

Enter on this line, the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line, the year for which the base year data is reported, e.g., 06–04.

Base Year Data Section

Column 1 - Costs

Line A - Wages and Salaries

Line B - Fringe Benefits

Line C - Depreciation and Amortization

Enter on this line the depreciation expense of hospital owned property and property capitalized under FASB 13 used in regulated hospital services.

Line C1 - Operating Leases

Enter on this line the leased equipment not eligible for capitalization under FASB 13. Report temporary rentals of equipment on line T Other. Report maintenance contracts on line J Contracted Services.

Line D - Interest Expense

Line E - Medical and Surgical Supplies

Surgical instruments	clamps, scissors, scalpels, stethoscopes
Gloves	used for medical surgical procedures
Pacemakers	permanent and temporary
Other supplies	sutures, intra ocular lens, unipaks, needles, dressings, thermometers, admission kits, syringes, identifications bracelets, and other medical supplies

Line F - I. V. Solutions and Pharmacy

I. V. Solutions	including blood substitutes, salines, sugar, plasma, albumin and others
Pharmacy	all types of drugs including but not limited to: antibiotics, tranquilizers, analgesic/anti-inflammatory, TPN's/VITS/electrolytes, EENT, oncology, cardiovascular/blood, respiratory, GI, GU and steroids

Line G - Laundry, Linen, Uniforms

Laundry, linen, uniforms	all purchased laundry services, including washing costs and replacement of linen, disposable linens, uniforms, drapes, curtains

Line H - Films and Solutions

Films and solutions	includes materials sensitive to light, radioactive radiation for recording emissions, X-ray film, dental packs, Polaroid film, solutions for automatic developing, hyposulfites, drying agents and replenishes

Line I - Blood, Plasmanate, Albumen

Blood, plasmanate, albumen	micro hogan, enhancement solutions, antilectin, anti=IGC, blood and blood derivatives, media

Contracted Services

Contracted services	purchased lab services, trash collection, purchased security, outside collection agency expense equipment maintenance contracts

Line K - Professional Fees

Professional fees	Consultant fees, legal fees, accounting fees

Line L - Agency Nurses

Agency nurses	includes all costs of agency nurses

Line M - Malpractice Insurance

Malpractice insurance

Line N - All Other Insurance

Insurance	insurance loss of income, property and liability coverage, crime and employee dishonesty, excess indemnity, director and officers liability, auto

Line O - Telephone

Telephone	telephone equipment cost, message unit cost, and service charges for local and long distance calls

Line P - Utilities and Water

Utilities	All utility expenses for heating and air conditioning such as electricity, gas and/or oil, expenses for water and sewerage
Water	

Line Q - Food

Food	includes all food and beverage costs

Line R - Printing, Office Supplies, Copying, Postage

Printing	pre-printed forms, letterheads, lab request cards, doctors orders sheets, admissions forms
Office supplies	envelopes, memo pads, typewriter ribbons, folders, pens, pencils
Paper supplies	drink cups, paper towels, toilet tissue, napkins, paper bags, data processing supplies
Books, periodicals, and publications	subscriptions to newspapers, periodicals, books, journals
Computer supplies	paper supplies for computer and other automated equipment supplies
Copying and postage	
Other Expenses	education materials, microfilming, etc.

Line S - Chemicals, Solutions, Lubrications, Gases

Chemicals, solutions, lubrications, gases	chemicals and reagents used mostly in laboratories, gases, irrigating fluids, anesthetic agents and lubricants

Line T - Other

Repairs, maintenance and building supplies	building, equipment and instrument repairs, grounds care supplies, plumbing, printing, electrical, carpentry supplies, and inspections of medical equipment
Equipment rental	all rental of equipment
Travel and registration	travel expenditures including meals, tips, fares, lodging and entertainment, conferences and seminars both in and out of town, taxi cab fares
Radiology and laboratory supplies	radiology and nuclear medicine supplies including but not limited to radioisotopes, screen hangers, x-rays accessories, lab supplies including plastics and disposables, etc.
Other	includes housekeeping supplies, dietary supplies (glassware, utensils, etc.) licenses and permits

Line U - Total

Enter on this line in the cost column, the result of adding Lines A through T. Total costs should equal the sum of the above and should equal HSCRC regulated expenses for the fiscal year.

Column 2 - Percent

Lines A to T

Enter on lines A to T, in the Percent Column, the result of dividing each line by the total costs (line U col. 1)

Line U - Total

Enter on this line in the percent column, the result of adding Lines A through T. This total should always be 100%.

Schedule TRE – Transactions with Related Entities .93

Overview .931

Schedule TRE is provided to enable each hospital to report significant transaction between the hospital and related entities, for the current fiscal year.

A. A related entity is an entity which can exercise control or significant influence over the management or operating policies of another entity, to the extent that one of the entities is , or may be prevented from fully pursuing its own separate interests.

B. Examples of related entity transactions include transactions between (1) parent and its subsidiaries (2) subsidiaries of a common parent (3) an entity and trusts for the benefit or employees, that are managed by or under the trusteeship of the entities' management (4) an entity and its principal owners, management, or members of their immediate families; (5) affiliates (An entity that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control of another entity). ; and (6) an entity and joint venture whose participants include the entity or a related entity

C. Significant transactions, for the purpose of this schedule, are those in which the value of the assets or services transferred are greater than $10,000. Report only the value of the asset or service provided to or from the Hospital.

Example: If the hospital has provided $10,000 of laboratory services to a related entity only "Value of Asset or Service Provided by the Hospital" column should be completed and coded "A" even thought he hospital has or will be paid by the related entity for these services.

A transaction of $10,000 that is recorded on TRE Schedule in both "Value of Asset or Service Provided To the Hospital" columns would be interpreted as both entities $10,000 of laboratory services to each other.

Detailed Instructions .932

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital located in appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099

Statement Section

Assign a number to each transaction between the hospital and related entity. The numbers assigned should be based upon the date of the transaction, beginning with the first transaction of the hospital's fiscal year. (Transactions which occur on a regular basis during the period may be summarized.) Report only one transaction per line.

Assign to each transaction the appropriate transaction category code:

Category Code	Category Description
A	Related entity has purchased services or staff support support (includes benefit costs) from hospital.
B	Hospital has purchased service or staff support (includes benefit costs) from related entity.
C	Related entity has purchased supplies or other non-capital related items from hospital.
D	Hospital has purchased supplies or other non-capital related item from related entity.
E	Related entity has purchased office space or equipment from hospital.
F	Hospital has purchased office space or equipment from hospital.
G	Hospital has provided a loan, loan repayment, working capital, or equity investments to related entity.
H	Related entity has provided a loan, loan repayment, working capital, or equity investments to hospital.
I	Hospital has provided a grant or gift to related entity.
J	Related entity has provided a gift or grant to hospital.

Column 1

Enter in this column the number assigned to each transaction between the hospital and related entity.

Column 2

Enter in this column, for each transaction between the hospital and related entity, the name of the related entity.

Columns 3

Enter in this column the value of the asset or service provoked to the hospital from the related entity.

Column 4

Enter in this column the value of the asset or service provided by the hospital to the related entity.

Column 5

Enter in this column, for each transaction between the hospital and the related entity, the transaction category.

Column 6

Enter in this column a brief description of each transaction. If necessary, submit details of the transaction of a separate schedule.

The total of Column 3, value of assets or services provided to hospital, and 4, value of assets or services provided by hospital, must agree with the hospital's audited financial statements. Schedule TRE must be completed for all hospitals.

Schedules PH1 and PH2 - Schedules D Personnel Schedules 1.00

Overview 1.01

Schedules PH1 and PH2 are provided to enable each private psychiatric hospital to report the salary expenses and FTE's listed on D Schedules by the following personnel categories:

Nomenclature

Licensed Psychologists

Licensed Social Workers

Registered Nurses

Licensed Practical Nurses

Other Nursing Staff - Mental Health Workers Psychiatric Technicians, Nursing Aides, etc. - all other non-licensed workers who work under the supervision of nurses.

All Other Patient Care Givers - Therapists - Occupational, Recreational, etc. - Counselors, Coordinators, etc. - and their staff.

Unit Clerical Staff - Unit Clerks, Ward Clerks, etc.

Round salary expenses to 1 decimal place (nearest hundred), e.g. $50,000.10 is entered as $50.0

Detailed Instructions 1.02

Heading Section

Institution Name Line

Enter on this line, the complete name of the reporting hospital.

Institution Number Line

Enter on this line, the number assigned to the reporting hospitals located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Column 1

Enter on the appropriate line, A1 to X1, the base year adjusted salary expense from the applicable Schedule D, Line F, Column 1 for Licensed Psychologists.

Column 2

Enter on the appropriate line, A1 to X1, the base year adjusted salary expense from the applicable Schedule D, Line F, Column 1 for Licensed Social Workers.

Column 3

Enter on the appropriate line, A1 to X1, the base year adjusted salary expense from the applicable Schedule D, Line F, Column 1 for Registered Nurses.

Column 4

Enter on the appropriate line, A1 to X1, the base year adjusted salary expense from the applicable Schedule D, Line F, Column 1 for Licensed Practical Nurses.

Column 5

Enter on the appropriate line, A1 to X1, the base year adjusted salary expense from the applicable Schedule D, Line F, Column 1 for Other Nursing Staff.

Column 6

Enter on the appropriate line, A1 to X1, the base year adjusted salary expense from the applicable Schedule D, Line F, Column 1 for All Other Patient Care Givers.

Column 7

Enter on the appropriate line, A1 to X1, the base year adjusted salary expense form the applicable Schedule D, Line F, Column 1 for Unit Clerical Staff.

Column 8

Enter on this line the total salary expenses, the result of adding the salary expenses in column 1 thru 7. This total should equal the total salaries on Line B, Column 1 of the applicable Schedule D.

Column 1

Enter on the appropriate line, A2 to X2, the base year FTE's from the applicable Schedule D, Line P, Column 1 for Licensed Psychologists.

Column 2

Enter on the appropriate line, A1 to X2, the base year FTE's from the applicable Schedule D, Line P, Column 1 for Licensed Social Workers.

Column 3

Enter on the appropriate Line, A2 to X2, the base year FTE's from the applicable Schedule D, Line P, Column 1 for Registered Nurses.

Column 4

Enter on the appropriate line, A2 to X2, the base year FTE's from the applicable Schedule D, Line P, Column 1 for Licensed Practical Nurses.

Column 5

Enter on the appropriate line, A2 to X2, the base year FTE's from the applicable Schedule D, Line P, Column 1 for Other Nursing Staff.

Column 6

Enter on the appropriate line, A2 to X2, the base year FTE's from the applicable Schedule D, Line P, Column 1 for All Other Patient Care Givers.

Column 7

Enter on the appropriate line, A2 to X2, the base year FTE's from the applicable Schedule D, Line P, Column 1 for Unit Clerical staff.

Column 8

Enter on this line the Total FTE's, the result of adding the FTE's in columns 1 thru 6. This total should equal the total FTE's on Line Q, Column 1, of the applicable Schedule D.

Line AA

Column 1 thru Column 8

Enter on this line the result of adding the salary expenses from lines A1 thru X1.

Line BB

Column 1 thru Column 8

Enter on this line the result of adding the FTE's from lines A2 thru X2.

Schedule TU - Utilization of Therapies Schedule 1.10

Overview 1.11

Schedule TU is provided to enable each private psychiatric hospital to report the number of hours of therapy that have been provided to patients in each patient care center.

Nomenclature	Account Number	Code
Individual Therapy	7671	ITH
Group Therapy	7672	GTH
Family Therapy	7673	FTH
Activity Therapy	7677	ATH
Psychological Testing	7675	PST
Education	7674	PSE

Detailed Instructions 1.12

Heading Section

Institution Name Line

Enter on this line, the complete name of the reporting hospital.

Institution Number Line

Enter on this line, the number assigned to the reporting hospitals located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line, the year for which the base year is reported, e.g. 06–90.

Base Year Data Section

Line A

Columns 1 thru 6
Enter on line A in the appropriate column, the number of hours of individual therapy provided to patients in each patient care center.

Line B

Columns 1 thru 6

Enter on line A, in the appropriate column, the number of hours of group therapy provided to patients in each patient care center.

Line C

Columns 1 thru 6

Enter on line A, in the appropriate column, the number of hours of family therapy provided to patients in each patient care center.

Line D

Columns 1 thru 6

Enter on line A, in the appropriate column, the number of hours of activity therapy provided to patients in each patient care center.

Line E

Columns 1 thru 6

Enter on line A, in the appropriate column, the number of hours of psychological testing provided to patients in each patient care center.

Line F

Columns 1 thru 6

Enter on line A, in the appropriate column, the number of hours of education provided to patients in each patient care center.

Lines G thru J

Columns 1 thru 6

Enter on line A, in the appropriate column, other therapies provided to patients in each patient care center.

Line K

Enter on this line in each column, 1 thru 7, the result of adding the hours on lines A thru J.

Column 7

Schedule TU - Utilization of Therapies Schedule

Lines A thru J

Enter on each line A thru J the result of adding the hours in column 1 thru 6. The total in this column should agree with the total hours on line A, column 1, of the schedule D of the therapy designated.

FOR FUTURE USE

Schedule D21A - Procedure Based Outpatient Surgery Supplemental Schedule 1.30

Overview 1.31

Schedule D21A is provided to enable hospitals to identify and report the FTE's, costs and volumes of the individual ancillary services that make the up the Outpatient Surgery - Procedure Based Center. Schedule D21. The information collected on this schedule when combined with the information on the appropriate D Schedules; Operating Room D24, Anesthesiology D25, Same Day Surgery D22, Medical/Surgical Supplies D26, and Cost of Drugs Sold D27, equal the total number of FTE's as well as the total number of units of service and the cost to produce them for each of the individual ancillary centers. Consolidation of FTE's costs and units of service is necessary so that the ancillary service information may be utilized in analyses, comparisons and rate review methodologies.

The entries on Line F; F.T.E.'s Column 1. Salaries and Fringe Benefits Column 3, Physician Supervision Expenses Column 4, Other Expenses Column 5, and Total Expenses Column 6 shall agree with the applicable totals on Schedules D21. Outpatient Surgery - Procedure Based.

Round the FTE data in Column 1, Line A through L to 1 decimal place, e.g., 22,612 hours divided by 2080 = 10.9.

Round the expenses on Lines A through K in Columns 2 through 5 to one decimal place (nearest hundred), e.g., 66,428.93 is entered as 66.4.

Detailed Instructions 1.32

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital. The assigned number corresponds to the last 4 digits of the reporting hospitals Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line the year for which the data is reported.

Column 1 - FTE's

Lines A through K

Enter on the appropriate lines the FTE's engaged in providing procedure based outpatient surgery services. FTE's are the result of dividing the hours worked by 2080, e.g., 10,912 divided by 2080 = 5.2.

Column 2 - Volumes

Lines A through K

Enter on the appropriate lines the volumes experienced in the base year to provide procedure based outpatient surgery services.

Column 3 - Salaries and Fringe Benefits

Enter on the appropriate lines the Salaries and Fringe Benefits Expenses incurred in the base year to provide procedure based outpatient surgery services.

Column 4 - Physician Supervision Expenses

Enter on the appropriate lines the physician supervision expenses incurred in the base year to provide procedure based outpatient surgery services.

Column 5 - Other Expenses

Enter on the appropriate lines the direct expenses other than salaries and fringe benefits incurred in the base year to provide procedure based outpatient surgery services.

Column 6 - Total Expenses

Enter on the appropriate lines the sum of Columns 2, salaries and fringe benefits Column 3, Physician Supervision Expenses and Column 4, other expenses.

Columns 1,3,4,5, and 6

Line L - Totals

Enter on this line in the appropriate column the sum of the entries on Lines A through K.

The entry on Line L. Column 5. Total Expenses shall agree with the entry on Column 4, Line F Total Expenses on Schedule D21. Outpatient Surgery - Procedure Based.

Schedule AR - 1 Capitation Income and Expense Report 1.40

Overview 1.41

Schedule AR-1 is provided to facilitate the reporting of income and expense information associated with managed care capitation arrangements on a calendar quarter and on an annual basis.

All income and expenses for all members covered under the managed care capitation arrangement shall be reported. All income and expenses amounts shall be provided on a paid basis.

Categories of expenses as reported on lines 10 through 81 are meant to be complete and mutually exclusive. That is, all expenses for services and supplies under the capitation arrangement must be reported in this schedule, and each expense must be reported only once.

Expenses which fall across two or more categories should be allocated using a reasonable approximation which does not systematically understate or overstate any of the categories.

Round all dollar amounts to 1 decimal place (nearest hundred), e.g. 66,428.93 is entered as 66.4.

Detailed Instructions 1.42

Heading Section

Hospital Name and Number Line

Enter on this line the complete name of the hospital responsible to ensure that this information be filed. Also enter on this line following the hospital's name the number assigned to the responsible hospital in Appendix B. The assigned number corresponds to the last 4 digits of the responsible hospital's Medicare Provider Number, e.g., 0099.

Period Ending Line

Enter on this line the period for which data is reported, e.g., 07-96 - 09/96.

Contact Person

Enter on this line the name of the person responsible for filling in this schedule.

Telephone Number

Enter on this line the telephone number of the person responsible for filling in this schedule.

Reporting Entity Name Line

Enter on this line the complete name of the entity reporting the information.

Paver/Contract Line

Enter on this line the complete name of the payer that has entered into the capitation arrangement with the reporting entity. In addition, enter on this line the contract number or other designation given the capitation arrangement for which this data is report.

Proceeding Number

Enter on this line the proceeding number of the Alternative Method of Rate Determination Application approved.

Line A - Member Months

Enter on this line the sum of the total number of paid members enrolled in each individual month of the period being reported. Members include all subscribers and all of their covered dependents. For members who enter or leave in the middle of a month, any reasonable approximation which does not systematically understate or overstate the time enrolled is acceptable.

Column 1 - Income Section

Line 1 - Capitation Income

Enter on this line the total revenue for all members under the capitation arrangement. The amount of revenue reported should correspond to the paid member months reported on Line A.

Line 2 - Reinsurance Recoveries

Enter on this line all income from reinsurance recovery payments received.

Line 3 - Other Income

Enter on this line all other income not reported on lines 1 and 2 above. Please provide a detailed description of the source and amounts of all income reported on this line.

Line 4 - Total Income

Enter on this line the sun of lines 1, 2 and 3 above.

Column 1 - Expense Section

Lines 10 to 14 - Total Inpatient Facility Expenses

Enter on these lines, in the total column, the expenses for inpatient facility expenses excluding mental health and substance abuse expenses.

Line 10 - Medical/Surgical - Acute, Pediatric - Acute and Definitive Observation

Enter on this line, in the total column, inpatient facility expenses for acute medical, surgical, pediatric, and definitive observation centers. Expenses for maternity centers or newborn nurseries should NOT be included here, but should be reported in Line 12.

Line 11 - Tertiary Care Expenses

Enter on this line the inpatient facility expenses for intensive care units, cardiac care units, trauma care units, burn centers, neo-natal intensive care units etc.

Line 12 - Maternity and Newborn Expenses

Enter on this line the inpatient facility expenses for obstetric units, birthing centers and newborn nurseries.

Line 13 - Rehabilitation Expenses

Enter on this line the inpatient facility expenses for physical rehabilitation units and facilities.

Line 14 - Extended Care Expenses

Enter on this line the inpatient extended care facility expenses, including expenses for care provided in skilled nursing facilities, intermediate care facilities, long term care facilities, hospices, and chronic hospital centers.

Lines 20 to 24 - Outpatient Facility Expenses

Enter on these lines, in the Total Column, the expenses for outpatient facility services excluding mental health and substance abuse expenses.

Line 20 - Ambulatory Services Expenses

Enter on this line the facility expenses for hospital based same day surgery centers and freestanding ambulatory surgery centers.

Line 21 - Emergency Department Expenses

Enter on this line the facility expenses for emergency departments, freestanding emergency services centers, outpatient trauma centers.

Line 22 - Imaging Expenses

Enter on this line the outpatient hospital-based and free-standing facility expenses for diagnostic imaging services (radiology, ultrasound, nuclear medicine, etc.).

Line 23 - Primary Care Expenses

Enter on this line the facility expenses for outpatient primary care services such as urgent care.

Line 24 - Other Expenses

Enter on this line the other outpatient facility expenses not included in the list above (except for psychiatric or substance abuse services which should be reported in lines 51 and 61). This includes specialty centers or facilities such as outpatient curative centers (chemotherapy, transfusions, etc.) and outpatient therapeutic centers (physical therapy, cardiac rehabilitation, etc.).

Lines 30 to 34 - Professional Services Expenses

Enter on these lines, in the Total Column, the expenses for Professional Services excluding mental health and substance abuse expenses.

Line 30 - Primary Care Expenses

Enter on this line the professional provider expenses for routine evaluation, management, and preventive care (except for maternity and newborn care which should be included in Line 33).

Primary care services include CPT codes:

Office/Outpatient Services:	99201-99205, 99211-99215
Preventive Medicine:	99381-99429, 99499
Immunization Injections:	90701-90749

Line 31 - Imaging Expenses

Enter on this line the professional provider expenses for diagnostic imaging services, including radiology, ultrasound, diagnostic nuclear medicine.

Imaging Services include CPT codes:

Diagnostic Radiology:	70010-76499
Diagnostic Ultrasound:	76506-76999
Nuclear Medicine:	78000-78999

Line 32 - Pathology (Surgical) Expenses

Enter on this line the professional provider expenses for surgical pathology. Surgical pathology services include CPT codes: 88300-88399

Line 33 - Maternity and Newborn Expenses

Enter on this line the professional provider expenses for maternity care and delivery, including all ante partum, delivery, and postpartum care for mother and newborn as well as fertility services and termination of pregnancy. Expenses for medical or surgical complications of pregnancy should also be included in this section.

Maternity services include CPT codes:

Maternity Care/Delivery	59000-59899, 00857, 00995, 00850, 00946, 99150–51
Newborn Care:	99431-33, 99438-40, 54150 54160, 94652, 54000, 36450, 36510, 36660
Fertility Services:	58970-76, 89300-20, 89329, 89330

Line 34 - Other Specialists Expenses

Enter on this line the expenses for all other medical and surgical professional provider services, as well as consultations, and anesthesia services.

Other specialist services include CPT codes:

Anesthesia:	00100-01999
Surgery:	10040-58999, 60000-69979
Radiation Oncology:	77261-77799
Therapeutic Nuclear:	79000-7999
Medicine:	90780-90799, 90900-99199
Hospital Inpatient:	99221-99238
Consultations:	99241-99275
Emergency Care:	99281-99288
Critical Care:	99291, 99292, 99295-99297
Medicine:	90780-90799, 90900-99199

Lines 40 to 44 - Non-Facility Expenses

Enter on these lines, in the Total Column, the expenses for Non-Facility Expenses.

Line 40 - Pharmacy Expenses

Enter on this line the expenses for pharmacy services and pharmaceuticals that are not included in the inpatient or outpatient facility charges reported above.

Line 41 - Laboratory Expenses

Enter on this line the expenses for pathology and laboratory services that are provided by the pathologist or by technologists. This line should include only those expenses that are not include in the facility or professional expenses reported above. Expenses for surgical pathology services should be included in Line 34. Laboratory and Pathology services include CPT codes: 80002-88299, 89050-89399.

Line 42 - Durable Medical Equipment and Prosthetics

Enter on this line all expenses for the sale, rental, fitting, or testing of durable medical equipment or prosthetics that are **not** included in facility or professional expenses reported above.

Line 43 - Home Health Care

Enter on this line all expenses for services and supplies for home health care services. Home Health Care Services include CPT codes: 99341-99353.

Line 44 - Other Expenses

Enter on this line all expenses for non-facility supplies and services that are not already reported in Lines 40 to 43, including ambulance fees.

Lines 50 to 53 - Mental Health Expenses

Enter on these lines, in the Total Column, the expenses for Mental Health Services. Include all expenses for services and supplies provided in a psychiatric hospital or unit, or by a mental health provider other than treatment for substance abuse.

Psychiatric CPT codes, 90801-90899, are not separated by inpatient and outpatient services.

Lines 50 - Inpatient Facility Expenses

Enter on this line the facility expenses for all mental health inpatient services and supplies, including expenses for psychiatric units and facilities.

Line 51 - Outpatient Facility Expenses

Enter on this line the facility expenses for all mental health outpatient services and supplies, including centers and facilities for psychiatric day/night care, partial hospitalization, and outpatient psychiatric therapy.

Line 52 - Inpatient Professional Expenses

Enter on this line the professional expenses for all providers that perform inpatient mental health services, including psychiatrists, psychologists, psychiatric nurses, social workers, rehabilitation counselors, and other providers giving care in an inpatient mental health care setting.

Line 53 - Outpatient Professional Expenses

Enter on this line the professional expenses for all providers that perform outpatient or partial hospitalization mental health services, including psychiatrists, psychologists, psychiatric nurses, social workers, rehabilitation counselors, and other providers giving care in an outpatient mental health care setting.

Lines 60 to 63 - Substance Abuse Expenses

Enter on these lines, in the Total Column, the expenses for Substance Abuse.

Line 60 - Inpatient Facility Services

Enter on this line the facility expenses for all substance abuse inpatient services and supplies, including expenses for substance abuse units and facilities.

Line 61 - Outpatient Facility Services

Enter on this line the facility expenses for all substance abuse outpatient services and supplies, including centers and facilities for substance abuse day/night care, partial hospitalization, and outpatient treatment.

Line 62 - Inpatient Professional Services

Enter on this line the professional expenses for all providers that perform inpatient substance abuse services, including psychiatrists, psychologists, psychiatric nurses, social workers, rehabilitation counselors, and other providers giving care in an inpatient substance abuse care setting.

Line 63 - Outpatient Professional Services

Enter on this line the professional expenses for all providers that perform outpatient or partial hospitalization substance abuse services, including psychiatrists, psychologists, psychiatric nurses, social workers, rehabilitation counselors, and other providers giving care in an outpatient substance abuse care setting.

Column 2 - Capitated Expenses/Related Entity

Lines 10 through 63

Enter on each applicable line all the expenses paid under a capitated arrangement to a related entity, as defined in COMAR 10.37.12(B)(4). Include salaries, expenses, and related benefits of employees who provide direct medical services to patients. Do not include the cost of utilization review, case management, health education, medical director or related services.

Column 3 - Capitated Expenses/Unrelated Entity

Lines 10 through 63

Enter on each applicable line all the expenses paid under a capitated arrangement to an unrelated entity.

Column 4 - Fee for Service Expenses/In - Network

Lines 10 through 63

Enter on each applicable line all the expenses paid on a fee for service basis to providers who are members of the reporting entity's provider network.

Column 5 - Fee for Service/Out of Network

Lines 10 through 63

Enter on each applicable line all the expenses paid on a fee for services basis to providers located in the network area, but which are not members of the reporting entity's provider network.

Column 6 - Fee for Service/Out of Area

Lines 10 through 63

Enter on each applicable line all the expenses paid on a fee for service basis to providers located outside the reporting entity's network area.

Columns 1 through 6 - Expenses

Line 70 - Total Medical Costs

Enter on this line, in each column, the result of adding the expenses from lines 10 to 63. The sum of the entries in Columns 2 to 6, Line 70, should equal the entry in Column 1, Line 70.

Line 71 - Global Fee Costs

Enter on this line from Schedule AR3 the total "Global Fee" paid. (This line shall be utilized only when the reporting entity has a managed care capitation arrangement and a "Global Fixed Price" arrangement the results of which are both reported to the HSCRC. Other global fees should be allocated to a category on lines 10 to 63 using a reasonable approximation which does not understate or overstate the entry for any of the categories. The amounts should be placed in column 2 or column 3 as appropriate.)

Line 72 - Total Claim Costs

Enter on this line the sum of lines 70 and 71. This line represents the total direct costs associated with claims.

Lines 80 and 81 - Other Expenses

Line 80 - Administration Expenses

Enter on this line all other expenses including, but not limited to, expenses for utilization review, case management, member services, health education, financial management, claim processing, contract management and marketing.

Line 81 - Reinsurance Expenses

Enter on this line all expenses for reinsurance, including specific and aggregate stop-loss coverage premiums and capitation hold-backs.

Line 82 - Total Expenses

Enter on this line the sum of lines 72, 80 and 81.

Line 89 - Net Income (Loss)

Enter on this line the difference between line 4, Total Income, and Line 82 Total Expenses.

Schedule AR-2 - Capitation Utilization Report 1.50

Overview 1.51

Schedule AR-2 is provided to facilitate the reporting of utilization information associated with capitation arrangements on a calendar quarter and on an annual basis. Round the entries in columns 2 and 3 to 2 decimal places, e.g., 10,241 / 7,564 = 1.35.

The entries in lines 10 to 63 should be reported in a manner consistent with the expenses reported in Schedule AR-1.

Detailed Instructions 1.52

Heading Section

Hospital Name and Number Line

Enter on this line the complete name of the hospital responsible to ensure that this information be filed. In addition, enter on this line the number assigned to the responsible hospital. The assigned number corresponds to the last 4 digits of the responsible hospital's Medicare Provider Number, e.g., 0099.

Reporting Entity Name Line

Enter on this line the complete name of the entity reporting the information.

Payer/Contract Line

Enter on this line the complete name of the payer that has entered into the capitation arrangement with the reporting entity. In addition, enter on this line the contract number or other designation given the capitation arrangement for which this data is report.

Proceeding Number

Enter on this line the proceeding number of the Alternative Method of Rate Determination Application approved.

Period Ending Line

Enter on this line the period for which this information is reported, e.g., 07/96 - 9/96.

Contact Person

Enter on this line the name of the person responsible for filling in this schedule.

Telephone Number

Enter on this line the telephone number of the person responsible for filling in this schedule.

Column 1 - Number of Units of Service

Describe any units reported that differ from those prescribed in these instructions.

Lines 10 to 14 - Inpatient Facility Units of Service

Enter on each applicable line the appropriate number of inpatient days.

Lines 20 to 23 - Outpatient Facility Units of Service

Enter on each applicable line the appropriate number of outpatient units of service.

Lines 30 to 34 - Professional Services Units of Service

Enter on the applicable line the appropriate number of professional units of service.

Lines 40 to 44 Non-Facility Units of Service

Enter on each applicable line the appropriate number of non-facility units of service.

Lines 50 to 53 Mental Health Units of Service

Enter on each applicable line the appropriate number of mental health units of service.

Lines 60 to 63 Substance Abuse Units of Service

Enter on each applicable line the appropriate number of substance abuse units of service.

Lines 90 to 93 Inpatient Admissions

Enter on the applicable line the appropriate number of admissions.

(Enter the number of admissions which correspond to the patient days reported on the appropriate prior lines of the schedule. That is, admissions on Line 90 correspond to patient days on Line 50; admissions on Line 91 correspond to patient days on Line 60; admissions on Line 92 correspond to patient days on Lines 10 to 13 and admissions on Line 93 correspond to patient days on Line 14.)

Column 2 - Average Unit cost

Lines 10 to 63

Enter on each applicable line the result of dividing the total cost, as reported in Column 1 of Schedule AR-1, by the total number of units of service on the appropriate line in Column 1 of this schedule, Schedule AR-2.

Column 3 - Number of Units Per Member Per Month

Lines 10 to 63

Enter on each applicable line the result of dividing the total units of service as reported in Column 1 of this schedule, Schedule AR-2, by the number of Member Months as reported on Line A of Schedule AR-1.

Schedule AR-3 - Global Price Revenue Report 1.60

Overview 1.61

Schedule AR-3 is provided to facilitate the reporting of revenue and volume information associated with global price arrangements on a calendar quarter and on an annual basis.

Round the entries in Columns 4, Hospital Changes, 5 Global Payment and 6 Difference to 1 decimal place (nearest hundred) e.g., 66,428.93 is entered as 66.4.

Detailed Instructions 1.62

Heading Section

Hospital Name and Number Line

Enter on this line the complete name of the hospital responsible to ensure that this information be filed. In addition, enter on this line the number assigned to the responsible hospital. The assigned number corresponds to the last 4 digits of the responsible hospital's Medicare Provider Number, e.g., 0099.

Reporting Entity Name Line

Enter on this line the complete name of the entity reporting the information.

Payer/Contract Line

Enter on this line the complete name of the payer that has entered into the capitation arrangement with the reporting entity. In addition, enter on this line the contract number or other designation given the capitation arrangement for which this data is reported.

Proceeding Number

Enter on this line the proceeding number of the Alternative Method of Rate Determination Application approved.

Period Ending Line

Enter on this line the date on which the calendar quarter for which this information was reported ended, e.g., 07/96 - 0/96.

Contact Person

Enter on this line the name of the person responsible for filling in this schedule.

Telephone Number

Enter on this line the telephone number of the person responsible for filling this schedule.

Columns 1 - DRG/Procedure

Lines 1 through 22

Enter into this column on separate lines the appropriate DRG or procedure, as delineated in the global price contract or arrangement.

Column 2 - Number of Cases

Lines 1 through 22

Enter on each applicable line the appropriate number of cases for the period.

Column 3 - Number of Days

Lines 1 through 22

Enter on the applicable line the total number of inpatient days associated with the cases recorded in column 2.

Column 4 - Hospital Charges

Lines 1 through 22

Enter on the applicable line the total HSCRC regulated charges, both inpatient and outpatient, associated with the cases as reported in column 1.

Column 5 - Global Payment

Lines 1 through 22

Enter on the applicable line the total global payments for medical services provided under the global price contract or arrangement for the cases in column 1. Medical services may include, but not be limited to, inpatient and outpatient hospital services as well as physicians' professional services.

Column 6 - Difference

Lines 1 through 22

Enter on the applicable line the result of subtracting the Hospital Charges in Column 4 from the Global Payments in Column 5.

Columns 2, 3, 4, 5 and 6

Lines 23 - Totals

Enter on this line in the appropriate column the sum of lines 1 through 22. This line represents the total number of cases, the total number of patient days, the total hospital charges, the total global payments and the total difference between the global payments and the hospital charges

Schedule CSS – Supplemental Schedule 1.70

Overview 1.71

This schedule is provided to report monthly compliance with HSCRC approved rate orders for hospitals with Medical/Surgical Supplies and Drugs listing approved levels of overhead for the rate year.

Detailed Instructions 1.72

Institution Name Line Enter on this line the complete name of the reporting hospital.

Institution Number Line Enter on this line the number assigned to the reporting hospital. The assigned number corresponds the last 4 digits of the reporting hospital's Medicare Provider number, e.g., 0099. For a list of Institution Numbers refer to Appendix B.

Rate Period Beginning Line: Enter on this line the beginning month of the rate period for which the data is reported, e.g., 05/93.

Rate Period Ending Line: Enter on this line the ending month of the rate period for which the data is reported, e.g. 04/94.

Line A – Invoice Cost Rate Year to Date:

Enter on this line for each revenue center the invoice cost for the rate period reported. For example, if the hospital's latest rate increase was February 1, 1996 and the report includes data through the month ended June 30, 1996, the rate period would include the invoice cost for the period from February 1, 1996 through June 30, 1996.

Round entries to the nearest dollar, e.g., $9,999.99 is reported as $10,000.

Line B – Mark Up

Enter on this line for each revenue center the approved mark-up for the rate period as it appears on the applicable rate order.

Line C – Invoice Cost with Mark-up

Enter on this line for each revenue center the result of multiplying the invoice cost, line A, by the approved mark-up, line B.

Round entries to the nearest dollar, e.g., $9,999.99 is reported as $10,000.

LINE D - GROSS REVENUE RATE YEAR TO DATE:

Enter on this line for each revenue center the gross patient revenue for the rate period reported.

Round entries to the nearest dollar, e.g., $9,999.99 is reported as $10,000.

LINE E - OVERHEAD COLLECTED:

Enter on this line for each revenue center the result of subtracting Invoice Cost with Mark-up, line C, from Gross Patient Revenue, line D.

LINE F - APPROVED OVERHEAD:

Enter on this line for each revenue center the approved overhead for the rate period as it appears on the applicable rate order.

LINE G - MONTHS OF RATE YEAR:

Enter on this line for each revenue center the number of months in the rate period reported. For example, if the rate period reported includes data from February 1, 1996 through June 30, 1996, the number of months in the rate year are five (5).

LINE H - APPROVED OVERHEAD FOR PERIOD:

Enter on this line for each revenue center the result of multiplying Approved Overhead, line F, by Months in Rate Year, line G, divided by 12.

Round entries to the nearest dollar, e.g., $9,999.99 is reported as $10,000.

LINE I - OVERHEAD VARIANCE:

Enter on this line for each revenue center the result of subtracting Approved Overhead, line H, from Overhead Collected, line E.

SCHEDULE DOC - DAY/BEDS OVER CAPACITY 1.80

Overview 1.81

Schedule DOC is provided to enable each hospital to report the dates and number of beds that exceeded the hospital's licensed capacity on each of those days for the reporting period. Where a hospital has exceeded its total licensed capacity, the number of patients/beds in excess, by major service type, is also reported.

Detailed Instructions 1.82

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital.

Month Ending Line

Enter on this line the month for which the data is reported. Data for the month of January 2001 would be entered as 01312001.

Column 1 - Dates

Lines 1 to 31

Enter the date(s) in which the hospital was over its total licensed capacity. January 1, 2001 would be entered as 01012001.

Column 2 - Total Beds

Lines 1 to 31

Enter the number of beds by which the hospital was over its licensed capacity.

Columns 3 - 6

Lines 1 to 31

Enter the number of beds for each service type the hospital exceeded its licensed capacity. MSG includes medical, surgical, gynecology, intensive care, definitive observation, burn, trauma, and oncology. Do not report nursery, neonatal, chronic, or rehabilitation services on this form.

Column 1 - Total

Line 32

Enter on this line in this column the total number of days the hospital was over its licensed capacity.

Columns 2 - 6 Total

Line 32

Enter on this line, in each applicable major service column, the result of adding lines 1 through 31.

SCHEDULE MTC - INCREMENTAL MIEMMS
REQUIREMENTS FOR TRAUMA HOSPITALS 1.90

Overview 1.91

Schedule MTC is provided to enable hospitals with designated trauma centers (Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Memorial Hospital of Cumberland, Peninsula Regional Medical Center, Prince George's Hospital Center, Sinai Hospital, Suburban Hospital, and Washington County Hospital) to report the incremental trauma costs incurred to meet the Maryland Institute for Emergency Medical Services Systems (MIEMMS) regulatory requirements. Such incremental costs are the costs associated with operating a hospital with a designated trauma center that are over and above the costs normally associated with hospitals that do not have a designated trauma center. These incremental costs consist of the costs associated with: a Trauma Director, a Trauma Department, Trauma Protocol, Specialized Trauma Staff, Education and Training, and Special Equipment included in the costs of the Emergency Department, as reported on Schedule D 18. The reporting schedules for these incremental trauma costs consist of a summary schedule and six supplementary schedules.

Detailed Instructions 1.92

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line, the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line, the year for which the base year data is reported, e.g., 06-04.

Instructions for Supplementary MTC Schedules
Supplementary Schedule A - Trauma Director

The purpose of this schedule is to provide detailed cost information associated with the Trauma Director incurred in the base year.

Line A - Column 1

Report the salary costs incurred by the Hospital for the Trauma Director in the base year.

Lines B through F - Column 1

Report the other, i.e., miscellaneous costs incurred by the Hospital associated with the Trauma Director.

Line G - Column 1

Report the sum of lines A through F.

Supplementary Schedule B - Trauma Department

The purpose of this schedule is to provide detailed cost information for the Trauma Coordinator and associated costs incurred in the base year.

Line A - Column 1

Report the salary and fringe benefits for the Trauma Coordinator in the base year.

Line B - Column 1

Report the salary and fringe benefits for the Trauma Assistant in the base year.

Line C - Column 1

Report the salary and fringe benefits for the Trauma Registrar(s) in the base year.

Line D - Column 1

Report the costs for technical and professional fees for the Trauma Committee incurred in the base year.

Line E - Column 1

Report the costs for dues and licenses incurred in the base year.

Line F - Column 1

Report the costs for travel, registration for courses and seminars incurred in the base year.

Line G - Column 1

Report the costs incurred by the Hospital for other, i.e., miscellaneous items utilized by the Trauma Department in the base year.

Line H - Column 1

Report the sum of lines A through G.

Supplementary Schedule C - Trauma Protocol

The purpose of this schedule is to provide detailed information associated with the incremental cost of staff who respond to trauma patients as opposed to normal Emergency Department patients.

Lines A through I - Column 1

Report by job category the costs incurred by the Hospital for the time of staff, who responds to trauma cases, spent on trauma cases in the base year.

Line J - Column 1

Report the sum of lines A through I.

Supplementary Schedule D - Specialized Trauma Staff

The purpose of this schedule is to provide the costs incurred by the Hospital in the base year for additional non-physician staffing in various departments associated with trauma.

Lines A - E - Column 1

Report the salary and fringe benefits incurred by the Hospital in the base year for additional non-physician staff in various departments.

Line F - Column 1

Report the sum of lines A through E.

Supplemental Schedule E - Education and Training Costs

The purpose of this schedule is to report costs incurred by the Hospital in the base year of the incremental costs of orientation, education, and training specifically required for trauma personnel incurred by the Hospital in the base year.

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Lines A through E - Column 1

Report the costs incurred by the Hospital in the base year associated with the orientation, education, and training specifically required for trauma personnel.

Line F - Column 1

Report the sum of lines A through E.

Supplementary Schedule F - Specialized Equipment

The purpose of this schedule is to enable hospitals to report the annual depreciation of equipment and cost of technology needed to support the trauma center incurred by the Hospital in the base year.

Lines A through F - Column 1

Report the annual depreciation of equipment and cost of technology incurred by the Hospital in the base year.

Line G - Column 1

Report the sum of lines A through F.

Summary Schedule - Total Incremental MIEMMS Requirements Costs

Lines A through F - Column 1

Report the total incremental MIEMMS costs incurred by the Hospital in the base year as reported on supplementary schedules A through F.

Line G - Column 1

Report the sum of lines A through F.

Schedules SBC I & II – Standby Costs Trauma Physicians 2.0

Overview 2.01

Schedules SBC I & II are provided to enable hospitals with designated trauma centers, (Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Memorial Hospital of Cumberland, Peninsula Regional Medical Center, Prince George's Hospital Center, Sinai Hospital, Suburban Hospital, and Washington County Hospital) to report the standby costs of trauma physicians, i.e., Trauma Surgeons, Orthopedic Surgeons, Neurosurgeons, and Anesthesiologists, included in the costs of the Emergency Department, Schedule D – Line D18. Trauma physicians' standby costs are defined as the cost generated as a result of the necessity to have the physical presence of a trauma physician, under a formal arrangement, to render services to trauma patients. These physicians must be on the hospital premises in reasonable proximity of the Emergency Department or trauma center and may not be "on-call."

Use Schedule SBC I for physician standby costs reimbursed under Hourly or Salary Based Arrangements. Use Schedule SBC II for physician standby costs reimbursed under Contract Based/Minimum Guarantee Arrangements. Do not disclose the name of physicians or physician groups providing standby services. Assign each physician or physician group a number or a letter.

Detailed Instructions for Schedule SBC I and SBC II 2.02

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line, the year for which the base year data is reported, e.g., 06–04.

Instructions for Schedule SBC I - Hourly or Salary Based Arrangements

Sections A, B, and C - Lines 1 and 2

Column 1 - Total Trauma Hours

Report the total number of hours each physician or physician group provided under a formal arrangement with the trauma center for availability, supervision and administrative services directly related to trauma in the base year. This amount shall be the sum of the "availability hours" column #2 and the "supervision and administration hours" column #3.

Column 2 - Availability Hours

Report the total number of hours each physician or physician group provided under a formal agreement with the trauma center for availability services in the base year. Availability services require the physical presence of the trauma physician in the hospital to render trauma services to patients when and as needed. The physician must be on the hospital premises within reasonable proximity to the trauma center. "On-call" hours and hours for which the physician or the hospital otherwise received reimbursement should not be reported in this column. **Do not include hours that the physician spends treating patients, i.e., providing billable Part B professional services to individual patients.**

Column 3 - Supervision and Administrative Hours

Report the total number of hours each physician or physician group provided supervision and administrative services to the trauma center under a formal arrangement in the base year. "On-call" hours and hours for which the physician or the hospital otherwise received reimbursement should not be reported in this column.

Column 4 - Payments for Availability

Report the total actual payments made to each physician or physician group under a formal arrangement to provide availability services to the trauma center in the base year. Payments for "on-call" services should not be reported in this column. Payments reported in this column shall be reduced by any reimbursement amounts the physician or hospital otherwise received for the provision of availability services to the trauma center.

Column 5 - Payments for Supervision and Administration

Report the total actual payments made to each physician or physician group under a formal arrangement for supervision and administration services to the trauma center in the base year. Payments for "on-call" services should not be reported in this column. Payments reported in this column shall be reduced by any reimbursement amounts the physician or hospital

otherwise received for the provision of supervision and administration services to the trauma center.

Column 6 - Percent Inpatient

Report the percent of all trauma cases at the trauma center reported on the State Trauma Registry which results in an inpatient stay.

Column 7 - Percent Outpatient

Report the percent of all trauma cases at the trauma center reported on the State Trauma Registry which does not result in an inpatient stay.

Column 8 - Professional Organization Membership

Report the total membership fees paid by the hospital on behalf of each physician or physician group for membership in trauma-related professional organizations in the base year.

Column 9 - Continuing Medical Education Costs

Report the total amount paid on behalf of each physician or physician group for required trauma-related continuing medical education in the base year.

Column 10 - Malpractice Insurance

Report the total premiums paid by the hospital on behalf of each physician or physician group for the provision of trauma services in the base year.

Column 11 - Total Trauma Standby Costs

Report the total of column #4, Payments for Availability, column #5 Payments for Supervision and Administration, column #8, Professional Organization Membership, column #9, Continuing Medical Education Costs, and column 10, Malpractice Insurance.

II. Instructions for SBC II - Contract Based/Minimum Guarantee Arrangements

Sections A, B, and C - Lines 1 and 2

Column 1 - Total Trauma Hours

Report the total number of hours each physician or physician group provided under a formal arrangement with the trauma center for availability, supervision and administrative services

directly related to trauma in the base year. This amount shall be the sum of the "availability hours" column #2 and the "supervision and administration hours" column #3.

Column 2 - Availability Hours

Report the total number of hours each physician or physician group provided under a formal agreement with the trauma center for availability services in the base year. Availability services require the physical presence of the trauma physician in the hospital to render trauma services to patients when and as needed. The physician must be on the hospital premises within reasonable proximity to the trauma center. "On-call" hours and hours for which the physician or the hospital otherwise received reimbursement should not be reported in this column. ***Do not exclude*** **hours that the physician spends treating patients, i.e., providing billable Part B professional services to individual patients.**

Column 3 - Supervision and Administrative Hours

Report the total number of hours each physician or physician group provided supervision and administrative services to the trauma center under a formal arrangement in the base year. "On-call" hours and hours for which the physician or the hospital otherwise received reimbursement should not be reported in this column.

Column 4 - Minimum Guarantee Amount

Report the total amount of charges billed (or payments received) for physicians professional services to individual patients guaranteed to the physician under the arrangement with the hospital in the base year.

Column 5 - Payments for Supervision and Administration

Report the total actual payments made to each physician or physician group under a formal arrangement for supervision and administration services to the trauma center in the base year. Payments for "on-call" services should not be reported in this column. Payments reported in this column shall be reduced by any reimbursement amounts the physician or hospital otherwise received for the provision of supervision and administration services to the trauma center.

Column 6 - Percent Inpatient

Report the percent of all trauma cases at the trauma center reported on the State Trauma Registry which resulted in an inpatient stay in the base year.

Column 7 - Percent Outpatient

Report the percent of all trauma cases at the trauma center reported on the State Trauma Registry which did not result in an inpatient stay in the base year.

Column 8 - Professional Organization Membership

Report the total membership fees paid by the hospital on behalf of each physician or physician group for membership in trauma-related professional organizations in the base year.

Column 9 - Continuing Medical Education Costs

Report the total amount paid on behalf of each physician or physician group for required trauma-related continuing medical education in the base year.

Column 10 - Malpractice Insurance

Report the total premiums paid by the hospital on behalf of each physician or physician group for the provision of trauma services in the base year.

Column 11 - Total Trauma Standby Costs Incurred by Hospital

Report the total of column #4, Minimum Guaranteed Amount, column #5 Payments for Supervision and Administration, column #8, Professional Organization Membership, column #9, Continuing Medical Education Costs, and column #10 Malpractice Insurance.

Column 12 - Physicians' professional Services Billed (or Payments Received)

Report the total amount of charges billed (or payments received) for physician professional services to individual patients as specified in the arrangement with the hospital.

Schedule AHA-R AHA/HSCRC Reconciliation 2.1

Overview 2.11

Schedule AHA-R is provided to enable hospitals to provide a reconciliation of the financial data associated with hospital activities that are reported to the American Hospital Association (AHA) for its Annual Survey and subsequently published in its publication Hospital Statistics. Reconciliation is necessary because the definition and the scope of hospital activities reported to the American Hospital Association for its Annual Survey differs from that reported to the HSCRC in its Annual Report. The AHA-R schedule reconciles the two sets of data.

Column 3 of the AHA-R Schedule, Total AHA Facility Survey, should agree with the consolidated financial statements of the facility or, if applicable, with the facility's component of its parent corporation's audited financial statements. Therefore, the AHA-R Schedule begins with the reporting of the Total column of the RE Schedule (regulated and unregulated data) and provides a column to accommodate the financial data for reconciling items, as well as a column for eliminating entries. In order to develop data for the hospital unit of the facility, as required in the AHA Survey, the data associated with Nursing Home Units (which includes all sub-acute hospital inpatient services hospital based or not), are removed from the Total Facility data.

Detailed Instructions 2.12

Hospital Name Line

Enter on this line, the complete name of the reporting hospital.

Hospital Number Line

Enter on this line, the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Reporting Period

Enter on this line, the year for which the base year is reported, e.g., 06-04.

Column 1 - RE Schedule

Enter on each line in this column the amount from RE Schedule Column 3, Total, for each referenced line in the source column.

Column(s) 2 - Eliminating Entries & Reconciling Items

Enter on each appropriate line the amounts applicable to Eliminating Entries and Reconciling Items. Provide a detailed description of all Reconciling Items.

Column 3 - Total Facility AHA Survey

Enter in this column on each line the sum of column 1, RE Schedule, and column(s) 2 Eliminating entries and Reconciling Items.

Column 4 - AHA Nursing Home Unit Facility

Enter in this column on these lines the revenues, expenses and admissions of AHA defined Nursing Home Units.

Column 5 - AHA Hospital Unit

Enter on these lines in this column the result of subtracting column 4, AHA Nursing Home Unit Facility from column 3, Total Facility AHA Survey

Schedule ADMN – Admissions Denied for Medical Necessity 2.2

Overview 2.21

Schedule ADMN is provided to enable hospitals to report cases where an admission has been denied for lack of medical necessity.

Detailed Instructions 2.22

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the six digit provider number assigned by Medicare to the reporting hospital, e.g., 21009.

Quarter Ending Line

Enter on this line the data period being reported. 0610

Column 1 Medical Record Number

Enter on this line the unique medical record number assigned by the hospital for the patient's medical record. The unique medical record number is to be assigned permanently to the patient and may not change regardless of the number of admissions for that particular patient during the patient's lifetime.

Column 2 - Admission Date

Enter on this line the month, day, and year of the patient's admission to the hospital. For example, April 4, 1992, is entered as 04041992 (mm/dd/yyyy).

Column 3 - Total Charges Billed

The full charges for all services provided to the patient shall be reported. These charges do not include Part B physician charges or charges not regulated by the Health Services Cost Review Commission (for example, telephone service, television charges, or private duty nursing charges).

Save file name as admdeny00##_qeyy.xls where 00xx is the hospital number; qe is quarter ending month; and yy is the calendar year. Submit electronic file to DeniedAdmissions@hscrc.state.md.us

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SCHEDULE IRS – Intern and Resident Survey 2.3

OVERVIEW 2.31

Schedule IRS is provided to allow each hospital to report the Intern, Resident, and eligible Fellow, data necessary for the Graduate Medical Education (GME) adjustment to the Reasonableness of Charges (ROC) and the Inter-hospital Cost Comparison (ICC) methodologies of the Commission.

(An eligible Fellow is a physician in a program of graduate medical education accredited by the Accreditation Council for Graduate Medical Education.)

The survey date is the first Tuesday after Labor Day. The report is due on January 15th of each year.

The form is an excel file available on the Commission's website for download. Completed surveys are emailed to nduka.udom@maryland.gov.

Detailed Instructions 2.32

Column 1 – Hospital ID – Enter the hospital's Medicare provider number, i.e., 0099.

Column 2 – Program -Use the drop down box to select the program the trainee is enrolled in.

Column 3 – Description of "Other" – Describe the program the trainee is enrolled in if other is selected in column 2.

Column 4 – Intern, Resident, or Fellow – Use the drop down box to select the appropriate status of the trainee.

Column 5 – Last Name – Enter the trainee's last name.

Column 6 – First Name – Enter the trainee's first name.

Column 7 - Social Security Number – Enter the trainee's social security number.

Column 8 – Years Completed – Enter the number of years in the program the trainee has completed.

Column 9 – Previous Program – Use the drop down box to select the previous program the trainee was enrolled in.

Column 10 - Description of "Other" – Describe the program the trainee is enrolled in if other is selected in column 9

Column 11 - Years Completed in Previous Program– Enter the number of years in the program the trainee completed in the previous program.

Column 12 – Form of Payment – Use the drop down box select the form of payment for the trainee.

Schedule DCFA – Debt Collection/Financial Assistance Report 2.4

Overview 2.41

Schedule DCFA is provided for hospitals to report specific information on their debt collection and financial assistance processes.

The report is due 120 days after the end of each hospital's fiscal year.

Detailed Instructions 2.42

Attach the hospital's policies and procedures for assigning a debt to a collection agent for collection, and for compensating such collection agent for services rendered. (PDF format required for electronic submission)

Attach a list of the documentation requirements utilized by the hospital for individuals to qualify for financial assistance. (PDF format required for electronic submission)

Heading Section

Hospital Name Line

Enter on this line the complete name of the reporting hospital.

Hospital Number Line

Enter on this line the six digit provider number assigned by Medicare to the reporting hospital, e.g., 0099.

Reporting Period

Enter on this line the fiscal year being reported, e.g., FY 2010.

Line 1 a-h - Collection Agency Name

Enter on each line a-h, as needed, the name(s) of any collection agent(s) used during the reported fiscal year.

Line 2 i – Number of Liens

Enter on this line the number of liens placed on residences during the reported fiscal year.

Line 3 j – Number of Extended Payment Plans

Enter on this line the number of extended payment plans exceeding 5 years established with patients during the reported fiscal year.

Line 4 k – Number of Applications for Financial Assistance Received

Enter on this line the number of applications for financial assistance received from patients during the reported fiscal year.

Line 5 i – Number of Applications for Financial Assistance Approved

Enter on this line the number of applications for financial assistance approved during the reported fiscal year.

Save file name as DCFA####_FYxx.xls where #### is the hospital number and xx is the calendar year.

Schedule SFI – Non-Operating Revenue and Expenses 2.5

Overview 2.51

Schedule SFI is provided to enable hospitals to report detailed information on Non-Operating Revenue and Expenses and Other Significant Financial Information in a standard format. The SFI schedule is to be submitted with Schedules FSA and FSB, Financial Statement Summary monthly or quarterly as applicable and as part of the Annual Report of Revenues, Expenses, and Volumes.

Detailed Instructions 2.52

To collect additional detail of non-operating revenue and expenses the format of the detail is as follows:

Line A – Enter on this line, Excess (Deficit) Operating Revenue over Operating Expenses, the amount from RE schedule line T, column 3.

Line B-1 – Enter on this line, Contribution (Unrestricted), - All unrestricted contributions including contributions previously restricted where the restriction was met.

Line B-2 – Enter on this line, Interested and Investment Income, - dividends and interest, excluding investment income on temporarily and permanently restricted investments.

Line B-3 – Enter on this line, Investment Gains/Losses Realized, - realized gains or losses on sale of investments, excluding realized gains or losses on temporarily and permanently restricted investments.

Line B4 – Enter on this line, Investment Gains/Losses Unrealized, - unrealized gains on securities held in trading portfolio, excluding unrealized gains or losses on temporarily and permanently restricted investments.

Line B-5 – Enter on this line, Swap Agreements Gains/Losses Realized, - all settlement payments received or made in relation to non-qualifying swap agreements (non-qualifying for hedging for accounting treatment purposes) as well as change in fair market value of non-qualifying swap agreements.

Line B-6 – Other (Specify)

Line B-7 – Enter on this line the result of adding lines T, Excess (Deficit) Operating Revenue over Operating expenses, U1, Contributions (Unrestricted), U2, Interest and Investment Income, U3, Investment Gains/Losses Realized, U4, Investment Gains/Losses Unrealized, U5, Swap Agreements Gains/Losses Realized and V, Other.

Line C – Enter on this line, Swap Agreements Gains/ (Losses) Unrealized, – all adjustments related to the fair market value of a qualifying swap agreement (qualifying for hedging for accounting treatment purposes).

Line D – Enter on this line, Collateral Received / (Posted) – Swap Agreements.

Line E – Enter on this line, Retirement of Debt – Gains/(Losses), – all gains or losses related to the retirement, refinancing, or early extinguishment of debt including write-offs of deferred financing costs and prepayment of interest costs on funds placed in escrow.

Line F - Enter on this line, Pension Adjustments – Defined Benefit Plans, – the change in the funded status of pension and other post retirement plans.

Line G – Enter on this line, Other (Specify), Examples could include: contributions of capital, changes in fair value of investments for available for sale portfolio, etc.

Line H Total – Enter on this line the result of adding lines C, Swap Agreements Gains/(Losses) Unrealized, line D Collateral Received/(Posted), line E Retirement of Debt – Gains/(Losses), line F Pension Adjustments – Defined Benefit Plans, and line G Other (Specify)

UCC WRITE-OFFS REPORT 2.6

Overview 2.61

This report enables hospitals to provide documentation on charity and bad debt write-offs and recoveries for REGULATED HOSPITAL SERVICES. Do not include write-offs for unregulated services. This information will assist the Commission in determining the sources of uncompensated care.

Your hospital's Write-Offs Report must be reconciled to charity and bad debts reported on Annual Report Schedule RE. We recognize that there are timing differences between write offs and accrual based accounting, and there may be reconciling differences.

The Write-Offs Report is to be submitted 30 days after the end of each calendar quarter.

The report may be considered late or not filed if the format prescribed is not followed to file this data. Please be sure that you have downloaded the most current Excel template for reporting the Uncompensated Care Write-Off Report.

Detailed Instructions 2.62

File Name

Upon submitting the initial file via Repliweb, the file name should include the Hospital's 6-digit Medicare I.D. Number as the main identifier, the reporting period, and the report name (e.g. 210001_FY15Q3_UCC.xlsx).

When submitting a revised file, it is imperative that the revision number is specified with each revised submission. It must not be named identical to the original file. (e.g. 210001_FY15Q3_UCCREV1, 210001_FY15Q3_UCCREV2, etc.)

Heading Section

The formatting must not be changed. It is contained in Rows 1 through 9 Columns A through F. Please do not enter Write-Off Data above Row 10.

Institution Name Line

Row 4, Column B. Enter in this cell the complete name of the reporting hospital.

Institution Number Line

Row 5, Column B. Enter in this cell the Hospital's 6-digit Medicare I.D. number. Do not enter hyphens, dashes or quotation marks. Example: Meritus Medical Center would be entered as 210001.
Please see attached list of hospital numbers for your reference.

Period

Row 4, Column E. Enter the 4 digit Fiscal Year (based on a July – June Schedule -2015) and the Quarter number (Q1=July-Sept, Q2=Oct-Dec, Q3=Jan-Mar, Q4=Apr-Jun). Example: January-March 2015 should be recorded as: 2015Q3

Reporting Section

This section begins with Row 10. Do not record Write-Off Data above Row 10. Do not include breaks for months (e.g., January, February) or summary lines (e.g., Sub Total, Grand Total). All data should be recorded on one worksheet -do not use a single worksheet for each month of the quarter.

Utilizing one line for each write-off (Charity, Bad Debt, or Recovery) provide the following information for each patient account with services written off to charity care, bad debt, or a patient account with funds recovered by your hospital in the calendar quarter:

Col. 1 Date of service – Enter in Column A from Row 10 down as needed – the date of service, e.g., date of admission or date of service for outpatient accounts. This must be a valid single date of service in m/d/yy, e.g., 1/1/15 or 1/25/15. (Do not enter in text format. Do not include a grouping of dates e.g., 1/1/15-1/10/15). If the write-off is for more than one admission or outpatient visit, enter the date of the most recent service.

Col. 2 Patient Account Number – Enter in Column B from Row 10 down as needed – the patient account number for the service being written off. If this is a recovery recorded as a group, please enter "group" for patient account number.

Col. 3 Total Amount Billed – Enter in Column C from Row 10 down as needed – the total amount of charges billed for this inpatient admission or outpatient visit. The total amount billed should never change. It should always be reported as the original amount billed. This must be entered as a positive number.

Col. 4 Charity, Bad Debt, or Recovery – Enter in Column D from Row 10 down as needed – Whether the amount of write-off is to Charity, Bad Debt or Recovery. Please use one of the three types as written: Charity, Bad Debt, or Recovery. Do not include any other information in Column D.

Col.5 Amount of Write-Off or Recovery – Enter in Column E from Row 10 down as needed – The total amount of the indicated type of write-off for Charity or Bad Debt. If the account is a recovery and a portion of the account was written off to both Charity and Bad Debt, please use a separate line to record the amount written off to Charity and Bad Debt. Please enter the write-off amount as a positive number. Recovery amounts should be entered as negative numbers.

Reversals: If a reversal of a write-off occurs, the write-off reversal should be recorded as a negative number in Col. 5 Amount of Write-Off or Recovery. (e.g., if an amount was written off to Bad Debt for $100.00, and more information is received to then classify the amount as Charity, a (-$100) would be entered for Bad Debt, and the Charity would be reported as instructed above for Col. 5.

Col. 6 Expected Payer – Enter in Column F from Row 10 down as needed – The Expected Primary Payer Code (excerpted from the FY2015 Maryland Hospital Inpatient Data Submission Elements and Formats, Data Item 21) as follows:

01 = Medicare
02 = Medicaid FFS Only and Pending Medicaid
03 = Title V
04 = Blue Cross
05 = Commercial Insurance, Other than Blue Cross
06 = Other Government Program
07 = Workmen's Compensation
08 = Self Pay
09 = Charity (Patient was not charged for care)
10 = Other
11 = Donor
12 = HMO
14 = Medicaid HMO
15 = Medicare HMO
16 = Blue Cross – National Capital Area
17 = Blue Cross – Other State (Non-MD)
18 = International Insurance
99 = Unknown

DENIALS REPORT 2.7

Overview 2.71

The HSCRC is collecting data on hospital services for which third party payers refused payment and the payment and was written off as a denial. This information will assist the Commission in understanding the prevalence of and justification for denials. The Commission will use the information to promote care processes and practices that will reduce denials.

Your hospital's Denials Reports should be reconciled to denials reported on Annual Report Schedule RE. If there are recoveries in the reporting period, they should be netted against the denials. We only want to see the summary line.

The Denials Report is to be submitted 30 days after the end of each calendar quarter.

Detailed Instructions 2.72

File Name

Upon submitting the initial file via Repliweb, the file name should include the Hospital's 6-digit Medicare I.D. Number as the main identifier, the reporting period, and the report name (e.g. 210001_Denials_FY15Q3.xlsx).

When submitting a revised file, it is imperative that the revision number is specified with each revised submission. It must not be named identical to the original file. (e.g. 210001_Denials_FY15Q3_REV1 210001_Denials_FY15Q3_REV2, etc.)

Heading Section
The formatting must not be changed. The header information is contained in Rows 1 through 9 Columns A through E. Please do not enter denial data above Row 9.

Institution Name Line

Row 3, Column B. Enter in this cell the complete name of the reporting hospital.
Institution Number Line

Row 3, Column D. Enter in this cell the Hospital's 6-digit Medicare I.D. Number. Do not enter hyphens, dashes or quotation marks. (e.g. Meritus Medical Center is entered as 210001).
Please see attached list for your reference.

Period

Row 5 Colum B. Enter the 4 digit Fiscal Year (based on a July –June Schedule -2015) and the Quarter number (Q1=July-Sept, Q2=Oct-Dec, Q3=Jan-Mar, Q4=Apr-Jun). Example: January – March 2015 should be recorded as 2015Q3.

Reporting Section

This section begins with Row 9. Do not record denials data above Row 9. All data should be recorded in one worksheet – do not use a single worksheet for each month of the quarter. Please do not include extra data. Only provide the data that is required in the template.
By payer, utilizing one line for each category of denial, provide the following information for the cases with denied services written off by your hospital in the calendar quarter.

Col. 1 Payer that Denied Claim – Enter the Payer code for the Payer that denied the claim, using the codes from the Maryland Hospital Inpatient Data Submission Elements and Formats, Data Item 21. These codes should be updated as the "Hospital Patient-Level Data Submission Requirements" are updated.

The FY 2015 Inpatient Data Submission Requirement are as follows:
01 = Medicare
02 = Medicaid FFS Only and Pending Medicaid
03 = Title V
04 = Blue Cross
06 = Other Government Program
07 = Workmen's Compensation
08 = Self Pay
09 = Charity (Patient was not charged for care)
10 = Other
11 = Donor
12 = HMO
14 = Medicaid HMO
15 = Medicare HMO
16 = Blue Cross-National Capital Area
17 = Blue Cross – Other State (Non-MD)
18 = International Insurance
99 = Unknown

Col. 1a Health Plan Payer –Enter the Payer code from the Inpatient Data Submission Regulations - Record Type 1, Data Element 16, Primary Health Plan Payer or 17 Secondary Health Plan Payer - Codes 01 to 99, use code 00 for not applicable. The Primary Health Plan Data Table from FY2015 Inpatient Data Submission Regulations (data element 16) is attached for reference. These codes should be updated as the "Hospital Patient-Level Data Submission Requirements" are updated.

Col. 2 Patient Category – Enter only one of the following patient categories per line, blanks are not acceptable:

- inpatient services
- emergency department services
- outpatient services

Col. 3 Denial Reason - Enter only one of the following reasons per line blanks are not acceptable:

- medical necessity
- no pre-authorization
- untimely filing
- RAC Audit
- other

Col. 4 Number of Cases Denied – Enter the total number of cases with billed charges written off as denied. Do not report reversals (or negative numbers). Only the total number of cases denied should be reported.

Col. 5 Total Amount Written Off as Denied – Enter the total amount of billed charges written off as denied (this should be a positive amount).

Primary Health Plan Data Table from FY2015 Inpatient Data Submission Regulations

(http://www.hscrc.state.md.us/hsp_Info1.cfm)

SHARED SAVINGS/LOSS REPORT 2.8

Overview 2.81

This report enables hospitals to provide information on payments received or payments made associated with the CMS Medicare Shared Savings Program. The amounts reported should be limited to payments made to the hospital or payment made by the hospital. They should not include payments received or made that are distributed to physicians or other providers other than the hospital. The Shared Savings Program involves participation in an Accountable Care Organization or other Medicare demonstration where a payment is made to the participating providers (or payment is due from participating providers) based on the savings (or loss) level achieved relative to a benchmark. This information is required as a condition of the new Medicare All Payer Model.

Your hospital's Shared Savings/Loss Reports should be reconciled to Shared Savings reported on Annual Report Schedule RE.

The Shared Savings Report is to be submitted 30 days after the end of each calendar quarter.

Detailed Instructions 2.82

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the Hospital Identification Number as reported in Appendix B of the HSCRC Accounting and Budget Manual.

Period

Enter on this line the period for which the data are reported.

Reporting Section

Utilizing one line for each payment, provide the following information for each Shared Savings Payment made to your hospital or payment made by your hospital in the calendar quarter.

Col. 1 Date of payment – Enter in this column on each line the date of the Shared Savings payment made to your hospital or a payment made by the hospital to compensate for a loss recovery. Loss recoveries should be negative figures.

Col. 2 Payer – Enter in this column on each line the name of the individual or organization that made the Shared Savings payment.

Col. 3 Payment Amount - Enter in this column on each line the total amount of the Shared Saving payment or loss recovery.

GROSS PATIENT REVENUE RECONCILIATION SCHEDULE 2.9

Overview 2.91

In order to monitor compliance with the new Medicare All-Payer Model, each hospital is required to submit gross patient revenue data (GPR) on a monthly basis split between in-state, out-of-state as well as Medicare GPR split between Medicare Fee-for-Service (FFS) and Medicare non-FFS. The purpose of this Schedule is to ensure that the split of the Total GPR into in-state and out-of-state and the split of the Medicare data into FFS and non-FFS reported in the Monthly Reports agree with the hospital's records, and that the Total GPR reported on the Monthly Reports agrees with the Total GPR on Schedule RE of the Annual Submission of Revenues, Expenses and Volumes.

Your hospital's annual gross patient revenue should be reconciled to the Annual Report Schedule RE.

Detailed Instructions 2.92

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the Hospital Identification Number as reported in Appendix B of the HSCRC Accounting and Budget Manual.

Base Year

Enter on this line the period for which the data are reported.

Reporting Section

Line 1- Total In-State Revenue

Column 1

Enter on this line, the total annual in-state inpatient revenue.

Column 2

Enter on this line the total annual in-state outpatient revenue.

Column 3

Enter on this line the sum of column 1, total annual in-state inpatient revenue and column 2, total annual in-state outpatient revenue.

Line 2- Total Out-State Revenue

Column 1

Enter on this line, the total annual out-state inpatient revenue.

Column 2

Enter on this line the total annual out-state outpatient revenue.

Column 3

Enter on this line the sum of column 1, total annual inpatient revenue, and column 2, total annual outpatient revenue.

Line 3- Total Gross Patient Revenue

Column 1

Enter on this line the sum of Line 1, total annual in-state inpatient revenue and Line 2, total annual out-state inpatient revenue

Column 2

Enter on this line the sum of line 1, total annual in-state outpatient revenue and Line 2, total annual out-state outpatient revenue.

Column 3

Enter on this line the sum of Line 1, total annual in-state revenue and Line 2, total annual out-state revenue.

Line 4- Medicare FFS Revenue

Column 1

Enter on this line the Medicare FFS total annual in-state inpatient revenue.

Column 2

Enter on this line the Medicare FFS total annual out-state inpatient revenue.

Column 3

Enter on this line the Medicare FFS total annual in-state outpatient revenue.

Column 4

Enter on this line the Medicare FFS total annual out-state outpatient revenue.

Column 5

Enter on this line the sum of column 1, Medicare FFS in-state inpatient revenue, column 2, Medicare FFS out-state inpatient revenue, column 3, Medicare FFS in-state outpatient revenue and column 4, Medicare FFS out-state outpatient revenue.

Line 5- Medicare Non-FFS Revenue

Column 1

Enter on this line the Medicare Non-FFS total annual in-state inpatient revenue.

Column 2

Enter on this line the Medicare Non-FFS total annual out-state inpatient revenue.

Column 3

Enter on this line the Medicare Non-FFS total annual in-state outpatient revenue.

Column 4

Enter on this line the Medicare Non-FFS total annual out-state outpatient revenue.

Column 5

Enter on this line the sum of column 1, total annual Medicare Non-FFS in-state inpatient revenue, column 2, total annual Medicare Non-FFS out-state inpatient revenue, column 3, total annual Medicare Non-FFS in-state outpatient revenue and column 4, total annual Medicare Non-FFS out-state outpatient revenue.

Line 6- Total Medicare Revenue

Column 1

Enter on this line the sum of Line 4, total annual Medicare FFS in-state inpatient revenue and Line 5, total annual Medicare Non-FFS in-state inpatient revenue.

Column 2

Enter on this line the sum of Line 4, total annual Medicare FFS out-state inpatient revenue and Line 5, total annual Medicare Non-FFS out-state inpatient revenue.

Column 3

Enter on this line the sum of Line 4, total annual Medicare FFS in-state outpatient revenue and Line 5 total annual Medicare Non-FFS in-state outpatient revenue.

Column 4

Enter on this line the sum of Line 4, total annual Medicare FFS out-sate outpatient revenue and Line 5 total annual Medicare Non-FFS out-state outpatient revenue.

Column 5

Enter on this line the sum of Line 4, total annual Medicare FFS revenue and Line 5, total annual Medicare Non-FFS revenue.

Schedule UR6A – Physicians Part B Services - Detail

3.00

Overview 3.01

Schedule UR6A is provided to enable hospitals to identify and report the Physicians Part B Services costs, revenue, and FTEs reported on Schedule UR6 by Physician Category. The information reported on Schedule UR6A must agree with the information reported on Schedule UR6 Physicians Part B Services. The Physician Categories to be use in this report are those listed in the HSCRC- Physician Category Code List.

Round the expenses and revenue in Columns 3 through 6 to one decimal place (nearest hundred), e.g., 66,428.93 is entered as 66.4.

Round the FTE data in Column 8 to 1 decimal place, e.g., 22,612 hours divided by 2080 = 10.9.

Detailed Instructions 3.02

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital. The assigned number corresponds to the last 4 digits of the reporting hospitals Medicare Provider Number, e.g., 0099.

Fiscal Year Line

Enter on this line the year for which the data is reported.

Column 1 – Physician Category Code

Enter on the appropriate lines the Physician Category Code provided in the HSCRC Physician Category Code List.

Column 2 – Physician Description

Enter on the appropriate lines the Physician Description, from the HSCRC- Physician Category Code List, that matches the Physician Category Code.

Column 3 - Salaries and Fringe Benefits

Enter on the appropriate lines the Salaries and Fringe Benefits Expenses reported on Schedule UR6 for this category of physician.

Column 4 - Other Expenses

Enter on the appropriate lines the direct expenses other than salaries and fringe benefits reported on Schedule UR6 for this category of physician, as well as allocations of expenses from schedules OADP, Cs and UA. These expenses should be included in the expenses of each applicable physician category. If these expenses cannot be attributed to a specific physician category, they should be allocated evenly across all physician categories.

Column 5 - Total Expenses

Enter on the appropriate lines the sum of Columns 3, salaries and fringe benefits Column 3 and Column 4, other expenses.

Column 6 - Revenue

Enter on the appropriate lines the revenue reported on Schedule UR6 for this category of physician.

Column 7 – Hospital Based

Enter an X in this column line for physicians that are Hospital Based (For the purposes of this report only House Staff, Pathologists, Radiologists, Anesthesiologists and Emergency Department physicians are considered to be “Hospital Based”). If your hospital has both Hospital Based and non-Hospital Based physicians in the same physician category, use one line for Hospital Based and a separate line for non-Hospital Based physicians.

Column 8 – FTEs

Enter on the appropriate lines the FTEs reported on Schedule UR6 for this category of physician.

The totals of Columns 3 through 5 shall agree with Line F Fiscal Year Adjusted Expenses reported on Schedule UR6 Physicians Part B Services. The total of Column 6 shall agree with Line G Base Year Revenue reported on Schedule UR6 Physicians Part B Services. The total of Column 8 shall agree with Line A No. of FTEs Base Year reported on Schedule UR6 Physicians Part B Services.

HSCRC PHYSCIAN CATEGORY CODE LIST

Code	Physician Description
XX	Hospitalist
1	General Practice
2	General Surgery
4	Otolaryngology
5	Anesthesiology
6	Cardiology
7	Dermatology
8	Family Practice
9	Interventional Pain Management
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative Medicine
13	Neurology
14	Neurosurgery
16	Obstetrics & Gynecology
17	Hospice & Palliative Care
18	Ophthalmology
19	Oral Surgery
20	Orthopedic Surgery
22	Pathology
23	Sports Medicine
24	Plastic & Reconstructive Surgery
25	Physical Medicine & Rehabilitation
26	Psychiatry
29	Pulmonary Disease
30	Diagnostic Radiology
33	Thoracic Surgery
34	Urology
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
40	Hand Surgery
44	Infectious Disease
46	Endocrinology
48	Podiatry
66	Rheumatology
72	Pain Management
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine
81	Critical Care Medicine
82	Hematology
83	Hematology- Oncology
84	Preventative Medicine

Code	Physician Description
85	Maxillofacial Surgery
86	Neuropsychiatry
90	Medical Oncology
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Interventional Radiology
98	Gynecological Oncology
C3	Interventional Cardiology
C0	Sleep Medicine
ZZ	Other *

*Provide detailed description

SECTION 600
REPORTING SCHEDULE FOR ANNUAL REPORT
OF REVENUE AND EXPENSES AND VOLUMES

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SCHEDULES V2A, V2B, - OUTPATIENT VISITS		
SCHEDULES V3A, V3D-ANCILLARY SERVICE UNITS		
SCHEDULE V5-EQUIVALENT INPATIENT DAYS AND ADMISSIONS		
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SCHEDULE RE-R – RECONCILATION OF THE AUDITED FINANCIALS TO RE SCHEDULE		
SCHEDULE AHA-R – RECONCILIATION OF FINANCIAL STATEMENTS TO AHA SUBMISSIOIN		
SCHEDULES J1, J2-OVERHEAD EXPENSE APPORTIONMENT		
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*I HEREBY CERTIFY THAT I HAVE REVIEWED THIS LIST OF ANNUAL REPORT SCHEDULES AND AM SUBMITTING ALL SCHEDULE APPLICABLE TO _____ HOSPITAL.

SIGNATURE: _____

TITLE: _____ DATE: _____

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CHECK IF SUBMITTING LEAVE BLANK IF N/A
ANNUAL CHECK OFF LIST

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D2	PED		D30	EKG		D71	PCD	
D3	PSY		D31	IRC		D73	PSG	
D4	OBS		D32	RAD		D74	ITH	
D5	DEF		D33	CAT		D75	GTH	
D6	MIS		D34	RAT		D76	FTH	
D7	CCU		D35	NUC		D77	PST	
D8	PIC		D36	RES		D78	PSE	
D9	NEO		D37	PUL		D79	OPT	
D10	BUR		D38	EEG		D80	ETH	
D11	PSI		D39	PTH		D81	ATH	
D12	TRM		D40	OTH		D83	CL-340	
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D14	NUR		D42	REC		D85	ORC-340	
D15	PRE		D43	AUD		D86	LAB-340	
D16	///		D44	OPM		D87	CDS-340	
D17	CRH		D45	RDL		E1	AMB	
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D19	CL		D47	///		E3	DPO	
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APPENDIX A - GLOSSARY

Abandonment

The complete retirement of a fixed asset from service, following salvage or other reclaiming of removable parts.

Account

A formal record of a particular type of transaction expressed in money and kept in a ledger.

Accountability

The obligation of an employee, agent, or other person to supply a satisfactory report, often periodic, of action or of failure to act following delegated authority/responsibility.

Accounting Control

The administrative procedures employed in maintaining the accuracy and propriety of transactions and the bookkeeping record thereof.

Accounting Manual

A handbook of accounting policies, principles, and concepts including a chart of accounts with definitions and standard units of measure, which establishes a foundation for uniform accounting for Health Services Institutions.

Accounting Period

The period of time for which an operating statement is prepared. This period shall consist of the 12 consecutive calendar months or 13 four-week periods that begin on any calendar quarter, e.g., January, April, July or October.

Accounting Policy

The general principles and procedures under which the accounts of an organization are maintained and reported; any one such principle or procedure.

Accounting Principles

The body of doctrine associated with accounting, serving as an explanation of current practices and as a guide in the selection of conventions and procedures.

APPENDIX A - GLOSSARY

Accrual

1. The recognition of events and conditions as they occur, rather than in the period of their receipt, or payment. 2. The partial recognition of an item of revenue or expense and its related assets or liability of resulting from the lack of coincidence of the accounting period and the contractual or benefit period. 3. An amount accrued.

Accrual Accounting

The recognizing and reporting of the effects of transactions and other events on the assets and liabilities of the hospital entity in the time period to which they relate rather than only when cash is received or paid.

Accrue

To give effect to an accrual; to record revenue or expense in the accounting period to which it relates, not withstanding that the required receipt or outlay may take place, in whole or in part, in a preceding or following accounting period.

Accrued Depreciation

The total depreciation incurred by an asset or asset group, based on customary or fairly determined rates or estimates of useful life, now generally referred to as accumulated depreciation.

Accrued Expenses

See accrued liability.

Accrued Liability

An amount of interest, wages, or other expense recognized or incurred on and before a given date but not paid; sometimes referred to as accrued expense.

Accrued Revenue

Revenue earned, but neither received nor past due.

Accumulated Depreciation

The fixed-asset valuation account resulting from depreciation provisions; also known as reserve for depreciation, accrued depreciation, and allowance(s) for depreciation.

APPENDIX A - GLOSSARY

Active Medical Staff

Hospital-based and non-hospital-based physicians, other than interns and residents who are voting members of and can hold office in the Medical staff organization of the hospital.

Actuarial Basis

A basis compatible with principles followed by actuaries: said of computations involving compound interest, retirement and mortality estimates, and the like.

Acute Care

Inpatient general routine care provided to patients who are in an acute phase of illness but not to the degree which requires the concentrated and continuous observation and care provided in the intensive care units of an institution.

Addition

An addition is some thing which does not merely replace a thing previously owned. This includes enlargements and extensions of existing facilities.

Additional (Paid-in) Capital

Contributions of corporate stockholders credited to accounts other than capital stock; sources: an excess over par or stated value received from the sale or exchange of capital stock, an excess of par or stated value of capital stock reacquired over the amount paid therefore, or an excess from recapitalization; often displayed on the balance sheet as a separate item or in combination with par or stated value and designated paid-in capital; known also as paid-in surplus.

Admission

The formal acceptance by an institution of a patient who is to be provided with room, board, continuous nursing service, and other institutional services while lodged in the institution.

Advance

1. Payment of cash or the transfer of goods for which an accounting must be rendered by the receipt at some later date. A payment of a contract before its completion. 3. The payment of wages, salaries, or commissions before they have been earned. 4. Deferred income or expense.

APPENDIX A - GLOSSARY

Affiliate

A corporation or other organization related to another by owning or being owned, by common management or by a long term lease of its properties or other control device.

Age

The number of years or other time periods an asset or asset group has remained in service at a given date.

AICPA

American Institute of Certified Public Accountants.

Ambulatory Care

Health services rendered to persons who are not confined overnight in a health care institution. Ambulatory care services are often referred to as "outpatient" services.

Ambulatory Services

The essential characteristic of "Ambulatory Services" is that the patients come to or are brought to a facility of the hospital for a purpose other than admission as an inpatient. Ambulatory services include emergency services, clinical services, ambulance services, and home health services but exclude ancillary services.

Amortization

1. The gradual extinguishment of any amount over a period of time: as, the retirement of a debt by serial payments to the creditor or into a sinking fund; the periodic write-down of an insurance premium or a bond premium. 2. A reduction of the book value of a fixed asset; a generic term for the depreciation, depletion, write-down, or write-off of a limited-life asset.

Ancillary Services

Diagnostic or therapeutic services performed by specific facility departments as distinguished from general or routine patient care such as room and board. Ancillary services generally are those special services for which charges are customarily made in addition to routine charges and include such services as laboratory, radiology, surgical services, etc.

APPENDIX A - GLOSSARY

Asset

Any owned physical object (tangible) or right (intangible) having economic value to its owner; an item or source of wealth expressed, for accounting purposes, in terms of its cost, depreciated cost, or fair market value at date of donation.

Audit

1. The examination of contracts, orders, and other original documents for the purpose of substantiating individual transactions before their settlement. 2. Any systematic investigation or appraisal of procedures or operations for the purpose of determining conformity with prescribed criteria; the work performed by an internal auditor. 3. (Auditing) an exploratory, critical review by a public accountant of the underlying internal controls and accounting records of a business enterprise or other economic unit, precedent to the expression by him of an opinion of the propriety ("fairness") of its financial statements.

Available Beds

Health facility beds which are maintained and staffed for the provision of patient care.

Average Daily Inpatient Census

Average number of inpatients (based on the daily inpatient census) present each day for a given period of time.

Average Length of Stay

The average number of days of service rendered to each inpatient discharged during a given period.

Average Occupied Beds

Average licensed beds times percent of occupancy.

Average Life

The arithmetic mean of the estimated useful-life expectancies of a group of assets subject to depreciation.

Bad Debt

An uncollectible receivable.

APPENDIX A - GLOSSARY

Balance

1. The difference between the total debits and the total credits of an account or the total of an account containing only debits or credits.

2. The equality of the total debit balances and the total credit balances of the accounts in a ledger.

3. Agreement of the total of the account balances in a subsidiary ledger with its general - ledger control.

Balance Sheet

A statement of financial position of any economic unit, or component thereof, reporting as at a given moment of time its assets (at cost, depreciated cost, or other indicated value), its liabilities and its ownership equities recorded under an accounting system.

Base Year

The Fiscal Year for which actual data is used.

Betterment

An expenditure having the effect of extending the useful life of an existing fixed asset, increasing its normal rate of output, lowering its operating cost; increasing rather than merely maintaining efficiency or otherwise adding to the worth of benefits it can yield.

Board-Designated Assets

Unrestricted assets set aside by the governing board for specific purposes or projects.

Boarder Baby

1. A baby receiving lodging in the institution and who is not an institution patient. 2. A newborn infant whose mother is discharged but the newborn does not occupy a patient bed but is retained in the nursery.

Bond

1. A certificate of indebtedness, in writing and often under seal. 2. An obligation in writing, binding one or more parties as surety for another.

Bond Discount

The excess of the face amount of a bond or class of bonds over the net amount yielded from its sale. On the books and balance sheet of the issuer it appears as amortizable contra liability.

APPENDIX A - GLOSSARY

Bond Premium

The net amount yielded by the sale of a bond or class of bonds in excess of its face value. On the books and balance sheet of the issuer it appears as a deferred credit.

Book Inventory

1. An inventory which is not the result of actual stocktaking but of adding the units and the cost of incoming goods to previous inventory figures and deducting the units and cost of outgoing goods. 2. The balances of materials or products on hand in quantities, dollars, or both, appearing in perpetual-inventory accounts.

Book of Original Entry

A record book, recognized by law or custom, in which transactions are successively recorded, and which is the source of postings to ledgers; a journal. Books of original entry include general and special journals, such as cashbooks and registers of sales and purchases.

Book Value

1. The net amount at which an asset or asset group appears on the books of account, as distinguished from its market value or some intrinsic value. 2. The face amount of a liability less any unamortized discount and expense. 3. As applied to capital stock; (a) the book value of the net assets; (b) in a corporation, the book value of the net assets, divided by the number of outstanding shares of capital stock.

Budget Year

Refers to the year in which costs are projected.

Capital Asset

An asset intended for continued use or possession, common sub-classifications being (a) land, buildings and equipment, leaseholds, (fixed assets); (b) goodwill, patents, trademarks, franchises (intangibles); (c) investments in affiliated companies.

Capital Expenditures

An expenditure intended to benefit future periods, in contrast to a revenue expenditure, which benefits a current period; an addition to a capital asset. The term is generally restricted to expenditures that add fixed-asset units or that have the effect of increasing the capacity, efficiency, life span, or economy of operation of an existing fixed asset.

APPENDIX A - GLOSSARY

Capital Lease

A lease which meets one of the following four criteria: 1. The present value of the minimum lease payments is 90% or more of the fair value of the property to the lessor. 2. The lease term is 75% or more of the leased property's estimated economic life. 3. The lease contains a bargain (less than fair value) purchase option. 4. Ownership is transferred to the leasee by the end of the lease terms. (See FASB Statement No. 13 for further details).

Capitalize

1. To record and carry forward into one or more future periods any expenditure the benefits or proceeds from which will then be realized. 2. To add to a fixed asset account the cost of plant additions, improvements, and expenditures having the effect of increasing the efficiency or yield of a capital asset or making possible future savings in a cost from its use. 3. To transfer surplus to a capital-stock account, as the result of the issue of a stock dividend, a recapitalization, or, under the laws of some States, resolution of the board of directors. 4. To discount or calculate the present worth of the projected future earnings of an asset or business.

Certificate of Deposit

1. A formal instrument, frequently negotiable or transferable, issued by a bank as evidence of indebtedness and arising from a deposit of cash subject to withdrawal under the specific terms of the instrument: (a) demand certificates, payable upon presentation, seldom bearing interest; (b) time certificates, payable at a fixed or determinable future date, usually bearing interest at a specific rate. 2. A formal certificate, usually printed or engraved, ordinarily negotiable or transferable, and issued by a depository or agent against the deposit of bonds or stock of a corporation under the terms of a reorganization plan or other agreement.

Chain Organization

A health care, or other organization consisting of a group of two or more facilities which are owned, leased or, through any other device, controlled by one business entity.

Chart of Accounts

A systematically arranged list of accounts applicable to a specific concern, giving account names and numbers. A chart of accounts, accompanied by descriptions of their use and of the general operation of the books of account, becomes a classification or manual of accounts.

APPENDIX A - GLOSSARY

Clearing Account

A primary account containing costs that are to be transferred to other account an intermediate account to which is transferred a group of costs or revenues or a group of accounts containing costs or revenues and from which a distribution of the total is made to other accounts.

Consistency

Continued uniformity, during a period or from one period to another, in method of accounting, mainly in valuation bases and methods of accrual, as reflected in the financial statements of an accounting entity.

Contract Service

Services performed in whole or in part by an outside organization on a contractual basis.

Contractual Adjustment

The difference between billings at established charges and amounts received due from third-party payors under contract agreements.

Contributed Capital

The payments in cash or property made to a corporation by its stockholders (a) in exchange for capital stock (b) in response to an assessment or the capital stock, or (c) as a gift; paid-in capital.

Contributed Services

See donated services.

Control

The process by which the activities of an organization are conformed to a desired plan of action and the plan is conformed to the organization's activities.

Cost

An expenditure or outlay of cash, other property, capital stock, or services, or the incurring of a liability therefore, identified with goods or services acquired or with any loss incurred, and measured by the amount of cash paid or payable or the market value of other property, capital stock, or services given in exchange or, in other situations, any commonly accepted basis of valuation. Implicit in the concept of cost is the accrual basis of accounting.

APPENDIX A - GLOSSARY

Cost Center

A cost center is an accounting device for accumulating items of cost that have common characteristics. A cost center may or may not be a department within the institution. A cost center such as Depreciation and Amortization, is an example where the cost center would not be a department of the institution. A cost center may be a function within the health facility as opposed to a department.

Current Assets

Unrestricted cash or other assets held for conversion within one year into cash or other readily convertible asset, or currently useful goods or services. The five customary subdivisions of current assets are cash, temporary investments, receivables, inventory, and prepaid expenses.

Current Liability

A short-term debt, regardless of its source, including any liability accrued and deferred and unearned revenue that is to be paid out of current assets or is to be transferred to income within one year. The currently maturing portion of long-term debt is thus classified unless it is to be paid from a sinking fund or other non-current asset source.

Daily Hospital Services

Daily Hospital Services are those inpatient services generally included by the hospital in a daily service charge——sometimes referred to as the "room and board" charge. Included in such services are the room, dietary, and nursing services, minor medical and surgical supplies, and the use of certain equipment and facilities for which the hospital does not customarily make a separate charge.

Daily Inpatient Census

The number of inpatients present at the census-taking time each day, plus any inpatients who were both admitted and discharged after the census-taking time the previous day. Generally, the inpatient census is taken each midnight. However, a facility may designate and consistently use any other specified hour for census taking.

Date of Acquisition

The effective purchase date of an asset. Usually, this is the date title is acquired, or the burdens of ownership are assumed and the asset is in possession.

Dedicated

Set aside for a particular future use, but not currently mandated.

APPENDIX A - GLOSSARY

Deductible

Under the Medicare program that portion of covered hospital and medical charges which an insured person must pay before his policy benefits begin. Proposed as a mechanism to discourage over-utilization or to avoid processing small claims.

Deductions from Revenue

Reductions in gross revenue arising from bad debts, contractual adjustments, uncompensated/charity care, administrative, courtesy, policy discounts, adjustments and others.

Deferral (or Deferment)

The accounting treatment accorded the receipt or accrual of revenue before it is earned, or the incurrence of an expenditure before the benefits there-from are received. Such items are balance-sheet liabilities or assets and are carried forward to the income account of succeeding periods as the revenue is earned or as the benefits are received from the expenditure.

Deferred Charge

An expenditure not recognized as a cost of operations of the period in which incurred but carried forward to be written off in one or more future periods.

Deferred Credit

Revenue received or recorded before it is earned, i.e. before the consideration is given, in whole or in part, for which the revenue is or is to be received.

Depreciable Cost

That part of the cost of a fixed asset that is to be spread over useful life; i.e., cost less the estimated recovery from resale or salvage.

Depreciation

Lose usefulness; expired utility; the diminution of service yield from a fixed asset or fixed-asset group that cannot or will not be restored by repairs or by replacement of parts.

Depreciation Fund

Money or marketable securities set aside for the purpose of replacing or providing assistance in replacing depreciable fixed assets.

APPENDIX A - GLOSSARY

Direct Expense

The cost of any good or service that contributes to, and is readily ascribable to, product or service output. Direct expense includes salaries and wages, employ benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Direct Recording of Cost

The process of identifying and assigning costs directly to the functional cost center generating those costs.

Discharge

The termination of lodging and the formal release of an inpatient by the institution. Since deaths are a termination of lodging, they are also inpatient discharges.

Discount Earned

A reduction in the purchase price of a good or service because of early payment.

Discrete Unit

A separately organized, staffed and equipped unit of the institution.

Distribution

1. Any payment to stockholders or owners of cash, property, or shares, including any of the various forms of dividends in non-corporate enterprise, a withdrawal. 2. A spread of revenue or expenditure or of capital additions to various accounts; an allocation. 3. Disposal of a product by sale.

Donated Commodities

Gifts of supplies and other materials such as medicines, blood, linen, and office supplies which are normally purchased by the institution, and are recorded on the books at their fair market value at the time of donation regardless of when actual receipt takes place.

APPENDIX A - GLOSSARY

Donated Services

The services performed by personnel who receive no compensation or partial compensation for their services. The equivalent of an employer-employee relationship must exist between the institution and the individual donating the services. The term is usually applied to services rendered by members of religious orders, societies, or similar groups to institutions operated by or affiliated with such institutions.

Due from Other Funds

A receivable for money loaned, stores issued, work performed, or services rendered to or for the benefit of another fund.

Due to Other Funds

A payable for money borrowed, stores received, work performed, or services from another fund.

Earned

Realized or accrued as revenue through sales of goods, services performed, or the lapse of time.

Empirical

Derived from experience; sometimes contrasted with rational (i.e., derived from some plan or principle).

Employee

As distinguished from an independent contractor, a person subject to the will and control of an employer with respect to what the employee does and how he does it and is on the payroll of the institution.

Employee Benefit

A pension provision, retirement allowance, insurance coverage, paid vacation, sick leave, and holiday time off or other cost representing a present or future return to an employee.

Encounter

A face-to-face contact between a patient and a provider who has primary responsibility for assessing and treating the condition of the patient at a given contact and exercises independent judgment in the care of the patient.

Endowment Funds

Funds in which a donor has stipulated, as a condition of his gift, that the principal of the fund is to be maintained inviolate and in perpetuity and that only income from investments of the fund be expended (See also Term Endowment Funds).

APPENDIX A - GLOSSARY

Equity

1. Any right or claim to assets. 2. An interest in property or in a business, subject to claims of creditors. 3. The difference between assets and liabilities. 4. Net Worth.

Equity Ownership

1. The interest of an owner in property or in a business or other organization, subject, in case of liquidation, to prior claim of creditors. 2. The interest (paid-in capital and retained earnings) of a stockholder or of stockholders collectively in a corporation; proprietorship.

Error

Deviation, inaccuracy, or incompleteness in the measurement or representation of fact.

Estimated Useful Life

Expected operating or service life of an asset group in terms of utility to the institution.

Expenditure

1. The incurring of a liability, the payment of cash, or the transfer of property for the purpose of acquiring an asset or service or settling a loss. 2. The amount of cash or property paid or to be paid for a service rendered, or an asset purchased. 3. Any cost, the benefits of which may extend beyond the current accounting period.

Expense

Expired cost; any item or class of cost of (or loss from) carrying on an activity; a present or past experience defraying a present operating cost or representing an irrecoverable cost or loss.

Expense Center

See Cost Center.

Expired Cost

An expenditure from which no further benefit is anticipated; an expense; a cost absorbed over the period during which benefits were enjoyed or a loss incurred.

APPENDIX A - GLOSSARY

Extraordinary Expense

A material expense (see Materiality) so unusual in nature or in frequency of occurrence as to be accorded special treatment in the accounts or separate disclosure in financial statements.

Facility

A coordinated group of fixed assets —— land, buildings, machinery, and equipment —— constituting a plant.

Fair Market Value

1. Value determined by bonafide bargaining between well-informed buyers and sellers, usually over a period of time. 2. An estimate of market value, in the absence of sales or quotations.

FASB

Financial Accounting Standards Board.

Fellow

A graduate of a medical/osteopathic/dental school who has had an advanced period of graduate training and is in a fellowship program in a subspecialty or in a clinical research program.

Fidelity Bond

Insurance against losses arising from dishonest acts of employees involving money, merchandise, or other property.

Fiduciary

Any person responsible for the custody or administration, or both, of property belonging to another; as, a trustee.

Financial Accounting Standards Board

A quasi-independent organization established in 1973 by the AICPA - Sponsored Financial Accounting Foundation for the purpose of developing principles for financial reporting by business enterprises.

Financial Statements

A balance sheet, income statement, funds statement, statement of changes in financial position, or any supporting statement or other presentation of financial data derived from accounting records.

APPENDIX A - GLOSSARY

Financially Indigent Patient

A patient lacking the financial ability to reasonably to be expected to pay for medical services received.

Fixed Assets

1. Assets of a relatively permanent nature held for continuous use in hospital operations and not intended to be converted into cash through sale. 2. A balance sheet classification denoting capital assets other than intangibles and investments in affiliated companies or other long-term investments. Included in the usual fixed-asset categories are land (from which the flow of services is seemingly permanent), land improvements, buildings, fixed equipment, tools, leasehold improvements, major movable and minor movable equipment; generally excluded are goodwill, patents, and other intangibles. The characteristic fixed asset has a limited life (land is the one important exception, and, in organizations where expenses are accounted for, its cost, less estimated salvage at the end of its useful life, is distributed over the periods it benefits by means of provisions for depreciation.

Fixed Capital

The investment in capital assets.

Fixed Cost (or Expense)

An operating expense, or operating expense as a class, that does not vary with business volume. Examples: interest on bonds; rent; property tax; depreciation (sometimes in part); minimal amounts of general overhead. Fixed costs are not fixed in the sense that they do not fluctuate or vary; they vary, but from causes independent of volume.

Fringe Benefit

See employee benefit.

Full Time Equivalent Employees (FTEs)

An objective measurement of the personnel employment of an institution in term of full time labor capability. To calculate the number of full time equivalent employees, sum all hours worked by employees and divide by 2080.

Function

A collection of activities having related purposes.

APPENDIX A - GLOSSARY

Functional Accounting

Accounting for the revenues and expense according to type of activity performed.

Fund

A self-contained accounting entity set up to account for a specific activity or project.

Fund Accounting

Maintenance of separate and/or group accounts for health facility resources according to spending objectives set by donors, other outside sources, or the governing body.

Fund Asset

An asset belonging to a particular fund or a group of funds.

Fund Balance

The excess of assets over liabilities (net equity). An excess of liabilities over assets is known as a deficit in fund balance.

Fund Balance Sheet

A balance sheet divided into self-balancing sections, each of which shows the assets and liabilities of a single fund or group of related funds.

Fund Liability

A liability of a fund which is to be met out of its existing resources.

Funded Debt

Debt evidenced by outstanding bonds or long-term notes.

Funded Depreciation

See Depreciation Fund.

Funded Reserve

A pension reserve, a reserve for bonuses or for the retirement of preferred stock, or other prospective future liability against which certain assets have been accumulated and set aside or earmarked.

APPENDIX A - GLOSSARY

Funds Held in Trust by Others

Funds held and administered, at the direction of the donor, by an outside trustee for the benefit of an institution or institutions.

GAAP

Generally Accepted Accounting Principles.

Gain or Loss

The net result of a concluded transaction or of an operating period, following the application of generally accepted accounting principles.

General Fund

See Operating Fund.

General Journal

The journal in which are recorded transactions not provided for in specialized journals.

General Ledger

A ledger containing accounts in which all the transactions of a business enterprise or other accounting unit are classified either in detail or in summary form.

Generally Accepted

Given authoritative recognition; said of accounting principles or audit standards, and the pronouncements concerning them, particularly, in recent years, those of the American Institute of Certified Public Accountants and the Financial Accounting Standards Board.

Gift

Any voluntary conveyance of assets gratuitously made and not in consideration of any kind of exchange.

Goodwill

The excess of the price paid for a business as a whole over the book value or over the computed or agreed value of all tangible net assets purchased. Normally, goodwill thus acquired is the only type appearing on books of account and in financial statements.

APPENDIX A - GLOSSARY

Governing Board

The policy-making board of the hospital. Some of the responsibilities usually attributed to the governing board may be assumed by appropriate committees.

Gross

Undiminished by related deductions, except corrections; applied to sales, revenues, income, expense, and the like.

Gross Charges (Gross Revenue)

The total charges at the hospital's full established rates for services rendered and goods sold (including patient related and non-patient related).

Gross Square Feet

The total floor areas of the plant, including common areas (hallways, stairways, elevators, lobbies, closets, etc.).

Health Facility

Any licensed facility, place, or building which is organized, maintained, and operated for the diagnosis, care and treatment of human illness, physical or mental, including convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of these purposes, for one or more persons to which such persons are admitted for a 24-hour stay or longer.

Health Related Care

Care, other than medical, that is performed by qualified personnel and pertains to protective, preventive, personal and social services.

Historical Cost

The amount of cash or cash equivalent given in exchange for properties or services at the time of acquisition. (See Basis of Valuation——Sec. 100, Sub-Sec. 28.

Home Office

The office of the controlling organization. This office generally incurs costs and provides services to or on behalf of the individual health facility.

Hospital

An establishment that provides —— through an organized medical or professional staff, permanent facilities that include inpatient beds, medical services, and continuous nursing services —— diagnosis and treatment for patients.

APPENDIX A - GLOSSARY

Hospital-Based Physicians

A physician who spends the predominant part of his practice time within one or more hospitals instead of in an office setting, or providing services to one or more hospitals or their patients. Such physicians have either a special financial arrangement with the hospital (salary or percentage of fees collected) or bills patients separately for his/her services. Such physicians include directors of medical education, pathologists, anesthesiologists and radiologists, as well as physicians who staff emergency rooms and outpatient departments.

Hospital Boarder

An individual who receives lodging in the hospital but who is not an inpatient. In most hospitals, a small number of persons who are not patients and who are not hospital personnel or physicians may, nevertheless, be occasionally provided with room and board, often in "areas of the hospital where patients generally stay at least overnight." Most often this is arranged so that they can be near children or other members of the family who are ill.

Hospital Patient

An individual receiving, in person or otherwise (telemetry), hospital-based or coordinated medical services for which the hospital is responsible.

Imprest Fund

A fixed cash fund or petty cash fund in the form of currency, a bank checking account, or both, maintained for expenditures that must be made in cash, and from time to time, restored to its original amount by a transfer from general cash of a sum equal to the aggregate of disbursements; a form of working fund.

Improvement

1. Betterment. 2. The clearing, draining, grading or other addition to the worth of a tract of land; any cost of developing real estate, whether paid for directly or through special assessment taxes. 3. A betterment of leased property or plant.

Income Realization

The recognition of income, the usual test being the passage of title to or delivery of goods, or the performance of services.

Income Statement

An accounting statement which reflects the financial results of a hospital during an accounting period. The data for this statement are accumulated in the revenue and expense accounts.

APPENDIX A - GLOSSARY

Indirect Liability

1. An obligation not yet incurred but for which responsibility may have assumed in the future; as, the possible liability from the premature settlement of a long-term contract. 2. A debt of another, as the result of which an obligation to pay may develop; a contingent liability.

Inpatient

A patient who is provided with room, board, and continuous general nursing service in an area of the hospital where patients stay overnight.

Inpatient Admission

The formal acceptance by a health facility of a patient who is to be provided with room, board, and continuous nursing service in an area of the health facility where patients generally stay at least overnight.

Intangible Asset

A capital asset having no physical existence, its value being limited by the rights and anticipative benefits that possession confers upon the owner.

Intensive Care

Services provided in a routine patient care unit to patients who require extraordinary observation and care on a concentrated exhaustive and continuous basis.

Inter-fund Transfer

The transfer of money or other asset or of a liability from one fund to another.

Intern

A graduate of a medical/osteopathic/dental school serving a first year of graduate clinical training.

Internal Control

The general methodology by which management is carried on within an organization; also, any of the numerous devices for supervising and directing an operation or operations generally.

APPENDIX A - GLOSSARY

Internal control, a management function, is a basic factor operating in one form or another in the administration of every organization, business or otherwise. Although sometimes identified with the administrative organism itself, it is often characterized as the nervous system that activates overall operating policies and keeps them within practicable performance ranges.

The principles contributing to internal control are usually these:

1) Recognition that within every organizational unit there are one or more functional or action components known as activities, costs or responsibility centers, or management units;

2) Delegated operating authority in each organizational unit permitting freedom of action within defined limits;

3) The linking of expenditures——their incurrence and disposition——with specific individual authority;

4) End-product planning (a) by means of a budget fitted to the organizational structure and to its functional components, thus maintaining dual forward operating disciplines; and (b) the adoption of standards of comparison other performance of measurements such as standard costs, quality controls and timing goals.

5) An accounting process that provides organizational and functional administrators with prompt, complete, and accurate information on operating performance, and comparisons with predetermined performance standards;

6) Periodic reports, consonant with accounting and related records, by activity heads to supervisory management; reports serving as feedbacks of informative pictures of operations, and as displays of favorable factors that have influenced performance;

7) Internal check, built into operating procedures, and providing maximum protection against fraud and error;

8) Frequent professional appraisals, through internal audit, of management and its policies and operations generally, as a protective and constructive management service, its emphasis varying with the quality of operating policies and their administration; and

9) The construction of the above controls in such a manner as to stimulate and take full advantage of those natural attributes of individual employees the recognition and exercise of which may obviate the need for some internal controls and determine the extent and rigidity of others.

APPENDIX A - GLOSSARY

Inventory Control

The control of merchandise, materials, goods in process, finished goods, and supplies on hand by accounting and physical methods. An accounting control is effected by means of a stock or stores ledger, mechanical storage records, or a ledger account in which the quantities or amounts (or both) of goods received during an accounting period are added to correspondence balances at the beginning of the period and amounts of goods sold or otherwise disposed of are deducted at a calculated cost based on individual identification or any of various methods of averaging. Physical controls consist of various plans of buying, storing, handling, issuing, supervising, and stocktaking. Stock ledger control is made more effective by physical control in the nature of continuous check of the goods on hand.

Inventory Valuation

The determination of the cost or the portion of cost assignable to on-hand raw materials, merchandise, merchandise held for resale, and supplies based on any generally accepted method consistently applied.

Invested Capital

1. The amount of capital contributed to a business by its owners; capital. 2. The amount so contributed, plus retained earnings (or less accumulated losses) and appropriated surplus.

Investor-Owned (Proprietary) Hospital

A hospital owned by a person, an unincorporated group of people, or a corporation. Operation of this type of hospital is usually intended to return a monetary gain to the investors; but may include instances where individuals own and operate hospitals primarily for community benefit.

Invoice

A document showing the character, quantity, price, terms, nature of delivery, and other particulars of goods sold or of services rendered.

Invoice Cost

Cost incurred by a buyer and reflected on an invoice which, unless otherwise specified, is net after deducting trade discounts.

Irrevocable Trust

A trust that cannot be set aside by its creator.

APPENDIX A - GLOSSARY

Lease

A conveyance of land or of the use of a building or a part of a building or equipment from one person (lessor) to another (lessee) for a specified period of time, in return for rent or other compensation.

Leasehold

An interest in land, buildings, and equipment under the terms of a lease, normally classified as a (tangible) fixed asset.

Liability

1. An amount owing by one person (a debtor) to another (a creditor), payable in money, or in goods or services: the consequence of an asset or service received or a loss incurred or accrued; particularly, any debt (a) due or past due (current liability), (b) due at a specified time in the future (e.g., funded debt, accrued liability), or (c) due only on failure to perform a future act (deferred income), contingent liability). 2. The title of the credit half of a balance sheet, often including net worth as well as obligations to outsiders; when thus used, the ??? is that the organization reflected in the balance sheet has a status independent to both its creditors and its owners—to whom it must account in the amounts shown.

License

A permission granted by competent authority to engage in a business or corporation or any activity otherwise unlawful.

Living Trust Funds

Funds acquired by an institution subject to agreement whereby resources are made available to the institution on condition that the institution pay periodically to a designated person, or persons, the income earned on the resources acquired for the lifetime of the designated person, or persons or for a specified period.

Maintenance

Effort expended to maintain assets in fit condition to do their work—such items are ordinary and recurring and do not improve the asset or add to its life. A useful distinction between maintenance as preventive and repairs as curative.

Materiality

The relative importance, when measured against a standard of comparison, of all items (cumulative by cost center or account) included in or omitted from books of account or financial statements, or any procedure or change in procedure that con-

APPENDIX A - GLOSSARY

Medicaid (Title XIX)

A Federally-aided, State operated and administered program which provides medical benefits for certain low-income persons in need of health and medical care. The program, authorized by Title XIX of the Social Security Act, is basically for the poor. It does not cover all the poor, however, but only persons who are members of one of the categories of people who can be covered under the welfare cash payment programs——the aged, the blind, the disabled, and members of families with dependent children where one parent is absent, incapacitated or unemployed. Subject to broad Federal guidelines, States determine the benefits covered, program eligibility, rates of payment for providers, and methods of administering the program.

Medical Record

A record kept on patients which properly contains sufficient information to identify the patient clearly, to justify his diagnosis and treatment, and to document the results accurately. The purposes of the record are to serve as the basis for planning and continuity of patient care; provide a means of communication among physicians and any professional contributing to the patient's care; furnish documentary evidence of the patient's course of illness and treatment; serve as a basis for review, study, and evaluation; serve in protecting the legal interests of the patient, hospital, and responsible practitioner; and provide data for use in research and education. Medical records and their contents are not usually available to the patient himself. The content of a record is usually confidential. Each different provider in a community caring for a given patient usually keeps an independent record of that care.

Medical Services

The services pertaining to medical care that are performed at the direction of a physician on behalf of patients by physicians, dentists, nurses, and other professional and technical personnel.

Medical Staff Classification

Appointments to the medical staff fall into several classes, the most common of which are:

1) Attending - Have full admitting privileges in accordance with their abilities and qualifications, and also participates as members of the medical staff committees, serve as officers of the medical staff and serve as directors or chiefs of departments. They are required to attend meetings of the general staff and departmental staff, and may be required to devote time to the education programs and supervise residents in outpatient clinics or emergency departments.
2) Associate - New applicants are generally appointed as associate staff members for a period of 2 to 4 year, after which they become members of the attending staff.
3) Courtesy - Certain doctors are designated as courtesy members when they have retired. They have privileges consistent with their abilities and qualifications.
4) Consulting - Physicians of recognized professional ability in their specialty but who are not members of the attending staff.
5) House staff (Paid Staff) - Licensed physicians who are employed by the hospital to provide service to all patients, according to need, and are subject to the approval of the patients' own physicians.

APPENDIX A - GLOSSARY

Medicare

A third-party reimbursement program administered by the Health Care Financing Administration that underwrites the medical costs of persons 65 and over and some qualified persons under 65. "Part A" covers hospital services and "Part B" covers physicians' services.

Mentally Disordered Patient

A person with a chronic psychiatric impairment and whose adaptive functioning is moderately impaired. This patient requires continuous supervision and can be expected to benefit from an active rehabilitation program effort designed to improve his adaptive functioning and develop a potential for replacement in a less protected living environment.

Modernization

Includes the alteration, expansion, major repair (to the extent permitted by regulations) remodeling, replacement, and renovation of existing buildings (including initial equipment thereof and the replacement of obsolete equipment of existing buildings).

Net

Diminished by all relevant and commonly associated deductions.

Net Square Feet

Gross square feet of a building less common areas. To determine net square feet, the number of square feet in each cost center of the hospital may be determined either by a physical measurement of the hospital or by a measurement from blueprints. Floor area measurements should be taken from the center of walls to the center of adjoining corridors if a hallway services more than one cost center. Exclude stairwells, elevators, and other shafts, commonly used (lobbies, etc.) and idle areas. Idle areas are those areas that are closed off or unused for a period of time. Hallways, waiting rooms, storage areas, etc., serving only one cost center should be included in that cost center. The effect of using only usable space in the allocable floor area is to allocate the non-productive space (commonly used and idle area) among the cost centers in the ratio of space used.

APPENDIX A - GLOSSARY

Net Worth

The aggregate presentation on the accounting records of the equities representing proprietary interests; the excess of the going-concern's value of assets over liabilities to outsiders; of a corporation, the total of paid-in capital, retained earnings, and appropriated surplus; of a sole proprietorship, the proprietor's account; of a partnership the sum of the partner's accounts.

Non-Operating Expense

The expenses of a hospital which is not directly related to patient care, related patient services, or the sale of related goods. For example, non-operating expenses include losses on sale of hospital property and retail operations expense.

Non-Operating Revenue

The revenue of a hospital which is not directly related to patient care, related patient services, or the sale of related goods. For example, non-operating revenue includes unrestricted gifts, unrestricted income from endowment funds, gain on sale of hospital properties, and retail operation revenue.

Non-Profit Corporation

An incorporate charity, or any corporation operated under a policy by which no stockholder or trustee shares in the profits or losses, if any, of the enterprise.

Non-Revenue-Producing Cost Centers

These are overhead units, such as dietary and plant operations and maintenance, that provide necessary support services to revenue-producing centers.

Nursing Services

Services pertaining to the curative, rehabilitative, and preventive aspects of nursing care that are planned, performed, supervised and/or directed by a registered professional nurse.

APPENDIX A - GLOSSARY

Obsolescence

The loss in usefulness of an asset, occasioned by the approach to the stage of economic uselessness through progress of the arts; economic inutility arising from external causes; disappearing usefulness resulting from invention, change of style, legislation, or other causes having no physical relation to the object affected. It is distinguished from exhaustion, wear and tear, and deterioration in that these terms refer to a functional loss arising out of a change in physical condition.

On-Call Pay (Standby)

Standby pay is compensation to an employee for being available to work.

Operating Expenses

Operating expenses include all necessary and proper costs which are appropriate in developing and maintaining the operation of the patient care facilities and activities. Necessary and proper costs related to patient care are those costs which are common and accepted occurrences in the hospital operation.

Operating Fund

The funds within the Unrestricted Fund which have not been designated by the governing board of the hospital for special uses.

Operating Income (or Profit)

The excess of the revenues of a business enterprise over the expenses pertaining thereto, excluding income and expense, derived from sources other than its regular activities.

Operating Lease

A lease which fails to meet all of the following four criteria:

1) The present value of the minimum lease payments is 90% of the fair value of the property to the lesser.
2) The lease term is 75% or more of the leased property's estimated economic life.
3) The lease contains a bargain (less than fair value) purchase option.
4) Ownership is transferred to the lessee by the end of the lease term. (See FASB Statement No. 13 for further details).

APPENDIX A - GLOSSARY

Operating Revenue

Operating Revenue includes revenue directly related to the rendering of patient care services and revenue from non-patient care services to patients and sales activities to persons other than patients.

Organization Cost (or Expense)

Any cost incurred in establishing a corporation or other form of organization as, incorporation, legal and accounting fees, promotional costs incident to the sale of securities, security qualification expense, and printing of stock certificates. These and similar costs constitute, theoretically, an intangible asset of value which continues throughout the life of the corporation and hence, strictly, do not constitute a deferred charge. The organization costs must be amortized over a period of time not less than 60 months.

Original Cost

Outlay for an asset by its owner, not including any adjustments of cost are from post-acquisition alterations, improvements, or depreciation.

Other Operating Revenue

Other operating revenue includes revenue from non-patient care services to patients and sales and activities to persons other than patients, and the value donated commodities.

Outpatient

A hospital patient who receives services in one or more of the facilities of the hospital when he is not currently an inpatient or a home care patient.

Outstanding

1. Uncollected or unpaid: said of an account or note receivable or payable a check sent to the payee but not yet cleared against the drawee bank. 2. In the hands of others: said of the units of funded debt of a corporation or of the certificates representing issued shares of capital stock in the hands of the public; treasury stock is defined in terms of shares issued but not outstanding.

APPENDIX A - GLOSSARY

Overhead

1. Any cost of doing business other than a direct cost of an output of product or service. 2. A general name for costs of materials and services not directly adding to or readily identifiable with the product or service constituting the main object of an operation.

Owners Equity

Net Worth.

Ownership

The right to and enjoyment of services or benefits flowing from an asset, usually evidenced by the possession of legal title or by a beneficial interest in the title.

Paid-In Capital

The total amount of cash, property, and services contributed to a corporation, by its stockholders and constituting a major balance sheet item. It may be reflected in a single account or dividend between Capital Stock and Additional Paid-In Capital accounts.

Paid Staff

See Medical Staff Classification.

Parent Company

A controlling company having subsidiaries. Without a trade or business of its own, a parent company may also be termed a holding company.

Part A and Part B Services

Medicare benefits are payable from two trust funds. Part A services, which, in general, are those rendered by institutions, are reimbursed from funds derived from payroll tax. Part B services, generally medical and surgical physicians' services, and outpatient treatment and diagnosis are reimbursed from the fund created by voluntary premium payments and general Federal revenues.

APPENDIX A - GLOSSARY

Patient Care Services Revenue

The hospital's full established charges for services rendered to patients regardless of amounts actually paid to the hospital by or in behalf of patients.

Patient Day

A unit of measure denoting lodging facilities provided and services rendered to one inpatient between the census taking hour on two successive days. The day of admission but not the day of discharge or death is counted as a patient day. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Payor

A person or organization which pays the hospital for services rendered to patients. This can be the patient and/or third parties such as Medicare, Medicaid Blue Cross, or other private insurance plans.

Payroll

1. A record showing the wage or salary earned by employees for a certain period and the various deductions for withholding tax, health benefits, and so on. 2. Total wages and salaries accrued or payable for a given period.

Payroll Distribution

1. An analysis of the total amount of salaries and wages paid or accrued for a period, showing the component amounts to be charged to the various cost centers. 2. The entry by which the amount of salaries and wages paid or accrued for a period is charged in the required detail to the accounts or records.

Payroll Records

The records relating to the authorization, computation, distribution and payment of wages and salaries. They include payrolls, time slips, time-clock cards, withholding authorizations, cancelled payroll checks or receipts for wages paid, wage and salary authorizations and individual earning records.

Pediatric Patient

Children less than 14 years and including boarder patients, physically housed in a pediatric unit.

Periodic Interim Payment (PIP)

A plan under which the hospital receives cash payments from third-party payors (usually Medicare) in constant amounts each period. The total of these payments received over a year is the estimated cost of providing services to patients covered by the plan.

APPENDIX A - GLOSSARY

Perpetual Inventory

A book inventory kept in continuous agreement with stock on hand by means of a detailed record that may also serve as a subsidiary ledger where dollar amounts as well as physical quantities are maintained. Sections of the stockroom are inventoried at short intervals and the quantities or amounts or both are adjusted, where necessary, to the physical count.

Personal Property

Property or assets of a temporary and movable character as contrasted with real property.

Physical Inventory

An inventory determined by observation and evidenced by a listing of the actual count, weight, or measure.

Physical Life

Total potential operating life, as of a machine, as contrasted with useful or economic life, which may be much less because of the presence of obsolescence or inadequacy or both.

Physician

A doctor of medicine or of osteopathy who is fully licensed to practice medicine.

Physician, Attending

The physician who has legal responsibility for the care of a patient in a hospital.

Physician, Teaching

Physicians who have primary responsibility for teaching activities related to graduate physicians in training or medical/osteopathic/dental undergraduate students in an identified clinical service.

Plant

Physical properties used for institutional purposes, i.e., land, building, improvements, equipment, and so forth. The term does not include real estate or properties of restricted or unrestricted funds not used for health facility operations.

APPENDIX A - GLOSSARY

Plant Replacement and Expansion Funds

Resources restricted by donor and other third-parties for the acquisition or construction of plant assets or the reduction of related debt.

Pooled Investments

Assets of two or more funds consolidated for investment purposes.

Premature Infant

An infant born at any time through the 37th week of gestation (259 days).

Prepaid Expenses

An expenditure, often recurrent, for future benefits; a type of deferred charge. Examples: prepaid operating expenses, prepaid rent, taxes, royalties, commissions; unexpired insurance premiums; stationary and office supplies. Such items are classifiable as current assets and constitute a part of working capital; they are charged to future operations on the basis of measurable benefits or on a time or period-charge basis.

Prepay

To pay for a service before its receipt or enjoyment; such pre-payment, as for insurance or rent, reflecting long-established commercial practices, contrasts with accrue (or the recognition of the receipt or enjoyment of other types of services paid for after their receipt or enjoyment).

Present Value

The price a buyer is willing to pay for one or a series of future benefits, the term generally being associated with a formal computation of the estimated worth in the future of such benefits from which a discount or compensation for waiting is deducted.

Prior-Period Adjustment

A correction of an error in earlier financial statements or an adjustment that results from realization of income tax benefits of pre-acquisition loss carry forwards of purchased subsidiaries, all other items of profit or loss recognized in a fiscal year are required to be included in the determination of net income in the year recognized (see FASB Statement No.

Procedure

A unit of activity in an ancillary cost center. For example, a procedure in a radiology cost center may be a series of pictures which constitute an exam.

APPENDIX A - GLOSSARY

Professional Component

The professional services provided to patients by hospital-based physicians, as opposed to the education, research and administrative duties performed by the hospital-based physicians.

Program

Daily hospital or ambulatory service category of the patient.

Provider

An individual or institution which gives medical care. Institutional providers include a hospital, skilled nursing facility and intermediate care facility. Individual providers include individuals (physicians, dentists, etc.) who practice independently of institution providers and whose primary activity is the provision of health care to individuals.

Real Estate (or Property)

Land and land improvements, including buildings and appurtenances.

Record

A book or document containing or evidencing some or all of the activities of a hospital or containing or supporting a transaction, entry, or account. Examples: a book of account, subsidiary ledger; invoice; voucher; contract; correspondence; internal report; minute book.

Referred Outpatient

An outpatient who is referred by his private physician to the institution for diagnosis or treatment on an ambulatory basis. The responsibility for medical care remains with the referring physician.

Refund

An amount paid back or a credit allowed on account of an over-collection; rebate.

Registration

The process of formally entering a patient's name on the institution's records for service in a routine outpatient care service area.

APPENDIX A - GLOSSARY

Relative Value Unit

Index number assigned to various procedures based upon the relative amount of labor, supplies, and capital needed to perform the procedure. The unit value represents the costs of performing a service relative to some other service which is used as a base; i.e., has a unit value of one.

Remuneration

Compensation for value of service rendered or expense incurred.

Repair

1. The restoration of a capital asset to its full productive capacity, or a contribution thereto, after damage, accident, or prolonged use, without increase in its previously estimated service life or productive capacity. 2. The charge to operations representing the cost of such restoration.

Replacement

The substitution of one fixed asset for another, particularly of a new asset for an old, or of a new part for an old part. On the books of account, the recognition of the cost of the new asset requires the elimination of the cost of the asset it replaces.

Replacement Cost

1. The cost of an acquired asset or asset part, capitalizable if the cost of its retired counterpart is removed from the asset account. 2. The cost at current prices, in a particular locality or market area, of replacing an item or property or a group of assets.

Reserve

A segregation of retained earnings evidenced by the creation of a subordinate account. The segregation may be temporary or permanent, the purpose being to indicate to stockholders and creditors that a portion of retained earnings is recognized as unavailable for dividends. Examples: reserve for contingencies; reserve for improvements; sinking fund reserve.

Resident

A graduate of a medical/osteopathical / dental school serving an advanced period of graduate training. This may represent the first year of graduate training or any year thereafter.

APPENDIX A - GLOSSARY

Responsibility

The obligation prudently to exercise assigned or imputed authority attaching to the assigned or imputed role of an individual or group participating in organizational activities or decisions.

Responsibility Accounting

An accounting system which accumulates and communicates historical and projected monetary and statistical data relating to revenues and controllable expenses, classified according to organizational units producing the revenues and responsible for incurring the expenses.

Restricted Funds

Funds restricted by donors or grantors for specific purposes. Restricted funds generally fall into three categories: Plant Replacement and Expansion Fund, Specific Purpose Fund, and Endowment Fund. The accounts within each restricted fund are self-balancing, as each fund constitutes a separate accounting entity.

Retained Earnings (or Income)

Accumulated net income, less distributions to stockholders and transfers to paid-in capital accounts.

Retirement

The removal of a fixed asset from service, following its sale or the end of its productive life, accompanied by the necessary adjustment of fixed asset and depreciation-reserve accounts.

Retirement of Indebtedness Funds

Funds required by external sources to be used to meet debt service charges and the retirement of indebtedness on plant assets. The term "sinking funds" is sometimes used to describe these funds.

Revenue

Sales of products, merchandise, and services and earnings from interest, dividends, and wages.

Revenue Center

An account for accumulating revenue consistent with the functional definition of the matching cost center.

APPENDIX A - GLOSSARY

Revenue-Producing Cost Centers

Health facility activities providing direct services to patients (such as nursing, physical therapy, and laboratory) and thereby generating revenue.

Routine

Regular; customary; ordinary, repetitive; everyday.

Salvage Value

The price at which an asset of any kind can be sold less whatever cost is yet to be incurred.

Self-Responsible (Self-Pay) Patient

A patient who pays either all or part of his hospital bill from his own funds as opposed to third party funds.

Self-Insurance

The assumption by a hospital of a risk arising out of the ownership of proper or from other cause.

Share of Pooled Investments

The proportion of pooled investments, including accumulated gains or losses owned by a particular fund, usually expressed by a number (units) indicating the fractional ownership of total shares in the pool or by a percentage expressing the portion of the total pool owned by the particular fund.

Sinking Fund

See Retirement of Indebtedness Funds.

Specific Purpose Funds

Funds restricted by the donor for a specific purpose or project. Board-designated assets do not constitute specific purpose funds.

Standard Unit of Measure

The standard unit of measure is used to provide a uniform statistic for measuring and comparing hospital costs and productivity output, not activity.

Standby Pay (On-Call)

Compensation paid to an employee for being available to work.

APPENDIX A - GLOSSARY

Step-down Method

The allocation of the accumulated costs of the non-revenue producing centers to those other non-revenue producing centers which utilize their services, as well as to the revenue producing centers to which they render services. Once the costs of a non-revenue producing center have been allocated that center is considered closed.

Straight-Line Method of Depreciation

This method of allocating depreciation is a function of the passage of time and recognizes equal periodic charges over the useful life of the asset. The depreciation charge calculated by the straight-line method is not affected by asset productivity, efficiency, or degree of use. The periodic charge is computed by relating the cost of the asset, less any salvage, to the useful life of the asset.

Sub-Acute Care Service

Services provided to patients who require a level of nursing care less than acute, including residential care.

Subsidiary Ledger

A supporting ledger consisting of a group of accounts the total of which is in agreement with a control account.

Tangible Assets

A capital asset having physical existence.

Target Beds

Average occupied beds plus unoccupied bed allowance.

Teaching Program (Approved)

A medical internship or residency training approved by the Council on Medical Education of the American Medical Association or, in the case of osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association. Intern or residency programs in the field of dentistry must have the approval of the Council on Dental Education of the American Dental Association.

APPENDIX A - GLOSSARY

Teaching Program (Non-Approved)

To be a non-approved Teaching Program means that, a medical internship or residency training program is not approved by the Council of Medical Education of the American Medical Association or, in the case of an osteopathic hospital, is not approved by the committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association. An intern or residency program in the field of dentistry is not approved unless approval has been received by the Council of Dental Education of the American Dental Association.

Term Endowment Funds

Donated funds which by the terms of the agreement become available either for any legitimate purpose designated by the board or for a specific purpose designated by the donor upon the happening of an event or upon the passage of a stated period of time.

Third Party Payor

An agency such as Blue Cross or the Medicare Program which contracts with hospitals and patients to pay for the care of covered patients.

Trade Discount

The discount allowed to a class of customers on a list price before consideration of credit terms; as a rule, invoice prices are recorded in the books of account net after the deduction of trade discounts. Trade discounts are not to be confused with cash or purchase discounts which are other operating revenues.

Transaction

An event or condition the recognition of which gives rise to an entry in accounting records.

Treasury Stock

Full-paid capital reacquired by the issuing company through gift, purchase, or otherwise and available for resale or cancellation. Treasury stock is not a part of capital stock outstanding; and the term does not apply to unissued capital stock or to shares forfeited for non-payment of subscriptions.

Triage

The process of screening patients to determine the severity of the medical emergency and type of care necessary.

APPENDIX A - GLOSSARY

Trial Balance

A list or abstract of the balances or of total debits and total credits of the accounts in a ledger, the purpose being to determine the quality of posted debits and credits and to establish a basic summary for financial statements. The term is also applied to a list of account balances (and their total) abstracted from a customer's ledger or other subsidiary ledger for the purpose of testing their totals with the related control account.

Trust

A right, enforceable in courts of equity, to the beneficial enjoyment of property, the legal title to which is in another.

Trust Fund

A fund held by one person (trustee) for the benefit of another pursuant to the provisions of a formal trust agreement.

Uniform Accounting System

A system of accounts common to similar organizations.

Unit of Service

A unit of measure, often commonly accepted for determining average cost, time, or efficiency, thus making possible (a) comparisons of one operation with another or with the same operation in a preceding period, and (b) estimates of future operations. Synonymous with standard unit of measure.

Unrealized Revenue

Revenue attributable to a completed business transaction but accompanied by the receipt of an asset other than cash or other form of current asset; as, an installment sale (gross revenue) or the prospective profit from such a sale (net revenue).

Unrestricted Funds

Funds which bear no external restrictions as to use or purposes; i.e., funds which can be used for any legitimate purpose designated by the Governing Board as distinguished from funds restricted externally for specific operating purposes, for plant replacement and expansion and for endowment.

APPENDIX A - GLOSSARY

Useful Life

Normal operating life in terms of utility to the hospital.

Vested Interest

An interest (as a title to an estate) carrying a legal right to present or future enjoyment and of present alienation.

Wing

A distinct part of a building consisting of an architecturally subordinate extension of a building with a corridor connecting the main building and the extension. A wing could also be represented by the addition of one or more floor to an existing building.

Zero Level Accounts

Accounts which have an account number with a fourth digit of zero.

GENERAL ACUTE HOSPITALS

NAME OF HOSPITAL	HOSPITAL NUMBER
Anne Arundel Medical Center	0023
Atlantic General Hospital	0061
Baltimore Washington Medical Center	0043
Bon Secours Hospital	0013
Calvert Memorial Hospital	0039
Carroll County Hospital Center	0033
Chester River Hospital Center	0030
Civista Medical Center	0035
Doctors Community Hospital	0051
Dorchester General Hospital	0010
Fort Washington Medical Center	0060
Franklin Square Hospital	0015
Frederick Memorial Hospital	0005
Garrett County Memorial Hospital	0017
Good Samaritan Hospital	2004
Greater Baltimore Medical Center	0044
Harbor Hospital Center	0034
Harford Memorial Hospital	0006
Holy Cross Hospital	0004
The Johns Hopkins Hospital	0009
The Johns Hopkins/Bayview Medical Center	0029
Howard County General Hospital	0048
Kernan Hospital	2001
Laurel Regional Hospital	0055
Maryland General Hospital	0038
Edward W. McCready Memorial Hospital	0045
Memorial Hospital at Easton	0037
Mercy Medical Center	0008
Montgomery General Hospital	0018
Meritus Medical Center	0001
Northwest Hospital Center	0040
Peninsula Regional Medical Center	0019
Prince Georges Hospital Center	0003
St. Agnes Healthcare, Inc.	0011
St. Joseph Medical Center	0007
St. Mary's Hospital	0028
Shady Grove Adventist Hospital	5050
Sinai Hospital of Baltimore	0012

GENERAL ACUTE HOSPITALS

NAME OF HOSPITAL	HOSPITAL NUMBER
Southern Maryland Hospital Center	0054
Suburban Hospital	0022
Union Hospital of Cecil County	0032
Union Memorial Hospital	0024
University of Maryland Medical System	0002
Upper Chesapeake Medical Center	0049
Western Maryland Regional Medical Center	0016

PSYCHIATRIC HOSPITALS

NAME OF HOSPITAL	HOSPITAL NUMBER
Adventist Behavioral Health	4013
Brook Lane Health Services	8012
Chesapeake Youth Center	3478
St. Luke Institute	2781
The Sheppard Pratt Health System	4000

CHRONIC HOSPITALS

NAME OF HOSPITAL	HOSPITAL NUMBER
Adventist Rehabilitation Hospital	3029
Levindale Hebrew Geriatric Center & Hospital	5033
Healthsouth Chesapeake Rehabilitation Hospital	3028
Mount Washington Pediatric Hospital	5034
University Specialty Hospital	5089

CENTER CODE

CODE	CENTER
ADD	PSYCHIATRIC ADOLESCENT NEUROPSYCHIATRY
ATH	ACTIVITY THERAPIES
ADM	ADMISSIONS CHARGE
AMB	AMBULANCE SERVICES
ANS	ANESTHESIOLOGY
AUD	AUDIOLOGY SERVICES
BB	BLOOD BANK
BUR	BURN CARE UNIT
CAF	CAFETERIA
IRC	INTERVENTIONAL RADIOLOGY/CARDIOVASCULAR
CAT	CT SCANNER
CSS	CENTRAL SERVICES AND SUPPLY
BAD	CHARITY AND BAD DEBTS
CL	CLINIC SERVICES
CHE	COMMUNITY HEALTH EDUCATION
CCU	CORONARY CARE UNIT
CNA	CERTIFIED NURSE ANESTHETIST
EDP	DATA PROCESSING
DEB	DAY CARE - RECREATION AREAS
DEF	DEFINITIVE OBSERVATION
DEP	DEPRECIATION AND AMORTIZATION
DTY	DIETARY
DPO	DOCTOR'S PRIVATE OFFICE RENTAL
CDS	DRUGS SOLD
PSE	EDUCATION
EEG	ELECTROENCEPHALOGRAPHY
EKG	ELECTROCARDIOGRAPHY
EMG	EMERGENCY SERVICES
FTH	FAMILY THERAPIES
FSC	FREE STANDING CLINIC
FSE	FREE STANDING EMERGENCY SERVICE
FIS	GENERAL ACCOUNTING
GTH	GROUP THERAPIES
HDP	HOME DIALYSIS PROGRAM
HHC	HOME HEALTH SERVICES
MGT	HOSPITAL ADMINISTRATION
HKP	HOUSEKEEPING
HOU	HOUSING
HYP	HYPERBARIC CHAMBER
ITH	INDIVIDUAL THERAPIES
IST	INTEREST - SHORT TERM
ILT	INTEREST - LONG TERM
ICC	INTERMEDIATE (CHRONIC) CARE
KA	KIDNEY ACQUISITION
DEL	LABOR AND DELIVERY SERVICES
LL	LAUNDRY AND LINEN
LAB	LABORATORIES
LEA	LEASES & RENTALS
LEU	LEUKOPHERESIS

CENTER CODE

CODE	CENTER
LIC	LICENSES & TAXES
LIT	LITHOTRIPSY
MAL	MALPRACTICE INSURANCE
MRI	MAGNETIC RESONANCE IMAGING
MCR	MEDICAL CARE REVIEW
MRD	MEDICAL RECORDS
MSA	MEDICAL STAFF ADMINISTRATION
MSS	MEDICAL SUPPLIES SOLD
MSG	MEDICAL SURGICAL ACUTE
MIS	MEDICAL SURGICAL INTENSIVE CARE
NEO	NEO NATAL INTENSIVE CARE
NUR	NEWBORN NURSERY
NUC	NUCLEAR MEDICINE
NAD	NURSING ADMINISTRATION
RNS	NURSING EDUCATION
OBS	OBSTETRICS ACUTE
OBV	OBSERVATION
OTH	OCCUPATIONAL THERAPY
OOR	OFFICE AND OTHER RENTAL
ONC	ONCOLOGY
ORC	OPERATING ROOM CLINIC
OHE	OTHER HEALTH PROFESSION EDUCATION
OIN	OTHER INSURANCE
OOA	OTHER ORGAN ACQUISITION
OPM	OTHER PHYSICAL MEDICINE
OPT	OTHER THERAPIES
ORD	OUTPATIENT RENAL DIALYSIS
PAR	PARKING
PAC	PATIENT ACCOUNTS
PTE	PATIENT TELEPHONES
PED	PEDIATRICS ACUTE
PIC	PEDIATRIC INTENSIVE CARE
PHM	PHARMACY
PTH	PHYSICAL THERAPY
PME	POST-GRADUATE MEDICAL EDUCATION
POP	PLANT OPERATIONS
PRE	PREMATURE NURSERY
PSY	PSYCHIATRIC ACUTE
PAD	PSYCHIATRIC - ADULT
PCD	PSYCHIATRIC - CHILD/ADOLESCENT
PDC	PSYCHIATRIC DAY AND NIGHT CARE
PSG	PSYCHIATRIC GERIATRIC
PSI	PSYCHIATRIC INTENSIVE CARE
PPS	PSYCHIATRIC/PSYCHOLOGICAL SERVICE
PST	PSYCHOLOGICAL TESTING
PUL	PULMONARY FUNCTION TESTING
PUR	PURCHASING AND STORES
RAD	RADIOLOGY - DIAGNOSTIC
RAT	RADIOLOGY - THERAPEUTIC

CENTER CODE

CODE	CENTER
REC	RECREATIONAL THERAPY
RHB	REHABILITATION
PAP	PREFERRED AMBULATORY SERVICES
RDL	RENAL DIALYSIS
REG	RESEARCH
RES	RESPIRATORY THERAPY
REO	RETAIL OPERATIONS
TRM	SHOCK TRAUMA
SDS	SAME DAY SURGERY
EFC	SKILLED NURSING CARE
SSS	SOCIAL SERVICES
STH	SPEECH PATHOLOGY

07/01/19

APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES
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STANDARD UNIT OF MEASURE REFERENCES
DIAGNOSTIC RADIOLOGY

Diagnostic-Radiology Relative Value Units were developed with the aid of an industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions of codes in this section of Appendix D were obtained from the 2017 edition of the Current Procedural Terminology (CPT) manual and the 2017 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2017 Medicare Physician Fee schedule (MPFS) released November 2, 2016. RVUs were assigned using the following protocol ("RVU Assignment Protocol").

The RVUs reported in the 2017 MPFS include 2 decimal points. In order to maintain whole numbers in Appendix D, while maintaining appropriate relative value differences reported in the MPFS, the RVU work group agreed to remove the decimals by multiplying the reported RVUs by one hundred ten and then rounding the product of the calculation, where values less than X.5 are rounded down and all other values are rounded up.

1. CPT codes with RVUs listed in the MPFS.
    a. For CPT codes with RVUs that include both professional (modifier 26) and technical (modifier TC) components, use only the technical (TC) component RVU.
    b. CPT codes with only a single RVU listed
        a. CPT codes that are considered technical only (such as treatment codes), the single RVU reported will be used.
        b. CPT codes considered professional only are not listed in Appendix D.
2. CPT codes that do not have RVUs listed in the MPFS (e.g. CMS Status Code "C")
    a. CPT 70170, 74190, 74235, 74300, 74301, 74328, 74329, 74330, 74340, 74355, 74360, 74363, 74425, 74450, 74470, 744885, 74740, 74742, 75801, 75803, 75805, 75807, 75810, 75894, 75952, 75954, 75956, 75957, 75958, 75959, 75970, 76930, 76932, 76940, 76941, 76945 and 76975 did not have a published RVU in the MPFS. As these codes are bundled with a surgical code, these procedures should be reported under Interventional Radiology/Cardiovascular.
    b. CPT 74420 did not have a published RVU in the MPFS. The work group agreed the work activity associate with this code is similar to CPT 74415. Given the similarity of the work activity, it was determined the same RVU should be applied to CPT 74420.
    c. CPT 74445 did not have a published RVU in the MPFS. The work group agreed that this code is priced similar to CPT 74415 by various state Medicaid agencies. Given the similarity in pricing it was determined the same RVU should be applied to CPT 74445.
    d. CPT 74775 did not have a published RVU in the MPFS. The group agreed that this code is priced similar to CPT 74455 by various state Medicaid agencies. Given the similarity in pricing it was determined the same RVU should be applied to CPT 74775. Note: 74455 is moving to RIC but its federal RVU was used for 74775.
    e. CPT 76001 did not have a published RVU in the MPFS. The group agreed the work activity associated with this code is similar to CPT 76000. Given the similarity of the work activity, it was determined the same RVU should be applied to CPT 76001.
    f. CPT 76125 did not have a published RVU in the MPFS. The group agreed the work activity associated with this code is similar to CPT 76120. Given the similarity of the work activity, it was determined the same RVU should be applied to CPT 76125.
    g. CPT 76140 did not have a published RVU in the MPFS. This code is a professional fee and weighted at 0.

h. CPT 76496, 76499 and 76999 did not have a published RVU in the MPFS. As these codes are for unlisted procedures, the group agreed these codes should be considered "By Report" and RVUs should be developed using the guidelines below.
i. CPT 76998 does not have a published RVU in the MPFS. As this service is for guidance, the group agreed to mirror fluoroscopic guidance CPT 76000 (11 RVUs).
j. CPT 77061 did not have a published RVU in the MPFS. The group agreed the work activity associated with this code is similar to CPT 77063. Given the similarity of the work activity, it was determined the same RVU should be applied to CPT 77061.
k. CPT 77062 did have a published RVU in the MPFS. The group agreed the work activity associated with this code is similar to CPT 77063. Given the similarity of the work activity, it was determined the same RVU should be applied to CPT 77062.
l. CPT 77065 did not have a published RVU per the MPFS. This code is not valid for Medicare reporting purposes as Medicare requires a HCPCS code for this service. Therefore, RVUs will be established at 26 RVUs to mirror HCPCS code G0206.
m. CPT 77066 did not have a published RVU per the MPFS. This code is not valid for Medicare reporting purposes as Medicare requires a HCPCS code for this service. Therefore, RVUs will be established at 34 RVUs to mirror HCPCS code G0204.
n. CPT 77067 did not have a published RVU per the MPFS. This code is not valid for Medicare reporting purposes as Medicare requires a HCPCS code for this service. Therefore, RVUs will be established at 28 RVUs to mirror HCPCS code G0202.
o. CPT 93315, 93317 and 93318 did not have a published RVU in the MPFS. The group agreed that these codes should be reported under the Electrocardiology section of Appendix D.
p. CPT 93895 did not have a published RVU in the MPFS. This service is non-covered by Medicare and should be developed "By Report" following the protocol listed below.
q. CPT 93998 did not have a published RVU in the MPFS. As this code are for unlisted procedures, the group agreed these codes should be considered "By Report" and RVUs should be established using the guidelines below.
r. HCPCS code C9744 did not have a published RVU in the MPFS. This code is similar to CPT 76705, however, testing time is approximately double. A factor of 1.88 to account for additional testing time will be applied to the RVU value for CPT 76705 and will be assigned 34 RVUs (1.88 x 18= 33.84).
s. HCPCS R0070 and R0075 did not have a published RVU in the MPFS. The group agreed that these codes were not diagnostic and therefore were excluded from Appendix D.

3. CPT/HCPCS codes for which the published RVU did not make sense,
    a. G0365 is a level II HCPCS associated with other vessel mapping services. To allow flexibility for reporting this service to all payers, it will be listed as "By Report."

Services with Both a HCPCS Code for Medicare and CPT Code for Non-Medicare

All known HCPCS codes have been addressed in a payer-neutral fashion with this update. In instances of where Medicare implements a new HCPCS code to be utilized in lieu of a CPT code for a service, the RVU developed by the hospital must mirror the established CPT RVUs. The RVU for the service must be the same for all payers.

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CPT Codes with Bundled Procedures

CPT codes from 2017 with a surgical component have been assigned a zero (0) RVU value. When a Radiology CPT becomes bundled with a surgical code or replaced with a surgical code, these procedures should be charged as Interventional Radiology/Cardiovascular (IRC) and the associated costs of the procedure are to be reclassified to the IRC cost center.

Labor & Delivery Imaging

CPT codes that are listed in both Radiology and Labor & Delivery (e.g. Obstetrical Ultrasound) are to be charged based on where performed and the personnel performing the procedure. Procedures performed by Radiology staff are to be charged through Radiology and procedures performed by Labor & Delivery staff are to be charged through Labor & Delivery

Reporting of Imaging Guidance for Invasive Cases

Standard imaging RVUs are to be used for non-invasive imaging services. For invasive imaging services, the imaging guidance is either separately reportable or bundled into the code for the invasive service. Invasive imaging services occurring in an imaging suite must be charged using IRC minutes based on case time. For separately reportable imaging guidance, hospitals are to report one (1) IRC minute per imaging code. Imaging expenses associated with the guidance are to be allocated from the diagnostic imaging rate center to the IRC rate center.

When an operating room or operating room-clinic case involves separately reportable intraoperative/intraprocedural imaging guidance or imaging services, standard imaging RVUs are to be used. These cases are charged based on OR or ORC minutes. When imaging guidance is bundled into the underlying procedure, hospitals should not report any additional RVUs for the imaging. If imaging staff is assisting during a case where the imaging is bundled into the underlying procedure, expenses should be allocated from the imaging department to the operating room or operating room clinic rate center.

CPT Codes without an Assigned RVU Value

RVUs for new codes developed and reported by CMS after the FY 2017 reporting, must be developed "By Report". When assigning RVUs to these new codes, hospitals should use the RVU Assignment Protocol described above where possible using the most current MPFS. For codes that are not listed in the MPFS, hospitals should assign RVUs based on time and resource intensity of the services provided compared to like services in the department. Documentation of the assignment of RVUs to codes not listed in Appendix D should always be maintained by the hospital.

For any codes that are in the surgical series of CPT (i.e. 1XXXX – 6XXXX) and being performed in the imaging suite, these services are not "By Report", they are to be reported via IRC.

General Guidelines

The AMA CPT Code will be used as the identifier throughout the system. Assigned RVUs will be strictly tied to the CPT code.

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No additional RVUs are to be added to portable procedures regardless when or where the service is performed.

All RVUs are per CPT unless otherwise stated.

Standard supplies and contrast material are included in the RVU assignment and should not be assigned separately.

No drug is considered a routine part of any Radiology- Diagnostic examination; however, sedation and pain reducing agents may be used to make procedures more easily tolerated. These drugs should NOT be included in the RVU of the exam but would be billed separately through the pharmacy on an "as needed" basis. Drugs should not be assigned an RVU

CPT CODE	DESCRIPTION	RVU's
70010	Myelography, posterior fossa, supervision and interpretation only	IRC
70015	Cisternography, positive contrast, supervision and interpretation only	26
70030	Radiological exam, eye, for detection of foreign body	5
70100	Radiological exam, mandible, partial, less than four views	7
70110	Radiological exam, mandible, complete, minimum four views	7
70120	Radiological exam, Mastoids, less than three views per side	7
70130	Radiological exam, Mastoids complete, minimum of three views per side	10
70134	Radiological exam, Internal auditory meati, complete	10
70140	Radiological exam, Facial bones, less than three views	5
70150	Radiological exam, Facial Bones complete, minimum of three views	8
70160	Radiological exam, Nasal bones, complete, minimum of three views	7
70170	Dacryocystography, Nasolacrimal duct, radiological supervision and interpretation	IRC
70190	Radiological exam, Optic foramina	7
70200	Radiological exam, Orbits, complete, minimum of four views	8
70210	Radiological exam, Sinuses, paranasal, less than three views	6
70220	Radiological exam, Sinuses, paranasal complete, minimum of three views	7
70240	Radiological exam, Sella turcica	6
70250	Radiological exam, Skull, less than four views	7
70260	Radiological exam, Skull complete, minimum of four views	8
70300	Radiological exam, Teeth, single view	2
70310	Radiological exam, Teeth partial examination, less than full mouth	8
70320	Radiological exam, Teeth complete, full mouth	11

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CPT CODE	DESCRIPTION	RVU's
70328	Temporomandibular joint, open and closed mouth, unilateral	6
70330	bilateral	10
70332	Temporomandibular joint arthrography, radiological supervision and interpretation	IRC
70350	Cephalogram (orthodontic)	3
70355	Orthopantogram	3
70360	Neck, soft tissue examination	5
70370	Pharynx or larynx, including fluoroscopy	17
70371	complete dynamic pharyngeal and speech evaluation by cine or video recording	13
70380	Salivary gland for calculus	7
70390	Sialography, supervision and interpretation only	IRC
71010	Radiological exam, chest, single view, frontal	4
71015	Radiological exam, chest, stereo, frontal	5
71020	Radiological exam, chest, 2 views, frontal & lateral	5
71021	Radiological exam, chest, 2 views, frontal & lateral w, apical lordotic procedure	6
71022	Radiological exam, chest, 2 views, frontal & lateral w, oblique projections	7
71023	Radiological exam, chest, 2 views, frontal & lateral, w, fluoroscopy	12
71030	Radiological exam, chest, complete, minimum of 4 views	7
71034	Radiological exam, chest, complete, minimum of 4 views, w, fluoroscopy	17
71035	Radiological exam, chest, special views, (e.g. lateral, decubitus, Bucky studies)	7
71100	Radiological exam, Ribs, unilateral, 2 views	6
71101	Radiological exam, Ribs, unilateral, including posteroanterior chest, minimum of 3 views	6
71110	Radiological exam, Ribs, bilateral, 3 views	7
71111	Radiological exam, Ribs, bilateral, including posteroanterior chest, minimum of 4 views	9
71120	Radiological exam, Sternum, minimum of 2 views	5
71130	Sternoclavicular joint or joints, minimum of 3 views	7
72020	Radiological exam, spine, single view, specify level	4
72040	Radiological exam, spine, cervical, 2 or 3 views	6
72050	Radiological exam, spine, cervical, 4 or 5 views	8
72052	Radiological exam, spine, cervical, 6 or more views	11

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CPT CODE	DESCRIPTION	RVU's
72070	Radiological exam, spine, thoracic, 2 views	6
72072	Radiological exam, spine, thoracic, 3 views	7
72074	Radiological exam, spine, thoracic, minimum 4 views	8
72080	Radiological exam, spine, thoracolumbar junction, minimum 2 views (to report thoracolumbar junction one view see CPT 72020)	5
72081	Radiological exam, spine, entire thoracic & lumbar, including skull, cervical and sacral spine if performed (e.g. scoliosis eval); one view	7
72082	Radiological exam, spine, entire thoracic & lumbar, including skull, cervical and sacral spine if performed (e.g. scoliosis eval); 2 or 3 views	13
72083	Radiological exam, spine, entire thoracic & lumbar, including skull, cervical and sacral spine if performed (e.g. scoliosis eval); 4 or 5 views	14
72084	Radiological exam, spine, entire thoracic & lumbar, including skull, cervical and sacral spine if performed (e.g. scoliosis eval); minimum 6 views	17
72100	Radiological exam, spine, lumbosacral, 2 or 3 view(s)	7
72110	Radiological exam, spine, lumbosacral, minimum 4 views	9
72114	Radiological exam, spine, lumbosacral, complete, including bending views, minimum of 6 views	13
72120	Radiological exam, spine, lumbosacral, bending views only, 2 or 3 views	8
72170	Radiological exam, pelvis, 1 or 2 view(s)	6
72190	Radiological exam, pelvis, minimum 3 view(s)	8
72200	Radiological exam, sacroiliac joints, less than three views	5
72202	Radiological exam, sacroiliac joints, 3 or more views	7
72220	Radiological exam, sacrum and coccyx, minimum of two views	5
72240	Myelography, cervical, supervision and interpretation only	IRC
72255	Myelography, thoracic, supervision and interpretation only	IRC
72265	Myelography, lumbosacral, supervision and interpretation only	IRC
72270	Myelography, entire spine canal, supervision and interpretation only	IRC
72275	Epidurography, radiological supervision and interpretation (includes 77003)	IRC

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CPT CODE	DESCRIPTION	RVU's
72285	Discography, cervical or thoracic, radiological supervision and interpretation	IRC
72295	Discography, lumbar, radiological supervision and interpretation	IRC
73000	Radiological exam, clavicle, complete	5
73010	Radiological exam, scapula complete	6
73020	Radiological exam, shoulder, one view	4
73030	Radiological exam, shoulder, complete, minimum 2 views	5
73040	Radiological exam, shoulder, arthrography, supervision and interpretation only	IRC
73050	Radiological exam, acromioclavicular joints, bilateral, w, or w, o weighted distraction	7
73060	Radiological exam, humerus, minimum two views	6
73070	Radiological exam, elbow, 2 views	5
73080	Radiological exam, elbow complete, minimum of three views	6
73085	Radiologic examination, elbow, arthrography, radiological supervision and interpretation	IRC
73090	Radiological exam, forearm, 2 views	5
73092	Radiological exam, forearm, upper extremity, infant, minimum of 2 views	5
73100	Radiological exam, wrist, 2 views	6
73110	Radiological exam, wrist complete, minimum of 3 views	7
73115	Radiological examination, wrist, arthrography, radiological supervision and interpretation	IRC
73120	Radiological exam, hand, minimum of 2 views	5
73130	Radiological exam, hand minimum of 3 views	6
73140	Radiological exam, finger(s), minimum of 2 views	7
73501	Radiological exam, hip, unilateral, w, pelvis when performed; 1 view	6

STANDARD UNIT OF MEASURE REFERENCES
DIAGNOSTIC RADIOLOGY

CPT CODE	DESCRIPTION	RVU's
73502	Radiological exam, hip, unilateral, w, pelvis when performed; 2 to 3 views	8
73503	Radiological exam, hip, unilateral, w, pelvis when performed; minimum 4 views	10
73521	Radiological exam, hips, bilateral, w, pelvis when performed; 2 view	8
73522	Radiological exam, hips, bilateral, w, pelvis when performed; 3 to 4 views	9
73523	Radiological exam, hips, bilateral, w, pelvis when performed; minimum of 5 views	11
73525	Radiologic examination, hip, arthrography, radiological supervision and interpretation	IRC
73551	Radiological exam, femur, 1 view	5
73552	Radiological exam, femur, minimum 2 views	6
73560	Radiological exam, knee, 1 or 2 views	6
73562	Radiological exam, knee, 3 views	7
73564	Radiological exam, knee, complete, 4 or more views	8
73565	Radiological exam, both knees, standing , anteroposterior	8
73580	Radiological exam, knee, arthrography, supervision and interpretation only	IRC
73590	Radiological exam, tibia and fibula, 2 views	6
73592	Radiological exam, tibia and fibula, lower extremity, infant, minimum of two views	5
73600	Radiological exam, ankle, 2 views	6
73610	Radiological exam, ankle complete, minimum of 3 views	6
73615	Radiological examination, ankle, arthrography, radiologic supervision and interpretation	IRC
73620	Radiological exam, foot, 2 views	5
73630	Radiological exam, foot, complete, minimum of 3 views	6
73650	Radiological exam, calcaneus, minimum of 2 views	5
73660	Radiological exam, toe(s), minimum of 2 views	6
74000	Radiological exam, abdomen, single anteroposterior view	4
74010	Radiological exam, abdomen, anteroposterior and additional oblique and cone views	7
74020	Radiological exam, abdomen, complete, including decubitus and, or erect views	7
74022	Radiological exam, complete acute abdomen series, including supine, erect, and, or decubitus views, single view chest	8

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CPT CODE	DESCRIPTION	RVU's
74190	Peritoneogram (eg, after injection of air or contrast), radiological supervision and interpretation	IRC
74210	Radiological exam, pharynx and, or cervical esophagus	17
74220	Radiological exam, esophagus	18
74230	Swallowing function, with cineradiography, videoradiography	28
74235	Removal of foreign body(s), esophageal, with use of balloon catheter, radiologic supervision and interpretation	IRC
74240	Radiological exam, gastrointestinal tract, upper, w, or w, o delayed films, without KUB with and without delayed films, with KUB	22
74241	Radiological exam, gastrointestinal tract w, or w, o delayed films, with KUB	23
74245	Radiological exam, gastrointestinal tract, upper, w, small intestines, includes multiple serial images	35
74246	Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon, with or without delayed films, without KUB	26
74247	Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon, with or without delayed films, with KUB	30
74249	Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon, with or without delayed films, without KUB; w, small intestine follow-through	39
74250	Radiological exam, small intestines, includes multiple serial images	22
74251	Radiological exam, small intestines, includes multiple serial images via enteroclysis tube	108
74260	Duodenography hypotonic	89
74270	Radiological exam, colon, barium enema w, or w, o KUB	32
74280	Radiological exam, colon; air contrast with specific high density barium, w, or w, o glucagon	46
74283	Therapeutic enema, contrast or air, for reduction of intussusception or other intraluminal obstruction (e.g.. meconium ileus)	30
74290	Cholecystography, oral contrast	15

STANDARD UNIT OF MEASURE REFERENCES
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CPT CODE	DESCRIPTION	RVU's
74300	Cholangiography and, or pancreatography; intraoperative, radiological supervision and interpretation	IRC
74301	additional set intraoperative, radiological supervision and interpretation	IRC
74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	IRC
74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	IRC
74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	IRC
74340	Introduction of long gastrointestinal tube (e.g. Miller-Abbott) with multiple fluoroscopies and films	IRC
74355	Percutaneous placement of enteroclysis tube, radiological supervision and interpretation	IRC
74360	Intraluminal dilation of strictures and, or obstructions (eg esophagus) radiological supervision and interpretation	IRC
74363	Percutaneous transhepatic dilation of biliary duct structure w, or w, o placement of stent, radiological supervision & interpretation	IRC
74400	Urography (pyelography), intravenous, w, or w, o KUB, w or w, o tomography	IRC
74410	Urography, infusion, drip technique and, or bolus technique	24
74415	Urography, infusion, drip technique and, or bolus technique, with nephrotomography	31
74420	Urography, retrograde, w, or w, o KUB	31
74425	Urography, antegrade (pyleostogram, nephrostogram, loopogram) supervision and interpretation only	IRC
74430	Cystography, contrast or chain, minimum of 3 views, supervision and interpretation only	IRC
74440	Vasography, vesiculography, epididymography, radiological supervision and interpretation only	IRC
74445	Corpora cavernosography, radiological supervision and interpretation	31
74450	Urethrocystography, retrograde, radiological supervision and interpretation only	IRC
74455	Urethrocystography, voiding, radiological supervision and interpretation only	IRC
74470	Radiological exam, renal cyst study, translumbar, contrast visualization, radiological supervision and interpretation only	IRC
74485	Dilation of nephrostomy, ureters, or urethra, radiological supervision and interpretation	IRC

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CPT CODE	DESCRIPTION	RVU's
74710	Pelvimetry, with or without placental localization	5
74740	Hysterosalpingogram, supervision and interpretation only	IRC
74742	Transcervical catheterization of fallopian tube, radiological supervision and interpretation	IRC
74775	Perineogram (e.g.. vaginogram, for sex determination or extent of anomalies)	18
75600	Aortography, thoracic, without serialography, radiological supervision and interpretation	IRC
75605	Aortography, thoracic, by serialography, radiological supervision and interpretation	IRC
75625	Aortography, abdominal, by serialography, radiological supervision and interpretation	IRC
75630	Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation	IRC
75658	Angiography, brachial, retrograde, radiological supervision and interpretation	IRC
75705	Angiography, spinal, selective, radiological supervision and interpretation	IRC
75710	Angiography, extremity, unilateral, radiological supervision and interpretation	IRC
75716	Angiography, extremity, bilateral, radiological supervision and interpretation	IRC
75726	Angiography, visceral, selective or supraselective (with or without flush aortogram), radiological supervision and interpretation	IRC
75731	Angiography, adrenal, unilateral, selective, radiological supervision and interpretation	IRC
75733	Angiography, adrenal, bilateral, selective, radiological supervision and interpretation	IRC
75736	Angiography, pelvic, selective or supraselective, radiological supervision and interpretation	IRC
75741	Angiography, pulmonary, unilateral, selective, radiological supervision and interpretation	IRC
75743	Angiography, pulmonary, bilateral, selective, radiological supervision and interpretation	IRC
75746	Angiography, pulmonary, by nonselective catheter or venous injection, radiological supervision and interpretation	IRC
75756	Angiography, internal mammary, radiological supervision and interpretation	IRC
75774	Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)	IRC
75801	Lymphangiography, extremity only, unilateral, radiological supervision and interpretation	IRC
75803	Lymphangiography, extremity only, bilateral, radiological supervision and interpretation	IRC
75805	Lymphangiography, pelvic, abdominal, unilateral, radiological supervision and interpretation	IRC
75807	Lymphangiography, pelvic, abdominal, bilateral, radiological supervision and interpretation	IRC

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CPT CODE	DESCRIPTION	RVU's
75809	Shuntogram for investigation of previously placed indwelling nonvascular shunt (eg, LeVeen shunt, ventriculoperitoneal shunt, indwelling infusion pump), radiological supervision and interpretation	IRC
75810	Splenoportography, radiological supervision and interpretation	IRC
75820	Venography, extremity, unilateral, radiological supervision and interpretation	IRC
75822	Venography, extremity, bilateral, radiological supervision and interpretation	IRC
75825	Venography, caval, inferior, with serialography, radiological supervision and interpretation	IRC
75827	Venography, caval, superior, with serialography, radiological supervision and interpretation	IRC
75831	Venography, renal, unilateral, selective, radiological supervision and interpretation	IRC
75833	Venography, renal, bilateral, selective, radiological supervision and interpretation	IRC
75840	Venography, adrenal, unilateral, selective, radiological supervision and interpretation	IRC
75842	Venography, adrenal, bilateral, selective, radiological supervision and interpretation	IRC
75860	Venography, venous sinus (eg, petrosal and inferior sagittal) or jugular, catheter, radiological supervision and interpretation	IRC
75870	Venography, superior sagittal sinus, radiological supervision and interpretation	IRC
75872	Venography, epidural, radiological supervision and interpretation	IRC
75880	Venography, orbital, radiological supervision and interpretation	IRC
75885	Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation	IRC
75887	Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation	IRC
75889	Hepatic venography, wedged or free, with hemodynamic evaluation, radiological supervision and interpretation	IRC
75891	Hepatic venography, wedged or free, without hemodynamic evaluation, radiological supervision and interpretation	IRC
75893	Venous sampling through catheter, with or without angiography (eg, for parathyroid hormone, renin), radiological supervision and interpretation	IRC
75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	IRC

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CPT CODE	DESCRIPTION	RVU's
75898	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis	IRC
75901	Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access, radiologic supervision and interpretation	IRC
75902	Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen, radiologic supervision and interpretation	IRC
75952	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation	IRC
75953	Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal aortic or iliac artery, aneurysm, pseudoaneurysm, dissection, radiological supervision and interpretation	IRC
75954	Endovascular repair of iliac artery aneurysm, pseudoaneurysm, arteriovenous malformation, or trauma, using ilio-iliac tube endoprosthesis, radiological supervision and interpretation	IRC
75956	Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation	IRC
75957	Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation	IRC
75958	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption), radiological supervision and interpretation	IRC
75959	Placement of distal extension prosthesis(s) (delayed) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, radiological supervision and interpretation	IRC
75970	Transcatheter biopsy, radiological supervision and interpretation	IRC
75984	Change of percutaneous tube or drainage catheter with contrast monitoring (eg, genitourinary system, abscess), radiological supervision and interpretation	IRC

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CPT CODE	DESCRIPTION	RVU's
75989	Radiological guidance (fluro, US or CT) for percutaneous drainage (e.g. abscess, specimen collection) w, placement of catheter, radiological supervision and interpretation	IRC
76000	Fluoroscopy (separate procedure- other than 71034 or 71023) up to 1 hour physician or other qualified health care professional time (e.g. cardiac fluoroscopy)	11
76001	Fluoroscopy, more than 1 hour physician or other qualified health care professional time, assisting a non-radiological physician or other qualified health care professional (e.g. Nephrosto-lithotomy, ERCP, bronchoscopy, transbronchial biopsy)	11
76010	Radiologic exam from nose to rectum for foreign body, single view, child	5
76080	Radiological exam, abscess, fistula or sinus tract study, radiological supervision and interpretation	8
76098	Radiological exam, surgical specimen	2
76100	Radiologic exam, single plane, body section (eg. tomography) other than w, urography	17
76101	Radiological examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; unilateral	27
76102	Radiological examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; bilateral	39
76120	Cineradiography, videography, except where specifically included	18
76125	Cineradiography, videography to complement routine examination	18
76140	Consultation on x-ray examination made elsewhere, written report	0
76376	3D Rendering w/ interpretation and reporting of CT, MRI, US, or other tomographic modality w/ image post processing under concurrent supervision; not requiring image postprocessing on an independent workstation - use in conjunction w/ code(s) for base imaging procedure	By Report
76377	3D Rendering w/ interpretation and reporting of CT, MRI, US, or other tomographic modality w/ image post processing under concurrent supervision; requiring image postprocessing on an independent workstation - use in conjunction w/ code(s) for base imaging procedure	By Report
76496	Unlisted fluoroscopic procedure (eg, diagnostic, interventional)	By Report
76499	Unlisted diagnostic radiographic procedure (see guidelines)	By Report

STANDARD UNIT OF MEASURE REFERENCES
DIAGNOSTIC RADIOLOGY

CPT CODE	DESCRIPTION	RVU
76506	Echoencephalography, real time w, image documentation (gray scale) (for determination of ventricular size, delineation of cerebral contents, and detection of fluid masses or other intracranial abnormalities) including A-mode encephalography as secondary component where indicated	24
76510	Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter	23
76511	Ophthalmic ultrasound, diagnostic; quantitative A-scan only, performed during the same patient encounter	14
76512	Ophthalmic ultrasound, diagnostic; B-scan (w, or w, o superimposed non-quantitative A-scan) performed during the same patient encounter	11
76513	Ophthalmic anterior segment ultrasound, diagnostic; immersion (water bath) B-scan or high resolution biomicroscopy performed during the same patient encounter	17
76514	Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness) performed during the same patient encounter	1
76516	Ophthalmic biometry by ultrasound, echography, A-scan	13
76519	Ophthalmic biometry by ultrasound, echography, A-scan w, intraocular lens power calculation	15
76529	Ophthalmic ultrasonic foreign body localization	13
76536	Ultrasound soft tissue of head and neck (thyroid, parathyroid, parotid), real-time w, image documentation	25
76604	Ultrasound chest (includes mediastinum) real-time w, image documentation	17
76641	Ultrasound breast, unilateral, real-time w, image documentation includes axilla when performed; complete	20
76642	Ultrasound breast, unilateral, real-time w, image documentation includes axilla when performed; limited	15
76700	Ultrasound, abdominal, real time w, image documentation; complete	23
76705	Ultrasound, abdominal, real time w, image documentation; limited (ie single organ, quadrant, follow-up)	18
76706	Ultrasound, abdominal aorta, real time w/ image documentation, screening study for abdominal aortic aneurysm (AAA)	19
76770	Ultrasound, retroperitoneal (eg renal, aorta, nodes), real time w, image documentation; complete	22
76775	Ultrasound, retroperitoneal (eg renal, aorta, nodes), real time w, image documentation; limited	8
76776	Ultrasound, transplanted kidney, real time & duplex doppler w, image documentation;	34

STANDARD UNIT OF MEASURE REFERENCES
DIAGNOSTIC RADIOLOGY

CPT CODE	DESCRIPTION	RVU
76800	Ultrasound, spinal canal and contents	23
76801	Ultrasound, pregnant uterus, real-time w, image documentation, fetal and maternal eval, first trimester (<14 wks 0 days) transabdominal approach; single or first gestation	21
76802	Ultrasound, pregnant uterus, real-time w, image documentation, fetal and maternal eval, first trimester (<14 wks 0 days) transabdominal approach; each additional gestation	6
76805	Ultrasound, pregnant uterus, real-time w, image documentation, fetal and maternal eval, after first trimester (> or = 14 wks 0 days) transabdominal approach; single or first gestation	26
76810	Ultrasound, pregnant uterus, real-time w, image documentation, fetal and maternal eval, plus detailed fetal anatomic examination, transabdominal approach; each addt'l gestation	12
76811	Ultrasound, pregnant uterus, real-time w, image documentation, fetal and maternal eval, plus detailed fetal anatomic exam, transabdominal approach; single or first gestation	24
76812	Ultrasound, pregnant uterus, real-time w, image documentation, fetal and maternal eval, plus detailed fetal anatomic exam, transabdominal approach; each additional gestation	32
76813	Ultrasound, pregnant uterus, real-time w, image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation	17
76814	Ultrasound, pregnant uterus, real-time w, image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation	8
76815	Ultrasound, pregnant uterus, real-time w, image documentation, limited (eg fetal heartbeat, placental location, fetal position and, or qualitative amniotic fluid volume), 1 or more fetus	15
76816	Ultrasound, pregnant uterus, real-time w, image documentation, follow-up (eg re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach , per fetus	20
76817	Ultrasound, pregnant uterus, real-time w, image documentation; transvaginal	17
76818	Fetal biophysical profile; w, non-stress testing	20
76819	Fetal biophysical profile; w, o non-stress testing	14
76820	Doppler velocimetry, fetal; umbilical artery	6

STANDARD UNIT OF MEASURE REFERENCES
DIAGNOSTIC RADIOLOGY

CPT CODE	DESCRIPTION	RVU
76821	Doppler velocimetry, fetal; middle cerebral artery	16
76825	Echocardiography, fetal, cardiovascular system, real-time w, image documentation (2D); w, or w, o M-mode recording	55
76826	Echocardiography, fetal, cardiovascular system, real-time w, image documentation (2D); w, or w, o M-mode recording; follow-up or repeat study	35
76827	Doppler Echocardiography, fetal pulsed wave and, or continuous wave w, spectral display; complete	13
76828	Doppler Echocardiography, fetal pulsed wave and, or continuous wave w, spectral display; follow-up or repeat study	7
76830	Ultrasound, transvaginal	25
76831	Endovaginal introduction of the saline enhanced endometrium	IRC
76856	Ultrasound pelvic (non-obstetric) real time w, image documentation; complete	21
76857	Ultrasound pelvic (non-obstetric) real time w, image documentation; limited or follow-up (eg follicles)	7
76870	Ultrasound scrotum and contents	10
76872	Ultrasound, transrectal	17
76873	Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning	26
76881	Ultrasound, extremity, non-vascular, real-time w, image documentation; limited; complete	25
76882	Ultrasound, extremity, non-vascular, real-time w, image documentation; anatomic specific	3
76885	Ultrasound, infant hips, real-time w, image documentation; dynamic; (requiring physician or other healthcare prof. manipulation)	31
76886	Ultrasound, infant hips, real-time w, image documentation; limited; static; (NOT requiring physician or other healthcare prof. manipulation)	22
76930	US guided aspiration of pericardium	IRC
76932	US guided endomyocardial biopsy	IRC
76936	US scan to localize and therapeutically compress a pseudo-aneurysm	IRC
76937	US guided for vascular access requiring US eval., of potential access sites, vessel patency, visualization of vascular needle entry w, permanent recording and reporting	IRC

STANDARD UNIT OF MEASURE REFERENCES
DIAGNOSTIC RADIOLOGY

CPT CODE	DESCRIPTION	RVU
76940	US guidance for & monitoring of parenchymal tissue ablation	IRC
76941	US guidance for intrauterine fetal transfusion or cordocentesis, imaging supervision and interpretation	IRC
76942	US guidance for needle placement (eg. Biopsy, aspiration, injection, localization device), imaging supervision and interpretation	IRC
76945	US guidance for chorionic villus sampling, imaging supervision and interpretation	IRC
76946	US guidance for amniocentesis, imaging supervsion and interpretation	IRC
76948	US guidance for aspiration of ova, imaging supervision and interpretation	IRC
76965	US guidance for interstitial radioelement application	IRC
76970	Ultrasound study follow-up (specify)	21
76975	Gastrointestinal endoscopic ultrasound, supervision and interpretation	IRC
76977	US bone density measurement and interpretation, peripheral site(s); any method	1
76998	Ultrasonic guidance, intraoperative	11
76999	Unlisted ultrasonic procedure (eg diagnostic)	By Report
77001	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)	IRC
77002	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) ** NOTE surgical &, or injection codes listed depends on anatomical location	IRC
77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)	IRC
77053	Mammary ductogram or galactogram, single ducts, radiological supervision and interpretation	11
77054	Mammary ductogram or galactogram, multiple ducts, radiological supervision and interpretation	15
77061	Digital breast tomosynthesis; unilateral	7
77062	Digital breast tomosynthesis; bilateral	7
77063	Screening digital breast tomosynthesis; bilateral (list separately in addition to code for primary procedure)	7

STANDARD UNIT OF MEASURE REFERENCES
DIAGNOSTIC RADIOLOGY

CPT CODE	DESCRIPTION	RVU
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	26
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	34
77067	Screening mammography, bilateral (2 view study of each breast), including computer-aided detection (CAD) when performed	28
77071	Manual application of stress performed by physician or other qualified healthcare professional for joint radiography; including contralateral joint if indicated	9
77072	Bone age studies	4
77073	Bone length studies (orthoroentgenogram)	6
77074	Radiologic examination, osseous survey, limited (eg. for metastasis)	12
77075	Radiologic examination, osseous survey; complete (axial and appendicular skeleton)	17
77076	Radiologic examination, osseous survey, infant	17
77077	Joint survey, single view, one or more joints (specify)	6
77080	Dual-energy X-ray absorptiometry (DXA) bone density study, 1 or more sites; axial skeleton (eg hips, pelvis, spine)	9
77081	Dual-energy X-ray absorptiometry (DXA) bone density study, 1 or more sites; appendicular skeleton (eg hips, pelvis, spine)	5
77085	Dual-energy X-ray absorptiometry (DXA) bone density study, 1 or more sites; appendicular skeleton (eg hips, pelvis, spine) including vertebral fracture assessment	11
77086	Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)	7

STANDARD UNIT OF MEASURE REFERENCES
DIAGNOSTIC RADIOLOGY

CPT CODE	DESCRIPTION	RVU
93880	Duplex scan of extracranial vessels complete bilateral study	46
93882	Duplex scan of extracranial vessels, unilateral or limited study	29
93886	Transcranial doppler study of the intracranial arteries; complete	65
93888	Transcranial doppler study of the intracranial arteries; limited	35
93890	Transcranial doppler study of the intracranial arteries; vasoreactivity study	66
93892	Transcranial doppler study of the intracranial arteries; emboli detection w, o intravenous microbubble injection	76
93893	Transcranial doppler study of the intracranial arteries; emboli detection w, intravenous microbubble injection	81
93895	Quantitative carotid intima media thickness and carotid atheroma eval; bilateral	
93922	Limited bilateral non-invasive physiologic study of Upper or Lower extremities arteries; (eg, for lower extremity: ankle, brachial indices at distal posterior tibial and anterior tibial, dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle, brachial indices at distal posterior tibial and anterior tibial, dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle, brachial indices at distal posterior tibial and anterior tibial, dorsalis pedis arteries w, transcutaneous oxygen tension measurement at 1-2 levels	21
93923	Complete bilateral non-invasive physiologic studies of Upper or Lower extremities arteries; 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurement at 3 or more levels, or single level study with provocative functional maneuvers (eg, measurements with postural provocative test, or measurements with reactive hyperemia)	32
93924	Non-Invasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing (i.e. bidirectional Doppler waveform or volume plethysmography recording and analysis at rest with ankle, brachial indices immediately after and at timed intervals following performance of a standardized protocol on a motorized treadmill plus recording of time of onset of claudication or other symptoms, maximal walking time, and time to recovery) complete bilateral study	41
93925	Duplex scan of lower extremity arteries or arterial bypass grafts, complete bilateral study	62

STANDARD UNIT OF MEASURE REFERENCES
DIAGNOSTIC RADIOLOGY

CPT CODE	DESCRIPTION	RVU
93926	Duplex scan of lower extremity arteries or arterial bypass grafts, unilateral or limited study	36
93930	Duplex scan of upper extremity arteries or arterial bypass grafts, complete bilateral study	47
93931	Duplex scan of upper extremity arteries or arterial bypass grafts, unilateral or limited study	29
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study	46
93971	Duplex scan of lower extremity veins including responses to compression and other maneuvers, unilateral or limited study	28
93975	Duplex scan of arterial inflow or venous outflow of abdominal, Pelvic and, or scrotal contents and, or retroperitoneal organs; complete study	63
93976	Duplex scan of arterial inflow or venous outflow of abdominal, Pelvic and, or scrotal contents and, or retroperitoneal organs; limited study	35
93978	Duplex scan of aorta, inferior vena cava, iliac vasculature or bypass grafts, complete study	43
93979	Duplex scan of aorta, inferior vena cava, iliac vasculature or bypass grafts, unilateral or limited study27	27
93980	Duplex scan of arterial inflow and venous outflow of penile vessels, complete study	17
93981	Duplex scan of arterial inflow and venous outflow of penile vessels, follow-up or limited study	15
93982	Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording analysis of pressure and waveform tracings, interpretation and report	9

STANDARD UNIT OF MEASURE REFERENCES
DIAGNOSTIC RADIOLOGY

CPT CODE	DESCRIPTION	RVU
93990	Duplex scan of hemodialysis access including arterial inflow, body of access and venous outflow	38
93998	Unlisted noninvasive vascular diagnostic study	By Report
C9744	Ultrasound, abdominal, with contrast	34
G0365	Vessel mapping of vessels for hemodialysis access	By Report
G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema (Medicare reporting only)	46
G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema (Medicare reporting only)	46
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk (Medicare reporting only)	53
G0130	Single energy x-ray absorptiometry (sexa) bone density study, on ore more sites, appendicular skeleton (peripheral) (e.g., radius, wrist, heel) (Medicare reporting only)	6
G0202	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (cad) when performed (Medicare reporting only)	28
G0204	Diagnostic mammography, including computer-aided detection (cad) when performed; bilateral (Medicare reporting only)	34
G0206	Diagnostic mammography, including computer-aided detection (cad) when performed; unilateral (Medicare reporting only)	26
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to G0204 or G0206) (Medicare reporting only)	7

STANDARD UNIT OF MEASURE REFERENCES
NUCLEAR MEDICINE

Approach

Nuclear Medicine Relative Value Units were developed with the aid of an industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions of codes in this section of Appendix D were obtained from the 2017 edition of the Current Procedural Terminology (CPT) manual and the 2017 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2017 Medicare Physician Fee schedule (MPFS) released November 2, 2016. RVUs were assigned using the following protocol ("RVU Assignment Protocol").

The RVUs reported in the 2017 MPFS include 2 decimal points. In order to maintain whole numbers in Appendix D, while maintaining appropriate relative value differences reported in the MPFS, the RVU work group agreed to remove the decimals by multiplying the reported RVUs by ten and then rounding the product of the calculation, where values less than X.5 are rounded down and all other values are rounded up.

1. CPT codes with RVUs listed in the MPFS.
    a. For CPT codes with RVUs that include both professional (modifier 26) and technical (modifier TC) components, use only the technical (TC) component RVU.
    b. CPT codes with only a single RVU listed
        a. CPT codes that are considered technical only, the single RVU reported will be used.
        b. CPT codes considered professional only are not listed in Appendix D.

2. CPT codes that do not have RVUs listed in the MPFS (e.g. CMS Status Code "C")
    a. CPTs 78099, 78199, 78299, 78399, 78499, 78599, 78699, 78799 and 78999 did not have a published RVU in the MPFS. As these codes are for an unlisted procedure, RVUs should be developed "By Report" following the protocol below in the section "CPT Codes without an Assigned RVU Value."
    b. CPT 78267 did not have a published RVU in the MPFS. Due to its similarity to CPT 78270 in time and resources, it was assigned 26 RVUs.
    c. CPT 78268 did not have a published RVU in the MPFS. As time and resources used are about one-half of CPT 78267, it was assigned 13 RVUs.
    d. CPT 78282 did not have a published RVU in the MPFS. CMS APC weights for this code are similar to other gastrointestinal codes that are assigned approximately 2.5 RVUs per the MPFS, it was assigned 25 RVUs.
    e. CPT 78351 did not have a published RVU in the MPFS. Due to its similarity to CPT 78350 in time and resources, it was assigned 6 RVUs.
    f. CPT 78414 did not have a published RVU in the MPFS. Due to its similarity to CPT 78320 in assigned CMS APC weights, it was assigned 52 RVUs.
    g. CPTs 0331T and 0332T are new technology CPTs and did not have published RVUs in the MPFS. 0331T will mirror 78453 (74 RVUs) as workload is comparable and 0332T will mirror 78452 (115 RVUs) due to comparable workload.
    h. CPTs 78459, 78491, 78492, 78608, 78609, 78811, 78812, 78813, 78814, 78815 and 78816 did not have a published RVU in the MPFS. The workgroup agreed that two (2) RVUs per minute for average testing plus an additional one (1) RVU per minute to account for machine cost and other resources is a reasonable basis for establishing

RVUs for PET scans for a total of 3 RVUs per minute as follows:

CPT CODE	AVERAGE TESTING TIME	RVUS
78459	240 minutes	720
78491	80 minutes	240
78492	150 minutes	450
78608	120 minutes	360
78609	120 minutes	360
78811	90 minutes	270
78812	120 minutes	360
78813	150 minutes	450
78814	120 minutes	360
78815	145 minutes	435
78816	165 minutes	495

3. CPT/HCPCS codes for which the published RVU did not make sense
    a. CPT 38792 did not have a published non-facility RVU, the facility RVU was used.

Services with both a HCPCS for Medicare and CPT for Non-Medicare

All known HCPCS codes have been addressed in a payer-neutral fashion with this update. In instances of where Medicare implements a new HCPCS code to be utilized in lieu of a CPT code for a service, the RVU developed by the hospital must mirror the established CPT RVUs. The RVU for the service must be the same for all payers.

CPT Codes with Bundled Procedures

CPT codes from 2017 with a surgical component have been assigned a zero (0) RVU value. If a NUC CPT becomes bundled with a surgical code or replaced with a surgical code, these procedures should be charged as Interventional Radiology/Cardiovascular (IRC) and the associated costs of the procedure are to be reclassified to the IRC cost center. (This is minimal for Nuclear Medicine.)

Reporting of Imaging Guidance for Invasive Cases

Standard imaging RVUs are to be used for non-invasive imaging services. For invasive imaging services, the imaging guidance is either separately reportable or bundled into the code for the invasive service. Invasive imaging services occurring in an imaging suite must be charged using IRC minutes based on case time. For separately reportable imaging guidance, hospitals are to report one (1) IRC minute per imaging code. Imaging expenses associated with the guidance are to be allocated from the diagnostic imaging rate center to the IRC rate center.

When an operating room or operating room-clinic case involves separately reportable intraoperative/intraprocedural imaging guidance or imaging services, standard imaging RVUs are to be used. These cases are to be charged based on OR or ORC minutes. When imaging guidance is bundled into the underlying procedure, hospitals should not report any additional RVUs for the imaging. If imaging staff is assisting during a case where the imaging is bundled into the underlying procedure,

expenses should be allocated from the imaging department to the operating room or operating room clinic rate center.

CPT Codes without an Assigned RVU Value

RVUs for new codes developed and reported by CMS after the 2017 reporting, must be developed "By Report". When assigning RVUs to these new codes, hospitals should use the RVU Assignment Protocol described above where possible using the most current MPFS. For codes that are not listed in the MPFS, hospitals should assign RVUs based on time and resource intensity of the services provided compared to like services in the department. Documentation of the assignment of RVUs to codes not listed in Appendix D should always be maintained by the hospital.

For any codes that are in the surgical series of CPT (i.e. 1xxxx-6xxxx) and being performed in the imaging suite, these services are not "By Report"; they are to be reported via IRC. There is one exception to this rule – see Sentinel Node information below

Sentinel Node Injection

CPT 38792, although in the surgical series of CPT, will be kept in the NUC rate center with its associated RVUs of 6.

General Guidelines

The AMA CPT Code will be used as the identifier throughout the system. Assigned RVU's will be strictly tied to the CPT Code.

All RVUs are per CPT unless otherwise stated.

Standard supplies and contrast material are included in the RVU assignment and should not be assigned separately.

No drug, including radiopharmaceuticals, is considered a routine part of any NUC examination. Radiopharmaceuticals and sedation and pain reducing agents may be used with these procedures. These drugs should NOT be included in the RVU of the exam and are to be billed separately through the pharmacy on an "as needed" basis. Drugs should not be assigned an RVU

CPT	Description	RVU
38792	Injection procedure, radioactive tracer for identification of sentinel node	6
78012	Thyroid uptake, single or multiple quantitative measurements including stimulation, suppression, or discharge, when performed.	21
78013	Thyroid imaging (including vascular flow, when performed)	50
78014	Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurements(s) (including stimulation, suppression, or discharge, when performed)	63
78015	Thyroid carcinoma metastases imaging; limited area (eg neck/chest only)	55
78016	Thyroid carcinoma metastases imaging; limited area (eg neck/chest only) w/additional studies (eg, urinary recovery)	73

STANDARD UNIT OF MEASURE REFERENCES
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CPT	Description	RVU
78018	Thyroid carcinoma metastases imaging; whole body	79
78020	Thyroid carcinoma metastases uptake (List separately in addition to code for primary procedure)	16
78070	Parathyroid planar imaging (including subtraction, when performed)	76
78071	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)	87
78072	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization	98
78075	Adrenal imaging, cortex and/or medulla	119
78099	Unlisted endocrine procedure, diagnostic nuclear medicine	By Report
78102	Bone marrow imaging; limited area	42
78103	Bone marrow imaging; multiple areas	54
78104	Bone marrow imaging; whole body	61
78110	Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); single sampling	26
78111	Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); multiple samplings	24
78120	Red cell volume determination (separate procedure); single sampling	24
78121	Red cell volume determination (separate procedure); multiple samplings	26
78122	Whole blood volume determination, including separate measurement of plasma volume and red cell volume (radiopharmaceutical volume-dilution technique)	22
78130	Red cell survival study;	40
78135	Red cell survival study; differential organ/tissue kinetics (e.g., splenic and/or hepatic sequestration)	94
78140	Labeled red cell sequestration, differential organ/tissue (e.g., splenic and/or hepatic)	31
78185	Spleen imaging only, with or without vascular flow	56
78190	Kinetics, study of platelet survival, with or without differential organ/tissue localization	99
78191	Platelet survival study	40
78195	Lymphatics and lymph node imaging	87
78199	Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine	By Report
78201	Liver imaging; static only	49
78202	Liver imaging; with vascular flow	52

STANDARD UNIT OF MEASURE REFERENCES
NUCLEAR MEDICINE

CPT CODE	DESCRIPTION	RVU's
78205	Liver imaging (SPECT);	52
78206	Liver imaging (SPECT); with vascular flow	86
78215	Liver and spleen imaging; static only	50
78216	Liver and spleen imaging; with vascular flow	29
78226	Hepatobiliary system imaging, including gallbladder when present;	86
78227	Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed	118
78230	Salivary gland imaging;	44
78231	Salivary gland imaging; with serial images	30
78232	Salivary gland function study	23
78258	Esophageal mobility	55
78261	Gastric mucosa imaging	62
78262	Gastroesophageal reflux study	61
78264	Gastric emptying study (e.g., solid, liquid, or both)	87
78265	Gastric emptying study (e.g., solid, liquid, or both); with small bowel transit	102
78266	Gastric emptying study (e.g., solid, liquid, or both); with small bowel and colon transit, multiple days	123
78267	Urea breath test, C-14 (isotopic); acquisition for analysis	26
78268	Urea breath test, C-14 (isotopic); analysis	13
78270	Vitamin B-12 absorption study (e.g. Schilling test); without intrinsic factor	26
78271	Vitamin B-12 absorption study (e.g. Schilling test); with intrinsic factor	23
78272	Vitamin B-12 absorption study combined, with and without intrinsic factor	25
78278	Acute gastrointestinal blood loss imaging	88
78282	Gastrointestinal protein loss	25
78290	Intestine imaging (e.g., ectopic gastric mucosa, Meckel's localization, volvulus)	87
78291	Peritoneal-venous shunt patency test (e.g., LeVeen, Denver shunt)	62

STANDARD UNIT OF MEASURE REFERENCES
NUCLEAR MEDICINE

CPT CODE	DESCRIPTION	RVU's
78299	Unlisted gastrointestinal procedure, diagnostic Nuclear Medicine	By Report
78300	Bone and/or joint imaging; limited area	44
78305	Bone and/or joint imaging: multiple areas	56
78306	Bone and/or joint imaging; whole body	61
78315	Bone and/or joint imaging; 3 phase study	87
78320	Bone and/or joint imaging; tomographic (SPECT)	52
78350	Bone density (bone mineral content) study, 1 or more sites; single photon absorptiometry	6
78351	Bone density (bone mineral content) study, 1 or more sites; dual photon absorptiometry, 1 or more sites	6
78399	Unlisted musculoskeletal procedure, diagnostic nuclear medicine	By Report
78414	Determination of central c-v hemodynamics (non-imaging) (e.g., ejection fraction with probe technique) with or without pharmacologic intervention or exercise, single or multiple determinations	52
78428	Cardiac shunt detection	42
78445	Non-cardiac vascular flow imaging (i.e., angiography, venography)	46
78451	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification , when performed); single study, at rest or stress (exercise or pharmacologic)	80
78452	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification , when performed); multiple studies, at rest and/or redistribution and/or rest reinjection	115
78453	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); singe study, at rest or stress (exercise or pharmacologic)	74
78454	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection	108
78456	Acute venous thrombosis imaging, peptide	79
78457	Venous thrombosis imaging, venogram; unilateral	40

STANDARD UNIT OF MEASURE REFERENCES
NUCLEAR MEDICINE

CPT CODE	DESCRIPTION	RVU's
78458	Venous thrombosis imaging, venogram; bilateral	47
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation	720
78466	Myocardial imaging, infarct avid, planar; qualitative or quantitative	47
78468	Myocardial imaging, infarct avid, planar; with ejection fraction by first pass technique	45
78469	Myocardial imaging infarct avid, planar; tomographic SPECT with or without quantification	53
78472	Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing	53
78473	Cardiac blood pool imaging, gated equilibrium; multiple studies, wall motion study plus ejection fraction, at rest and stress (exercise and/or pharmacologic), with or without additional quantification	64
78481	Cardiac blood pool imaging (planar), first pass technique; single study, at rest or with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction with or without quantification	37
78483	Cardiac blood pool imaging (planar) first pass technique; multiple studies, at rest or with stress (exercise and/or pharmacologic) wall motion study plus ejection fraction with or without quantification	50
78491	Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress	240
78492	Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest or stress	450
78494	Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing	49
78496	Cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular ejection fraction by first pass technique (list separately in addition to code for primary procedure)	6
78499	Unlisted cardiovascular procedure, diagnostic nuclear medicine	By Report

STANDARD UNIT OF MEASURE REFERENCES
NUCLEAR MEDICINE

CPT CODE	DESCRIPTION	RVU's
78579	Pulmonary ventilation imaging (e.g., aerosol or gas)	47
78580	Pulmonary perfusion imaging (e.g., particulate)	59
78582	Pulmonary ventilation (e.g., aerosol or gas) and perfusion imaging	82
78597	Quantitative differential pulmonary perfusion, including imaging when performed	49
78598	Quantitative differential pulmonary perfusion and ventilation (e.g., aerosol or gas), including imaging when performed	77
78599	Unlisted respiratory procedure, diagnostic nuclear medicine	By Report
78600	Brain imaging, less than 4 static views;	48
78601	Brain imaging, less than 4 static views; with vascular flow	55
78605	Brain imaging, minimum 4 static views;	51
78606	Brain imaging, minimum 4 static views; with vascular flow	87
78607	Brain imaging, tomographic (SPECT)	86
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation	360
78609	Brain imaging, positron emission tomography (PET); perfusion evaluation	360
78610	Brain imaging, vascular flow only	47
78630	Cerebrospinal fluid flow, imaging (not including introduction of material); cisternography	89
78635	Cerebrospinal fluid flow, imaging (not including introduction of material;) ventriculography	91
78645	Cerebrospinal fluid flow, imaging (not including introduction of material); shunt evaluation	87
78647	Cerebrospinal fluid flow, imaging (not including introduction of material); tomographic (SPECT)	90
78650	Cerebrospinal fluid leakage detection and localization	88
78660	Radiopharmaceutical dacryocystography	45

STANDARD UNIT OF MEASURE REFERENCES
NUCLEAR MEDICINE

CPT CODE	DESCRIPTION	RVU's
78699	Unlisted nervous system procedure, diagnostic nuclear medicine	By Report
78700	Kidney imaging morphology	44
78701	Kidney imaging morphology; with vascular flow	55
78707	Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention	54
78708	Kidney imaging morphology; with vascular flow and function, single study, with pharmacological intervention (e.g., angiotensin converting enzyme inhibitor and/or diuretic)	34
78709	Kidney imaging morphology; with vascular flow and function, multiple studies, with and without pharmacological intervention (e.g., angiotensin converting enzyme inhibitor and/or diuretic)	87
78710	Kidney imaging morphology; tomographic (SPECT)	50
78725	Kidney function study, non-imaging radioisotopic study	26
78730	Urinary bladder residual study (List separately in addition to code for primary procedure)	18
78740	Ureteral reflux study (radiopharmaceutical voiding cystogram)	56
78761	Testicular imaging with vascular flow	52
78799	Unlisted genitourinary procedure, diagnostic nuclear medicine	By Report
78800	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); limited area	46
78801	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); multiple areas	65
78802	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, single day imaging	82
78803	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); tomographic (SPECT)	85
78804	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring 2 or more days imaging	150
78805	Radiopharmaceutical localization of inflammatory process; limited area	43
78806	Radiopharmaceutical localization of inflammatory process; whole body	85
78807	Radiopharmaceutical localization of inflammatory process; tomographic (SPECT)	85
78808	Injection procedure for radiopharmaceutical localization by non-imaging probe study, intravenous (e.g., parathyroid adenoma)	11
78811	Positron emission tomography (PET) imaging; limited area (e.g., chest, head/neck)	270

STANDARD UNIT OF MEASURE REFERENCES
NUCLEAR MEDICINE

CPT CODE	DESCRIPTION	RVU's
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh	360
78813	Positron emission tomography (PET) imaging; whole body	450
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (e.g., chest, head/neck)	360
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh	435
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body	495
78999	Unlisted miscellaneous procedure, diagnostic nuclear medicine	By Report
79005	Radiopharmaceutical therapy, by oral administration	14
79101	Radiopharmaceutical therapy, by intravenous administration	14
79200	Radiopharmaceutical therapy, by intracavitary administration	15
79300	Radiopharmaceutical therapy, by interstitial radioactive colloid administration	IRC
79403	Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion	23
79440	Radiopharmaceutical therapy, by intra-articular administration	14
79445	Radiopharmaceutical therapy, by intra-articular particulate administration	IRC
79999	Radiopharmaceutical therapy, unlisted procedure	By Report
0331T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment	74
0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment with tomographic SPECT	115

STANDARD UNIT OF MEASURE REFERENCES
RADIOLOGY THERAPEUTIC

Approach

Therapeutic Radiology Relative Value Units were developed by an industry task force under the auspices of the Maryland Hospital Association. The descriptions of codes in this section of Appendix D were obtained from the 2015 edition of the Current Procedural Terminology (CPT) manual and the 2015 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2015 Medicare Physician Fee schedule (MPFS). RVUs were assigned using the following protocol ("RVU Assignment Protocol").

The RVUs reported in the 2015 MPFS include 2 decimal points. In order to maintain whole numbers in Appendix D, while maintaining appropriate relative value differences reported in the MPFS, the RVU work group agreed to remove the decimals by multiplying the reported RVUs by ten and then rounding the product of the calculation, where values less than X.5 are rounded down and all other values are rounded up.

1. CPT codes with RVUs listed in the MPFS.
    a. For CPT codes with RVUs that include both professional (modifier 26) and technical (modifier TC) components, use only the technical (TC) component RVU.
    b. CPT codes with only a single RVU listed
        a. CPT codes that are considered technical only (such as treatment codes), the single RVU reported will be used.
        b. CPT codes considered professional only (such as weekly treatment management and physician planning), are not listed in Appendix D.
2. CPT codes that do not have RVUs listed in the MPFS.
        a. CPT 77387 did not have a published RVU in the MPFS. The RVU work group agreed the work activity associated with this code is similar to CPT 77014. Given the similarity of the work activity, it was determined the same RVU should be applied to CPT 77387.
        b. CPT codes 77424 and 77425 did not have published RVUs in the MPFS. The RVU work group agreed the work activity associated with these codes is similar to CPT 77787. Given the similarity of the work activity, it was determined the same RVU should be applied to CPTs 77424 and 77425.
        c. CPT 77520 did not have a published RVU in the MPFS. The code does have an OPPS APC relative value weight, and it is valued the same as CPTs 77385 and 77386. It was determined the RVUs for 77385 and 77386 should be applied to CPT 77520.
        d. CPT 77522, 77523, and 77525 did not have published RVUs in the MPFS. These codes are in the same family of services as CPT 77520. The codes have an OPPS APC with a relative value weight 2.112 times greater than the APC for CPT 77520. It was determined CPT codes 77522, 77523, and 77525 should each have the same RVU which is calculated by multiplying 2.112 to the RVU of CPT 77520.

e. CPT 77402 did not have a published RVU in the MPFS. This is a code where Medicare's hospital based fee schedule and physician fee schedule differ. Since the 2015 MPFS is being used as the source for RVUs, the corresponding CPT value is G6003. The RVU work group used the same RVU for G6003 for CPT 77402.
f. CPT 77407 did not have a published RVU in the MPFS. This is a code where Medicare's hospital based fee schedule and physician fee schedule differ. Since the 2015 MPFS is being used as the source for RVUs, the corresponding CPT value is G6007. The RVU work group used the same RVU for G6007 for CPT 77407.
g. CPT 77412 did not have a published RVU in the MPFS. This is a code where Medicare's hospital based fee schedule and physician fee schedule differ. Since the 2015 MPFS is being used as the source for RVUs, the corresponding CPT value is G6011. The RVU work group used the same RVU for G6011 for CPT 77412.
h. CPT 77371 did not have a published RVU in the MPFS, and it was determined there was not a similar CPT for benchmarking. Table 1 provides the methodology employed to assign RVUs of 378 to CPT 77371.

Table 1: CPT 77371 RVU Assessment

CPT 77371 Gamma Knife Treatment Delivery RVU Assignment

a. Step One, Determine a base CPT: CPT 77385 and 77386 were used as a base to which the work associated with CPT 77371 could be compared and extrapolated. CPT 77385 and 77386 each have a RVU of 11.15

b. Step Two, Determine the comparative work components for the CPT in question (77371). These are the work components for which the relative workload will be evaluated against the base CPTs 77385 and 77386.

Component	Weighting	Weighting Methodology
Initial Set-up	65%	The setup for SRS treatment is 4Xs the work effort of an IMRT setup - criticality of coordinate system - application of frame
Treatment	20%	It takes on average 3Xs the amount of time to deliver an SRS Cobalt Based treatment vs. IMRT
QA	7.50%	The QA process is 50% less work effort than with IMRT
Resources	7.50%	The treatment delivery is managed by the Medical Physics personnel as compared to therapists for IMRT delivery. Physicists are 2Xs the resource intensity as IMRT therapists

c. Step Three, Extrapolate the RVU value

	Initial S/U	Treatment	QA	Resources			
Weighting	65%	20%	7.50%	7.50%			
Base RVU	11.15	11.15	11.15	11.15			
Multiplier	4	3	0.5	2	**Sum**	**Multiplier**	**RVUs**
Total RVUs	28.99	6.69	0.42	1.67	**37.77**	**10**	**378**

4. CPT codes for which the published RVU did not make sense,
    a. CPT 77333 had a RVU that did not seem reasonable as compared to CPT 77332 and 77334, which are in the same family of codes and clinical services. It was determined the RVU for CPT 77333 should be the average value of CPT codes 77332 and 77334.

CPT Codes without an Assigned RVU Value

An effort was made to assign RVUs to all codes that were effective in 2015. In the case of CPT codes listed as 'By Report', hospitals should assign RVUs based on the time and resource intensity of the service provided compared to like services in the department.

For new codes developed and reported by CMS after the 2015 reporting, these codes are considered to be "By Report". When assigning RVUs to these new codes, hospitals should use the RVU Assignment Protocol described above where possible. Documentation of the assignment of RVUs to codes not listed in Appendix D should always be maintained by the hospital.

STANDARD UNIT OF MEASURE REFERENCES
RADIOLOGY THERAPEUTIC

CPT Code	Procedure	RVU
77014	Computed tomography guidance for placement of radiation therapy fields	20
77280	Therapeutic radiology simulation-aided field setting; simple	66
77285	Intermediate	104
77290	Complex	120
77293	Respiratory motion management (list separately in addition to code for primary procedure)	101
77295	3-Dimensional radiotherapy plan, including dose-volume histograms	74
77299	Unlisted procedure, therapeutic radiology clinical treatment planning	By Report
	MEDICAL RADIATION PHYSICS, DOSIMETRY, TREATMENT DEVICES AND SPECIAL SERVICES	

CPT Code	Procedure	RVU
77300	Basic radiation dosimetry calculation, central axis depth dose, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician	9
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications	425
77306	Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)	20
77307	Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)	37
77316	Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)	32
77317	Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)	41
77318	Brachytherapy isodose plan; complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)	56
77321	Special teletherapy port plan, particles, hemibody, total body	12

STANDARD UNIT OF MEASURE REFERENCES
RADIOLOGY THERAPEUTIC

CPT Code	Procedure	RVU
77331	Special dosimetry (e.g., TLD, microdosimetry) (specify), only when prescribed by the treating physician	5
77332	Treatment devices, design and construction; simple, (simple block, simple bolus)	15
77333	Treatment devices, design and construction; intermediate, (multiple blocks, stents, bite blocks, special bolus)	20
77334	Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)	25
77336	Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of therapeutic radiologist, reported per week of therapy	21
77338	Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan	79
77370	Special medical radiation physics, consultation	32
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based	378
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based	297
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	377
77385	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple	112
77386	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex	112
77387	Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed	20
77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices	By Report
Radiation Treatment delivery (77401–77416) recognizes the technical component and the various energy levels.		

STANDARD UNIT OF MEASURE REFERENCES
RADIOLOGY THERAPEUTIC

RADIATION TREATMENT DELIVERY

Radiation Treatment delivery (77401–77416) recognizes the technical component and the various energy levels.

CPT Code	Procedure	RVU
77401	Radiation treatment delivery, superficial and/or ortho voltage, per day	6
77402	Radiation treatment delivery, > MeV; simple	45
77407	Radiation treatment delivery, >1 MeV; intermediate	72
77412	Radiation treatment delivery, >1 MeV; complex	77

CLINICAL TREATMENT MANAGEMENT

CPT Code	Procedure	RVU
77417	Therapeutic radiology port film(s)	3
77422	High energy neutron radiation treatment delivery; single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking	9
77423	High energy neutron radiation treatment delivery; 1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s)	18
77424	Intraoperative radiation treatment delivery, x-ray, single treatment session	147
77425	Intraoperative radiation treatment delivery, electrons, single treatment session	147
77470	Special treatment procedure (e.g., total body irradiation, hemibody irradiation, per oral, vaginal cone irradiation)	13
77999	Unlisted procedure, therapeutic radiology treatment management	By Report

PROTON TREATMENT DELIVERY

CPT Code	Procedure	RVU
77520	Proton treatment delivery, simple, without compensation	112
77522	Proton treatment delivery, simple, with compensation	235
77523	Proton treatment delivery, intermediate	235
77525	Proton treatment delivery, complex	235

STANDARD UNIT OF MEASURE REFERENCES
RADIOLOGY THERAPEUTIC

HYPERTHERMIA

Hyperthermia treatments as listed in this section include external (superficial and deep), interstitial and intracavitary. Radiation therapy when given concurrently is listed separately.

Hyperthermia is used only as an adjunct to radiation therapy or chemotherapy. It may be induced by a variety of sources, e.g., microwave, ultrasound, low energy radio-frequency conduction, or by probes.

Physics planning and interstitial insertion of temperature sensors, and use of external or interstitial heat generating sources are included.

CPT Code	Procedure	RVU
77605	Hyperthermia, externally generated; deep (i.e., heating to depths greater than 4 cm)	183
77610	Hyperthermia generated by interstitial probe(s); 5 or fewer interstitial applicators	266
77615	Hypothermia generated by interstitial probe(s); more than 5 interstitial applicators	252
77620	Hyperthermia generated by intracavitary probe(s)	105

STANDARD UNIT OF MEASURE REFERENCES
RADIOLOGY THERAPEUTIC

CLINICAL BRACHYTHERAPY

Clinical brachytherapy requires the use of either natural or manmade radioelements applied into or around a treatment field of interest. The supervision of radioelements and dose interpretation are performed solely by the therapeutic radiologist.

Definitions

(Sources refer to intracavitary placement or permanent interstitial placement; ribbons refer to temporary interstitial placement.)

Simple	Application with one to four sources/ribbons.
Intermediate	Application with five to ten sources/ribbons.
Complex	Application with greater than ten sources/ribbons.

CPT Code	Procedure	RVU
77750	Infusion or instillation of radioelement solution	31
77761	Intracavitary radiation source application; simple	53
77762	Intracavitary radiation source application; intermediate	61
77763	Intracavitary radiation source application; complex	79
77776	Interstitial radiation source application; simple	64
77777	Interstitial radiation source application; intermediate	54
77778	Interstitial radiation source application; complex	80
77785	Remote afterloading high dose rate radionuclide brachytherapy; 1 channel	46
77786	Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels	90
77787	Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels	147
77789	Surface application of radioelement	17
77790	Surface application of radiation source	12
77799	Unlisted procedure, Clinical brachytherapy	By Report

STANDARD UNIT OF MEASURE REFERENCES
ELECTROCARDIOGRAPHY

Account Number	Cost Center Title
7290	Electrocardiography Service

The Electrocardiography Relative Value Units were developed by an industry task force under the auspices of the Maryland Hospital Association. These Relative Value Units will be used as the standard unit of measure related to the output of the Electrocardiography Center.

Electrocardiography (EKG) is a transthoracic interpretation of the electrical activity of the heart over a period of time. The EKG cost center operates specialized equipment to (1) Record graphically electromotive variations in actions of the heart muscle; (2) Record graphically the direction and magnitude of the electrical forces of the heart's action, (3) Record graphically the sounds of the heart for diagnostic purposes; (4) Imaging; (5) Cardioversion; and/or (6) Tiltable. Additional activities include, but are not limited to, the following:

Explaining test procedures to patient; operating electrocardiograph equipment; inspecting, testing and maintaining special equipment; attaching and removing electrodes from patient; a patient may remove electrodes and remit recording data from home when appropriate.

Description

This cost center contains the direct expenses incurred in performing electrocardiographic examinations, as well as up to six hours of recovery time. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers. Cost of contrast material is included in this cost center.

Code	Description (CQ)	RVUs
92960	Cardioversion, elective, electrical conversion of arrhythmia; external	45
92960	Cardioversion in addition to TEE 5 RVUs. Also report TEE separately with 60 RVUs	5
93005	Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report	12
93017	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report	30
93024	Ergonovine provocation test	30
93025	Microvolt T-wave alternans for assessment of ventricular arrhythmias	30
93041	Rhythm ECG, 1-3 leads; tracing only without interpretation and report	5
93225	Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage, with visual superimposition scanning; recoding (includes connection, recording, and disconnection)	10
93226	Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage, with visual superimposition scanning; scanning analysis with report	50

STANDARD UNIT OF MEASURE REFERENCES
ELECTROCARDIOGRAPHY

Code	Description (CQ)	RVUs
93270	Wearable patient activated electrocardiographic rhythm derived event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; recording (includes connection, recording, and disconnection)	10
93278	Signal-averaged electrocardiography (SAECG), with or without ECG	30
93279	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead pacemaker system	15
93280	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; dual lead pacemaker system	15
93281	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; multiple lead pacemaker system	15
93282	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead implantable cardioverter-defibrillator system	20
93283	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; dual lead implantable cardioverter-defibrillator system	20
93284	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; multiple lead implantable cardioverter-defibrillator system	20
93285	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; implantable loop recorder system	20
93286	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system	15
93287	Single, dual or multiple lead implantable cardioverter-defibrillator system	15

STANDARD UNIT OF MEASURE REFERENCES
ELECTROCARDIOGRAPHY

Code	Description (CQ)	RVUs
93288	Interrogation device evaluation (in person) with physician analysis, review, and report, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system	15
93289	Interrogation device evaluation (in person) with physician analysis, review, and report, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead implantable cardioverter-defibrillator system, including analysis of heart rhythm derived data elements	20
93290	Interrogation device evaluation (in person) with physician analysis, review, and report, includes connection, recording and disconnection per patient encounter; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors	20
93291	Interrogation device evaluation (in person) with physician analysis, review and report , includes connection, recording and disconnection per patient encounter; Implantable loop recorder system, including heart rhythm derived data analysis	20
93292	Interrogation device evaluation (in person) with physician analysis, review, and report, includes connection, recording and disconnection per patient encounter; wearable defibrillator system	30
93293	Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with physician analysis, review and report(s), up to 90 days	15
93296	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system or implantable cardioverter-defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	20
93299	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	20
93303	Transthoracic echocardiography for congenital cardiac anomalies; complete	45
93304	Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study	20
93306	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography	60
93307	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography	45
93308	Echocardiography, transthoracic, real-time with image documentation (2D) includes M-mode recording, when performed, follow-up or limited study	20

STANDARD UNIT OF MEASURE REFERENCES
ELECTROCARDIOGRAPHY

Code	Description (CQ)	RVUs
93312	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report	60
3315	Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	90
93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete	10
93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); follow-up or limited study (List separately in addition to codes for echocardiographic imaging)	8
93325	Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)	5
93350	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report	60
93352	Use of echocardiographic contrast agent during stress echocardiography (List separately in addition to code for primary procedure)	1
93660	Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention. A standard tilt table evaluation of 45 minutes or less qualifies for 60 RVUs. A complex tilt table evaluation of greater than 45 minutes qualifies for 90 RVUs. Evaluation time includes the time necessary to prepare the patient for the evaluation and any post evaluation services.	60/90
93701	Bioimpedance, thoracic, electrical	5
93724	Electronic analysis of antitachycardia pacemaker system (includes electrocardiographic recording, programming of device, induction and termination of tachycardia via implanted pacemaker, and interpretation of recordings)	15
93740	Temperature gradient studies	By Report
93745	Initial set-up and reprogramming by a physician of wearable cardioverter-defibrillator includes initial programming of system, establishing baseline electronic ECG, transmission of data to data repository, patient instruction in wearing system and patient reporting of problems or events	30
93750	Interrogation of Ventricular Assist Device (VAD), in person, with physician or other qualified health care professional analysis of device parameters (e.g., drivelines, alarms, power surges), review of device function (e.g., flow and volume status, recovery), with programming, if performed, and report	15

STANDARD UNIT OF MEASURE REFERENCES
ELECTROCARDIOGRAPHY

Code	Description (CQ)	RVUs
93786	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only	10
93788	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report	30
93799	Unlisted cardiovascular services or procedure (AICD Reprogramming)	By Report
G0166	External Counterpulsation, per treatment session	By Report

STANDARD UNIT OF MEASURE REFERENCES
ELECTROCARDIOGRAPHY

Contrast Codes

Code	Description (CQ)	RVUs
C8921	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies, complete	45 (93303) + 1 for contrast = 46 RVUs
C8922	Transthoracic echocardiography with contrast or without contrast followed by with contrast, for congenital cardiac anomalies; follow-up or limited study	20(93304) + 1 for contrast = 21 RVUs
C8923	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler	45 (93307)+ 1 for contrast = 46 RVUs
C8924	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	20 (93308)+ 1 for contrast = 21 RVUs
C8925	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report	60 (93312) + 1 for contrast= 61 RVUs
C8926	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; including probe placement, image acquisition, interpretation, and report	90 (93315) + 1 for contrast = 91 RVUs
C8927	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis	By Report
C8928	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time image documentation (2D), includes M-mode recoding, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report	60 (93350) + 1 for contrast = 61 RVUs
C8929	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography	60 (93306)+ 1 for contrast = 61 RVUs

STANDARD UNIT OF MEASURE REFERENCES
ELECTROENCEPHALOGRAPHY

Codes Intentionally Omitted from List

93313	Placement of transesophageal probe only
93314	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only.
93316	Placement of transesophageal probe only
93317	Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only.
93351	Echocardiography, transthoracic, real-time with image documentation (2D) , includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision
C8930	Transthoracic echocardiography, with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision

STANDARD UNIT OF MEASURE REFERENCES
ELECTROENCEPHALOGRAPHY

Approach

Electroencephalography Relative Value Units were developed with the aid of an industry task force under the auspices of and approved by the Health Services Cost Review Commission. The description of codes in this section of Appendix D were obtained from the 2017 edition of the Current Procedural Terminology (CPT) manual and the 2017 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2107 Medicare Physician Fee Schedule (MPFS) released November 2, 2016. RVUs were assigned using the following protocol ("RVU Assignment Protocol").

The RVUs reported in the 2017 MPFS include 2 decimal points. In order to maintain whole numbers in Appendix D, while maintaining appropriate relative value differences reported in the MPFS, the RVU work group agreed to remove the decimals by multiplying the reported RVUs by ten and then rounding the product of the calculation, where values less than X.5 are rounded down and all other values are rounded up.

1. CPT codes with RVUS listed in the MPFS.
    a. For CPT codes with RVUs that include both professional (modifier 26) and technical (modifier TC) components, use only the technical (TC) component RVU.
    b. CPT codes with only a single RVU listed
        i. CPT codes that are considered technical only, the single RVU reported will be used.
        ii. CPT considered professional only are not listed in Appendix D.
2. CPT codes that do not have RVUs listed in the MPFS (e.g. CMS Status Code "C")
    a. CPT 95824 did not have a published RVU in the MPFS. This CPT is infrequently reported by hospitals and will be listed "By Report."
    b. CPT 95941 did not have a published RVU in the MPFS. This procedure is not reported to Medicare but may be utilized for other payers. This CPT (1 hour of time) will be reported at 3 RVUs, mirroring 94940 (which is for 15 minutes) because physician is not 1:1 with patient;
    c. CPT 95943, 94965, 94966 and 95967 did not have a published RVU in the MPFS. These CPTs will be assigned "By Report." As this procedure is not currently being provided by hospitals. When hospitals do provide this service, RVUs shall be assigned following the protocol below in the section "CPT Codes without an Assigned RVU Value."
    d. CPT 94951 did not have a published RVU in the MPFS. This CPT is infrequently reported by hospitals and will be listed "By Report."
    e. HCPCS codes G0398, G0399 and G0400 did not have published RVUs as they are for hospital use only. These procedures will mirror CPT 95806 at 30 RVUs.
3. CPT/HCPCS codes for which the published RVU did not make sense.
    a. There were not deviations from published RVUs when present.

Services with both a HCPCS for Medicare and CPT for NonMedicare

All known HCPCS codes have been addressed in a payer-neutral fashion with this update. In instances where Medicare implements a new HCPCS code to be utilized in lieu of a CPT code for a service, the

RVU developed by the hospital must mirror the established CPT RVUs. The RVU for the service must be the same for all payers.

Unattended and Home Sleep Studies

The RVUs for these services assumes the patients are coming to the hospital before and/or after the procedure to be hooked up/educated on equipment and unhooked/discharged from equipment. These RVUs do not relate to the portion of the service occurring without staff and/or at the patient's home.

CPT Codes without an Assigned RVU Value

RVUs for new codes developed and reported by CMS after the 2017 reporting, must be developed "By Report." When assigning RVUs to these new codes, hospitals should use the RVU Assignment Protocol described above where possible using the most current MPFS. For codes that are not listed in the MPFS, hospitals should assign RVUs based on time and resource intensity of the services provided compared to like services in the department. Documentation of the assignment of RVUs to codes not listed in Appendix D should always be maintained by the hospital.

General Guidelines

The AMA CPT Code will be used as the identifier throughout the system. Assigned RVUs will be strictly tied to the CPT Code.

All RVUs are per CPT unless otherwise stated.

Standard supplies are included in the RVU assignment and should not be assigned separately.

No drug is considered a routine part of any EEG examination, however, sedation and pain reducing agents may be used to make procedures more easily tolerated. These drugs should NOT be included in the RVU of the exam but would be billed separately through the pharmacy on an "as needed" basis. Drugs should not be assigned an RVU.

ELECTROENCEPHALOGRAPHY

CPT Code	Description	RVU
95782	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	251
95783	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist	285
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (e.g., by airflow or peripheral arterial tone), and sleep time	36
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (e.g., by airflow or peripheral arterial tone)	12
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	27
95805	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness	103
95806	Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (e.g., thoracoabdominal movement)	30
95807	Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist	113
95808	Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist	155

STANDARD UNIT OF MEASURE REFERENCES
ELECTROENCEPHALOGRAPHY

CPT Code	Description	RVU
95810	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	140
95811	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist	148
95812	Electroencephalogram (EEG) extended monitoring; 41-60 minutes	75
95813	Electroencephalogram (EEG) extended monitoring; greater than 1 hour	90
95816	Electroencephalogram (EEG); including recording awake and drowsy	85
95819	Electro-encephalogram (EEG); including recording awake and asleep	101
95822	Electroencephalogram (EEG); recording in coma or sleep only	89
95824	Electroencephalogram (EEG); cerebral death evaluation only	By Report
95827	Electroencephalogram (EEG); all night recording	170
95829	Electrocorticogram at surgery (separate procedure)	445
95830	Insertion by physician or other qualified health care professional of sphenoidal electrodes for electroencephalographic (EEG) recording	62
95831	Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk	9
95832	Muscle testing, manual (separate procedure) with report; hand, with or without comparison with normal side	9
95833	Muscle testing, manual (separate procedure) with report; total evaluation of body, excluding hands	11
95834	Muscle testing, manual (separate procedure) with report; total evaluation of body, including hands	15
95851	Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)	5
95852	Range of motion measurements and report (separate procedure); hand, with or without comparison with normal side	4
95857	Cholinesterase inhibitor challenge test for myasthenia gravis	15
95860	Needle electromyography; 1 extremity with or without related paraspinal areas	20
95861	Needle electromyography; 2 extremities with or without related paraspinal areas	26
95863	Needle electromyography; 3 extremities with or without related paraspinal areas	33
95864	Needle electromyography; 4 extremities with or without related paraspinal areas	39
95865	Needle electromyography; larynx	17
95866	Needle electromyography; hemidiaphragm	19
95867	Needle electromyography; cranial nerve supplied muscle(s), unilateral	15
95868	Needle electromyography; cranial nerve supplied muscles, bilateral	20
95869	Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)	20
95870	Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters	20
95872	Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied	12
95873	Electrical stimulation for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)	15
95874	Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)	15

STANDARD UNIT OF MEASURE REFERENCES
ELECTROENCEPHALOGRAPHY

CPT Code	Description	RVU
95875	Ischemic limb exercise test with serial specimen(s) acquisition for muscle(s) metabolite(s)	16
95885	Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)	11
95886	Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)	13
95887	Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)	12
95905	Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report;	19
95907	Nerve conduction studies; 1-2 studies	12
95908	Nerve conduction studies; 3-4 studies	16
95909	Nerve conduction studies; 5-6 studies	19
95910	Nerve conduction studies; 7-8 studies	25
95911	Nerve conduction studies; 9-10 studies	28
95912	Nerve conduction studies; 11-12 studies	28
95913	Nerve conduction studies; 13 or more studies	31
95921	Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio	11
95922	Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt	14
95923	Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential	27
95924	Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt	18
95925	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs	31
95926	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs	30
95927	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head	31
95928	Central motor evoked potential study (transcranial motor stimulation); upper limbs	37
95929	Central motor evoked potential study (transcranial motor stimulation); lower limbs	39
95930	Visual evoked potential (VEP) testing central nervous system, checkerboard or flash	31
95933	Orbicularis oculi (blink) reflex, by electrodiagnostic testing	13
95937	Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method (for ultrasonography, see 76500 et seq.)	13
95938	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs	83

STANDARD UNIT OF MEASURE REFERENCES
ELECTROENCEPHALOGRAPHY

CPT Code	Description	RVU
95939	Central motor evoked potential study (transcranial motor stimulation); upper and lower limbs	108
95940	Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)	3
95941	Continuous intraoperative neurophysiology monitoring from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)	3
95943	Simultaneous, independent, quantitative measures of both parasympathetic function and sympathetic function, based on time-frequency analysis of heart rate variability concurrent with time-frequency analysis of continuous respiratory activity, with mean heart rate and blood pressure measures, during rest, paced (deep) breathing, Valsalva maneuvers, and head-up postural change	By Report
95950	Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (e.g., 8 channel EEG) recording and interpretation, each 24 hours	71
95951	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (e.g., for pre-surgical localization), each 24 hours	By Report
95953	Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended	73
95954	Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase (e.g., thiopental activation test)	92
95955	Electroencephalogram (EEG) during nonintracranial surgery (e.g., carotid surgery)	45
95956	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours, attended by a technologist or nurse	404
95957	Digital analysis of electroencephalogram (EEG) (e.g., for epileptic spike analysis)	56
95958	Wada activation test for hemispheric function, including electroencephalographic (EEG) monitoring	99
95961	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of attendance by a physician or other qualified health care professional	40
95962	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of attendance by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	25
95965	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (e.g., epileptic cerebral cortex localization)	By Report
95966	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (e.g., sensory, motor, language, or visual cortex localization)	By Report
95967	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, each additional modality (e.g., sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure)	By Report

STANDARD UNIT OF MEASURE REFERENCES
ELECTROENCEPHALOGRAPHY

CPT Code	Description	RVU
95970	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (i.e., cranial nerve, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming	19
95971	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (i.e., peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming	14
95972	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (i.e., peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming	17
95974	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour	59
95975	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)	32
95978	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programing; first hour	71
95979	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programing; each additional 30 minutes after first hour (List separately in addition to code for primary procedure)	31
95980	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming	4

STANDARD UNIT OF MEASURE REFERENCES
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CPT Code	Description	RVU
95981	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming	9
95982	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming	15
95999	Unlisted neurological or neuromuscular diagnostic procedure	By Report
G0398	Home sleep test/type 2 portable (Medicare reporting only)	30
G0399	Home sleep test/type 3 portable (Medicare reporting only)	30
G0400	Home sleep test/type 4 portable (Medicare reporting only)	30
G0453	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)	3

STANDARD UNIT OF MEASURE REFERENCES
ELECTROENCEPHALOGRAPHY

STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)

ACCOUNT NUMBER	COST CENTER TITLE
7510	**Physical Therapy**
7530	**Occupational Therapy**

The descriptions in this section of Appendix D were obtained from the 2003 edition of the Current Procedural Terminology (CPT) manual, and the 2003 edition of the Healthcare Common Procedure Coding System (HCPCS). Some of the codes are designed with time as a multiple. For example, code 97032, "Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes." While other codes are silent on time. For example code 29105, "Application of long arm splint (shoulder to hand)."

The review committee has elected to assign all Relative Value Units (RVU's) in this section of Appendix D, based on time. That decision required converting CPT non-time based codes to time based codes. The time increment selected was 15 minutes. **The 15-minute increments used in this Appendix D are subject to the Medicare 8 minute rule.** (For the benefit of the reader, all applicable PT and OT codes are grouped, per CPT definition, as either "NON-TIME" or "TIME" codes. However, for CPT codes under "NON-TIME", it is implicit that the service is provided in time multiples, as defined by the review committee. For emphasis the phrase "(*per HSCRC: each 15 minutes*)" has been added to the CPT description).

Hospitals may want to contact MHA for billing suggestions

STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)

Other considerations:

1. Supply costs are included in the HSCRC rate per RVU. There is one exception, which is noted under CPT code 29580.
2. The CPT codes reviewed account for the majority of services provided in PT & OT. There are some CPT codes not listed and new codes may be added in the future. These codes should be considered as "by report" by the individual institution.
3. CPT codes are in a process of constant revision and as such providers should review their institution's use of CPT codes and stay current with proper billing procedures.
4. The RVU's listed in this section of Appendix D are time based. The time increments are in 15-minute multiples. HSCRC expects providers to round up/down for services, when not provided in exactly a 15-minute multiple. For example services that are:
   a. 8 to 22 minutes = 15 minutes,
   b. 23 to 37 minutes = 30 minutes,
   c. 38 to 52 minutes = 45 minutes,
   d. 53 to 67 minutes = 60 minutes, etc.
5. Time increments used in this section of Appendix D are for direct patient time. Direct patient time is billable. Time spent for set-up, documentation of service, conference, and other non-patient contact is not billable.
6. It is expected and essential that all appropriate clinical documentation be prepared and maintained to support services provided.

CPT code	Description	RVU
NON-TIME BASED CODES		
29105	Application of long arm splint (shoulder to hand) (per HSCRC: each 15 minutes).	12
29125	Application of short arm splint (forearm to hand); static (per HSCRC: each 15 minutes).	10

STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)

NON-TIME BASED CODES

CPT code	Description	RVU
29126	Application of short arm splint (forearm to hand); dynamic (per HSCRC: each 15 minutes).	12
29130	Application of finger splint; static (per HSCRC: each 15 minutes).	8
29131	Application of finger splint; dynamic (per HSCRC: each 15 minutes).	10
29505	Application of long leg splint (thigh to ankle or toes) (per HSCRC: each 15 minutes).	12
29515	Application of short leg splint (calf to foot) (per HSCRC: each 15 minutes).	10
29580	Strapping; Unna boot (per HSCRC: each 15 minutes. Per HSCRC: charge for unna boot separately).	6
64550	Application of surface (transcutaneous) neurostimulator (per HSCRC: each 15 minutes. Per HSCRC, to be used for initial Tens application only).	5
90901	Biofeedback training by any modality (exception see 90911) (per HSCRC: each 15 minutes).	6
90911	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry (e.g. Incontinence) (per HSCRC: each 15 minutes).	7
96110	Developmental testing, limited (e.g. Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report. (Per HSCRC: each 15 minutes).	9
97001	Physical Therapy evaluation (per HSCRC: each 15 minutes).	12

STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)

CPT code	Description	RVU
NON-TIME BASED CODES		
97002	Physical Therapy re-evaluation (per HSCRC: each 15 minutes).	9
97003	Occupational Therapy evaluation (per HSCRC: each 15 minutes).	12
97004	Occupational Therapy re-evaluation (per HSCRC: each 15 minutes).	9
97010	(per HSCRC: not reportable) Application of a modality to one or more areas; hot or cold packs.	0
97012	Application of a modality to one or more areas: traction, mechanical (per HSCRC: each 15 minutes).	4
97014	(per HSCRC: not reportable) Application of a modality to one or more areas; electrical stimulation (unattended).	0
97016	Application of a modality to one or more areas; Vasopneumatic devices (per HSCRC each 15 minutes).	3
97018	Application of a modality to one or more areas; Paraffin bath (per HSCRC: each 15 minutes).	2
97022	Application of a modality to one or more areas; Whirlpool, (per HSCRC: each 15 minutes).	3
97039	Unlisted modality (specific type and time if constant attendance), (per HSCRC: RVU assigned should be for a 15-minute increment)	by report
97139	Unlisted therapeutic procedure (specify), (per HSCRC: RVU assigned should be for a 15-minute increment).	By report

STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)

CPT Code	Description	RVU
NON-TIME BASED CODES		
97150	Therapeutic procedure(s), group (2, 3, or 4 patients). Therapeutic procedure(s), group (5 or more patients). (per HSCRC: each 15 minutes).	3 per patient 2 per patient
97601	Removal of devitalized tissue from wound(s); selective debridement, without anesthesia (e.g., high pressure waterjet, sharp selective debridement with scissors, scalpel and tweezers). Including topical application(s) wound assessment, and instruction(s) for ongoing care, per session. (per HSCRC: each 15 minutes).	12
97602	(per HSCRC: not reportable) Removal of devitalized tissue from wound(s); non-selective debridement, without anesthesia (e.g. wet-to-moist dressings, enzymatic, abrasion), including topical application(s). Wound Assessment and instruction(s) for ongoing care, per session.	0
97799	Unlisted physical medicine rehabilitation service or procedure (per HSCRC; RVU assigned should be for a 15-minute increment).	By report

HCPCS Code	Description	RVU
NON-TIME BASED CODES		
G0281	Electrical stimulation (unattended), to one or more areas, for Chronic Stage III and Stage IV pressure ulcers, arterial ulcers, Diabetic ulcers, and Venous stasis ulcers not demonstrating Measurable signs of healing after 30 days of conventional care, as Part of a therapy plan of care. (Per HSCRC: each 15 minutes).	4
G0282	Electrical stimulation (unattended), to one or more areas for wound care other than described in G0281 (per HSCRC: each 15 minutes).	4

STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)

HCPCS Code	Description	RVU
NON-TIME BASED CODES		
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care.	3
G0295	(per HSCRC: not reportable) Electromagnetic Stimulation, to one or more areas.	0

CPT Code	Description	RVU
TIME BASED CODES – (direct one to one patient contact)		
96111	Developmental testing, extended (includes assessment of motor, language, social adaptive and/or cognitive functioning by standardized developmental instruments, e.g. Bayley Scales of Infant Development) with interpretation and report, per hour.	48
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes.	4
97033	Application of a modality to one or more areas; iontophoresis, each 15 minutes.	5
97034	Application of a modality to one or more areas; Contrast baths, each 15 minutes.	3
97035	Application of a modality to one or more areas; Ultrasound. Each 15 minutes.	3
97036	Application of a modality to one or more areas; hubbard tank. Each 15 minutes.	4
97110	Therapeutic procedure, one or more areas, each 15 minutes, therapeutic exercises to develop strength and endurance, range of motion and flexibility.	6

STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)

CPT Code	Description	RVU
TIME BASED CODES – (direct one to one patient contact)		
97112	Therapeutic procedure, one or more areas; each 15 minutes, neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities.	6
97113	Therapeutic procedure, one or more areas; each 15 minutes, aquatic therapy with therapeutic exercises.	6
97116	Therapeutic procedure, one or more areas, each 15 minutes, gait training (includes stair climbing).	6
97124	Therapeutic procedure, one or more areas; each 15 minutes, massage including effleurage, enture co and/or tapotement (stroking, compression percussion), (Supplement HSCRC description: The clinician uses massage to provide muscle relaxation, increase localized circulation, soften scar tissue, or mobilize mucous secretions in the lung via tapotement and/or percussion).	4
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes.	6
97504	Orthotic(s) fitting and training, upper extremity (ies), lower extremity (ies), and/or trunk, each 15 minutes.	6
97520	Prosthetic training, upper and/or lower extremities each 15 minutes.	5
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes.	7
97532	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes.	5

STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)

CPT Code	Description	RVU
TIME BASED CODES – (direct one to one patient contact)		
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes.	5
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes.	6
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis), direct one-on-one contact by provider, each 15 minutes.	5
97542	Wheelchair management/propulsion training, each 15 minutes.	5
97545	Work hardening – conditioning, initial 2 hours.	40
97546	Work hardening – conditioning; each additional hour. (List separately in addition to code for primary procedure).	20
97703	Checkout for orthotic/ prosthetic use, established patient, each 15 minutes.	5
97750	Physical performance test or measurement (e.g. musculoskeletal, functional capacity), with written report, each 15 minutes (Supplemental HSCRC description: includes such tests as BTI, isokinetic tests, vision test with equipment, Etc.)	12

STANDARD UNIT OF MEASURE REFERENCES
RESPIRATORY THERAPY & PULMONARY FUNCTION TESTING

ACCOUNT NUMBER	COST CENTER TITLE
7420	Respiratory Therapy
7440	Pulmonary Function Testing

Respiratory Therapy and Pulmonary Function Testing encompass services that respiratory care practitioners and specially trained pulmonary function teams provide. In keeping with the principles in the Medicare Hospital Manual §210.10, when a respiratory therapist or pulmonary function technologist provides these services, they are reportable as respiratory or pulmonary services, ~~and~~ in accordance with the Code of Maryland Regulations (COMAR) for scope of service. If a nurse or other health care team member provides the services, they are considered a component of the patient day or visit, and they are not separately reportable.

Approach

Respiratory Therapy (RES) and Pulmonary Function (PUL) Relative Value Units (RVUs) were developed with the aid of an industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions of codes in this section of Appendix D were obtained from the 2018 edition of the Current Procedural Terminology (CPT) manual and the 2018 edition of the Healthcare Common Procedure Coding System (HCPCS). In addition, for those services requiring usage of an "unlisted" CPT code, the task force developed a description for the service. In assigning RVUs, the task force used the procedure minutes established in the 2012 AARC Uniform Reporting Manual as a reference with a ratio of 1 minute = 1 RVU. RVUs were then assigned using the following protocol ("RVU Assignment Protocol").

RVU Assignment Protocol

The AARC Uniform Reporting Manual has established minutes for respiratory therapy services. The AARC established minutes based on the mean and median time to perform the service within patient categories of Adult, Pediatric and Neonatal. The median number of minutes in the Adult category ~~will be~~ has been used as the basis for RVUs as adults are the majority patient population that receives respiratory therapy and pulmonary function services. All exceptions have been noted.

4. CPT codes that were not assigned in accordance with the AARC median:

    a. CPT 33946 [Extracorporeal membrane oxygenation {ECMO/extracorporeal life support (ECLS)} provided by physician; initiation, veno-venous] and CPT 33947 [Extracorporeal membrane oxygenation {ECMO/extracorporeal life support (ECLS)} provided by physician; initiation, veno-arterial] do not have any associated AARC minutes. These services require 1,820 minutes of staff time per initial day on average per the task force. 1,820 RVUs have been assigned.

    b. CPT 33948 [Extracorporeal membrane oxygenation {ECMO/extracorporeal life support (ECLS)} provided by physician; daily management, each day, veno-venous] and CPT 33949 [Extracorporeal membrane oxygenation {ECMO/extracorporeal life support (ECLS)} provided by physician; daily management, each day, veno-arterial] do not have any associated AARC minutes. These services require 1,440 minutes of staff time per subsequent day on average per the task force. 1,440 RVUs have been assigned.

c. CPT 36410 [Venipuncture, age 3 years or older] is assigned 15 minutes by the AARC. However, this procedure is typically "packaged" by Medicare and will be assigned zero (0) RVUs.

d. CPT 36416 [Collection of capillary blood specimen (egg, finger, heel, ear stick)] has a median of 17.5 AARC minutes. However, as this is a lab service, RVUs will not be assigned. The code will remain in Appendix D and will be referenced as a lab service. The task force also noted that Medicare requests hospitals not separately report this service.

e. CPT 92950 [Cardiopulmonary resuscitation (egg, in cardiac arrest)] has a median of 40 AARC minutes. This service typically involves includes two (2) respiratory therapists. Therefore, the task force agreed the AARC minutes would be doubled and 80 RVUs would be assigned.

f. CPT 93463 [Pharmacologic agent administration (egg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after, and repeat pharmacologic agent administration, when performed (list separately in addition to code for primary procedure)] has a median of 15.5 AARC minutes for Nitric Oxide Delivery- System Calibration and 30 AARC minutes for Nitric Oxide Delivery- Set up. The task force agreed that the minutes would be combined and 46 RVUs would be assigned. This code is sometimes referred to as a "Vaso-active challenge" test and is only used when support is provided by a respiratory therapist in the Cath Lab. This service is bundled into Inhaled Nitric Oxide Therapy, code 94799, daily reportable service, is used when provided in non-Cath lab, typically intensive care settings.

g. CPT 93503 [Insertion and placement of flow directed catheter (egg, Swan-Ganz) for monitoring purposes] does not have any associated AARC minutes. The task force indicated that this service is currently not performed in Maryland and is a physician service. Therefore zero (0) RVUs will be assigned.

h. CPT 94002 [Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day] has a median of 30 AARC minutes. This service has many component services within the AARC listing. The task force agreed to assign 250 RVUs for adults and 300 RVUs for neonates based on the combined amount of time spent on direct and indirect ventilator activities/support for patients. This service bundles all services provided to ventilator patients including but not limited to mobility, transports, spontaneous mechanics, patient assessments and system checks, etc. into a once daily reportable service.

i. CPT 94003 [Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, subsequent day] has a median 15 AARC minutes. This service has many component services within the AARC listing. The task force agreed to assign 250 RVUs for adults and 300 RVUs for neonates based on the combined amount of time spent on direct and indirect ventilator activities/support for patients. This service bundles all services provided to ventilator

patients including but not limited to mobility, transports, spontaneous mechanics, patient assessments and system checks, etc., into a once daily reportable service.

j. CPT 94004 [Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; nursing facility, per day] did not have assigned AARC minutes. This service is specific to a nursing facility. Therefore, zero (0) RVUs will be assigned.

k. CPT 94005 [Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or rest home (egg, assisted living) requiring review of status, review of laboratories and other studies and revision of orders and respiratory care plan (as appropriate), within a calendar month, 30 minutes or more] did not have assigned AARC minutes. This service is performed on patients at home or a rest home. Therefore, zero (0) RVUs will be assigned.

l. CPT 94014 [Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, period recalibration and review and interpretation by a physician or other qualified health care professional] and 94015 [Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration] did not have assigned AARC minutes. These services are rarely performed currently, therefore, the task force agreed these codes should be reported as "By Report."

m. CPT 94016 [Patient-initiated spirometric recording per 30-day period of time; review and interpretation only by a physician or other qualified health care professional] did not have assigned AARC minutes. This is a physician only service, therefore zero (0) RVUs will be assigned.

n. CPT 94150 [Vital capacity, total (separate procedure)] did not have assigned AARC minutes. The task force briefly discussed this code and agreed that the current 18 RVUs per Appendix D are still valid. Therefore, 18 RVUs will be assigned to this code. See note regarding SEPARATE PROCEDURES.

o. CPT 94250 [Expired gas collection, quantitative, single procedure (separate procedure)] did not have assigned AARC minutes. This code is similar in time and resources to CPT 94400. Therefore, 30 RVUs will be assigned. See note regarding SEPARATE PROCEDURES.

p. CPT 94375 [Respiratory flow volume loop] did not have assigned AARC minutes. This procedure is bundled into spirometry therefore zero (0) RVUs will be assigned.

q. CPT 94450 [Breathing response to hypoxia (hypoxia response curve)] has 60 AARC minutes. This code will be assigned 30 RVUs as it is more similar to CPT 94400 [Breathing response to CO2, CO2 response curve].

r. CPT 94453 [High altitude simulation test (HAST), with interpretation and report by a physician or other qualified health care professional; with supplemental oxygen titration] did not have assigned AARC minutes. This service is similar to CPT 94452 (45 RVUs) and therefore will be assigned 45 RVUs.

s. CPT 94617 [Exercise test for bronchospasm, including pre-and post-spirometry, electrocardiographic recording(s), and pulse oximetry] did not have assigned AARC

minutes. This service is similar to deleted CPT 94620 [Exercise-Induced Bronchospasm Challenge] with median minutes of 71 therefore, 71 RVUs will be assigned.

t. CPT 94618 [Pulmonary stress testing (egg, 6-minute walk test), including measurement of heart rate, oximetry, and oxygen titration, when performed] did not have assigned AARC minutes. This code was similar to deleted CPT 94620 [Shuttle Walk Test] with median minutes of 30 therefore, 30 RVUs will be assigned.

u. CPT 94621 [Pulmonary stress testing; complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings] has 30 AARC minutes. This code will be assigned 90 minutes as complex pulmonary stress testing should be higher than the simple pulmonary stress testing RVUs.

v. CPT 94640 [Pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device] is reportable once per encounter. An encounter starts when the patient enters the facility and ends when the patient leaves the facility. The time involved with this service varies with each patient and is considerably different between an inpatient and outpatient; as such, there is a different RVU based upon patient classification. An inpatient may receive on average of 6 treatments per day with each treatment requiring 20 minutes of clinical care time. An average stay for these patients may be 4 days. Calculation: 6 treatments x 20 minutes per treatment x 4 days = 480 minutes. An outpatient receives on average 2 treatments per day with each treatment requiring 20 minutes of clinical care time. Calculation: 2 treatments x 20 minutes per treatment = 40 minutes/RVUs.

w. CPT 94642 [Aerosol inhalation of Pentamidine for pneumocystis carinii pneumonia treatment or prophylaxis] did not have AARC minutes. This procedure is about 60 minutes in duration. Therefore, 60 RVUs will be assigned.

~~x.~~ CPT 94660 [Continuous positive airway pressure ventilation (CPAP), initiation and management] did not have AARC minutes. This service requires an average of six separate respiratory therapist visits per day with an average of 20 minutes each. Therefore, 120 RVUs will be assigned to this code. This service is inclusive of respiratory therapist time. Home equipment used only in the absence of respiratory therapist time is not reportable.

y. CPT 94662 [Continuous negative pressure ventilation (CNP), initiation and management] did not have AARC minutes. This service requires an average of six separate respiratory therapist visits per day with an average of 20 minutes each. Therefore, 120 RVUs will be assigned to this code.

z. CPT 94669 [Mechanical chest wall oscillation to facilitate lung function, per session] did not have AARC minutes. This procedure is approximately 30 minutes in duration. Therefore, the task force agreed to assign 30 RVUs to this code. This is not to be reported with CPT 94667 [Manipulation chest wall; Initial demonstration] and CPT 94668 [Manipulation chest wall; Subsequent demonstration].

aa. CPT 94680 [Oxygen uptake, expired gas analysis; rest and exercise, direct, simple] did not have AARC minutes. This procedure is approximately 75 minutes in length. Therefore, 75 RVUs will be assigned to this code.

bb. CPT 94681 [Oxygen update, expired gas analysis; including CO2 output, percentage oxygen extracted] did not have AARC minutes. This procedure is similar to CPT 94621 [Pulmonary Stress Testing, complex…] in time and resources, which is assigned 90 RVUs. Therefore, 90 RVUs will be assigned to this code.

cc. CPT 94727 [Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes] did not have AARC minutes. This procedure is similar to CPT 94726 (Plethysmography for determination of lung volumes and when performed, airway resistance) in time and resources, which is assigned 19 RVUs. Therefore, 19 RVUs will be assigned to this code.

dd. CPT 94750 [Pulmonary compliance study (egg, plethysmography, volume and pressure measurements] did not have AARC minutes. This procedure is approximately 30 minutes in length. Therefore, 30 RVUs will be assigned to this code.

ee. CPT 94761 [Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (egg, during exercise)] has a median of 20 AARC minutes. The task force agreed that 20 RVUs was not sufficient for this procedure as this typically takes 30 minutes. Therefore 30 RVUs will be assigned to this code.

ff. CPT 94762 [Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)] has a median of 20 AARC minutes. The task force agreed that 20 RVUs was not sufficient for this procedure as this typically takes 30 minutes as it is a separate procedure that includes downloading and reporting. Therefore 30 RVUs will be assigned to this code. See note regarding SEPARATE PROCEDURES.

gg. CPT 94770 [Carbon dioxide, expired gas determination by infrared analyzer] has a median of 7 AARC minutes. The task force referenced applicable to bedside end tidal CO2 procedures, and agreed that 7 RVU was not sufficient for this procedure it typically takes 40 minutes. Therefore, 40 RVUs will be assigned to this code.

hh. CPT 94774 [Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; includes monitor attachment, download of data, review, interpretation, and preparation of a report by a physician or other qualified health care professional]did not have AARC minutes. This code will be assigned zero (0) RVUs as this is a global CPT not to be used by hospitals.

ii. CPT 94775 [Pediatric home apnea monitoring event recording including respiratory rate, patter and heart rate per 30-day period of time; monitor attachment only (includes hook-up, initiation of recording and disconnection)] did not have AARC minutes. This service is currently not being reported. The task force agreed that this should remain in Appendix D for future reporting and RVUs should be established “By Report.”

jj. CPT 94776 [Pediatric home apnea monitoring event recording including respiratory rate, patter and heart rate per 30-day period of time; monitoring, download of information, receipt of transmission(s) and analyses by computer only] did not have AARC minutes. This code will be assigned zero (0) RVUs as the patient is not present at the hospital.

kk. CPT 94777 [Pediatric home apnea monitoring event recording including respiratory rate, patter and heart rate per 30-day period of time; review, interpretation and preparation of report only by a physician or other qualified health care professional] did not have AARC minutes. This code will be assigned zero (0) RVUs as this is a physician service.

ll. CPT 9780 [Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; 60 minutes] did not have AARC minutes. Per the AMA description, this procedure is 60 minutes. Therefore, 60 RVUs will be assigned.

mm. CPT 94781 [Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report each additional full 30 minutes (List separately in addition to code for primary procedure)] did not have AARC minutes. Per the AMA description, this procedure is 30 minutes. Therefore, 30 RVUs will be assigned.

nn. CPT 99406 [Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes] did not have AARC minutes. Per the AMA description, this service is up to 10 minutes. Therefore, 10 RVUs will be assigned.

oo. CPT 99407 [Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes] did not have AARC minutes. Per the AMA description, this service is 10 minutes or greater. Based on discussion from clinical staff, the task force agreed that this service is approximately 20 minutes. Therefore, 20 RVUs will be assigned.

pp. CPT 99464 [Attendance at delivery (when requested by the delivering physician or other qualified health care professional) and initial stabilization of newborn] has a median of 35 AARC minutes. The task force referenced applicable time and support and agreed that 35 minutes was not sufficient. After discussion, the task force agreed that this procedure requires approximately 60 minutes. Therefore, 60 RVUs will be assigned.

qq. HCPCS G0237 [Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)] did not have AARC minutes. Per the AMA description, this service is each 15 minutes. Therefore, 15 RVUs, for each 15 minutes, will be assigned.

rr. HCPCS G0238 [Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring)] did not have AARC minutes. Per the AMA description, this service is each 15 minutes. Therefore, 15 RVUs, for each 15 minutes, will be assigned.

ss. HCPCS G0239 [Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring)] did not have AARC minutes. The ratio of care team provider to patient is ~~often~~ generally 1:4 and sessions last one hour. Therefore, 15 RVUs (60 minutes/4 patients) will be assigned.

tt. HCPCS G0424 [Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day] did not have AARC minutes. The ratio of care team provider to patient is often 1:4 and sessions last one hour. The first and last sessions typically requires one-on-one time. Therefore, 18 RVUs (60 minutes/4 patients plus additional time to account for the first and last sessions) will be assigned.

STANDARD UNIT OF MEASURE REFERENCES
RESPIRATORY THERAPY & PULMONARY FUNCTION TESTING

SERVICES WITHOUT AN ASSIGNED CPT CODE

Various respiratory services do not have assigned CPT codes. These services will be included in Appendix D under CPT 94799. For all other usage of 94799, the RVU is "by report" and will require development based on minutes of staff time required.

a. Aerosol Therapy-

    a. Continuous aerosol mist= 30 RVUs/day. Note: Daily oxygen is bundled with this service.

    b. Continuous nebulization- non-bronchodilator= 250 RVUs/day. Used for continuous nebulization of non-bronchodilator medications, includes pulmonary vasodilator medications, antibiotics, or any non-bronchodilator nebulized medication administered.

    Patients receiving more than one of the types of aerosol therapies listed above report the highest complexity service I.e.) Cont Aerosol mist + Cont Neb-BD: Report ONLY Cont Neb-BD; I.e.) Cont Neb-BD + Cont Neb-Non BD: Report ONLY Cont Neb-Non BD. A second less complex aerosol therapy is bundled into the highest complexity service.

b. Arterial blood sampling via indwelling catheter – This service is bundled with other services and not to be reported separately.

c. Gas Therapies –

    a. High Flow Oxygen – This procedure requires an average of six ~~checks~~ patient visits per day with an average of 20 minutes per check. Therefore, 120 RVUs/day will be assigned to this code.

    b. Inhaled Nitric Oxide – Therapeutic gas administration for the treatment of Pulmonary Hypertension and other related conditions in patients who have this condition or related disease processes primarily in newborns and adults who exhibit signs of Pulmonary Hypertension. May also be used to treat reperfusion injury as in patients who have received heart and/or lung transplants. The task force agreed this service is similar in time and resources to CPT 94002 [Ventilation assist and management] therefore 250 RVUs/day will be assigned.

    c. Alternative Gases- The administration of gases or mixtures of gases other than the traditional administration of oxygen or medical air. Administration requires procuring special equipment, special expertise, and additional time in providing this gas and systems to patients. Examples of these gases are Helium, Helium oxygen measures, Carbon dioxide and mixtures, and Nitrogen gas mixtures excluding Nitric Oxide. The task force agreed this service is similar in time and resources as High Flow Oxygen therefore 120 RVUs/day will be assigned.

    d. Oxygen – This is all-inclusive rate for oxygen that is not high flow nasal cannula oxygen. The task force assigned 20 RVUs per day based on the average amount of minutes required for this service. This service may not be reported with CPT 94799 [Aerosol Therapy]. Daily care and cleaning of transtracheal oxygen catheter is not to be separately reported.

d. Bedside pulmonary mechanics – Non-vent- Used only for spontaneous breathing, non-ventilator patients, as a diagnostic measure of respiratory muscle strength, volumes, and capacities. Includes, not limited to, negative inspiratory force, tidal volume, and minute volumes. This must be performed stand-alone to be reported. The task force recommended using the AARC median minutes of 15. Therefore 15 RVUs will be assigned.

e. Generation of Non-Emergent NIV patient compliance study – The task force recommended using the AARC median minutes of 15. Therefore 15 RVUs will be assigned.

f. Incentive spirometry – This service is not to be reported separately; generally is performed by nursing and it does not meet the requirements of the spirometry CPT 94010. This is assigned zero (0) RVUs.

g. Comprehensive Patient Assessment- The process of gathering and evaluating data from a complete medical record, consultations, physiologic monitors, that does not lead to the immediate administration of another respiratory service/treatment. This service is not intended to be used for routine Respiratory Assess and Treat order and must be specifically ordered and provided stand alone. There is a maximum of once/day allowed. This service is approximately 20 minutes in duration, therefore, 20 RVUs will be assigned.

h. Manual ventilation – This cannot be reported with ventilator or rapid response service. The task force recommended keeping this service weighted at 15 RVUs per quarter hour.

i. Nasopharyngeal airway- This service is bundled with other services and not separately reportable. This is assigned zero (0) RVUs.

j. Peak flow/spirometry monitoring – This service is bundled with other services and not separately reportable. This is assigned zero (0) RVUs.

k. Mini broncho alveolar lavage (BAL) – This is for stand-alone usage only and would not be ~~charged~~ reported in addition to other bedside procedural assist. The task force recommended ~~used~~ using the AARC median minutes of 30. Therefore 30 RVUs will be assigned.

   This activity describes the collection of a non-bronchoscopic bronchoalveolar lavage to obtain fluid specimen for the diagnosis of ventilator associated pneumonia.

l. Bedside Procedural Assistance – This is used when respiratory therapists assist physicians or other authorized providers with complex bedside procedures including but not limited to bedside bronchoscopy, laryngoscopy, endoscopy, lung biopsy, chest tube insertion, percutaneous tracheostomy, A-line insertion, peripherally inserted central catheter (PICC), thoracentesis, cricothyrotomy, central line insertion pulmonary artery catheter setup, and hemodynamic monitoring/measurements. The task force assigned 30 minutes for this service based on the average amount of support time. Therefore 30 RVUs will be assigned.

m. Rapid response –This service is reportable once per rapid response event and may not be used in combination with Cardiopulmonary Resuscitation. These events typically require an average of 30 minutes of support. Therefore 30 RVUs will be assigned.

n. Bedside Sleep Apnea Screening- The application of an Impedance Monitoring system to assess a patient's ventilatory pattern with periodic evaluation of patient. When in hospital bedside sleep apnea screenings are performed by inpatient respiratory therapists as a separate service, average amount of support time 30 minutes. Therefore 30 RVUs will be assigned.

o. Speech Services-The task force agreed certain services are reportable via the Speech Therapy rate center/assigned zero (0) RVUs

   a. Placement/Removal of Assistive Speech Value

   b. Transdiaphragmatic pressure

p. Subsequent Patient Assessment- Limited patient assessments are bundled with associated procedures and therefore zero (0) RVUs will be assigned.

q. Tracheostomy Tube Care- This service cannot be charged with ventilator daily charges. For non-vent patients, the task force agreed this procedure is approximately 20 minutes. Therefore 20 RVUs will be assigned. Initial placement, daily care, and removal of tracheostomy button are bundled with this service.

~~r.~~ Transcutaneous Monitoring- Transcutaneous (existing, applied, or measured across the depth of the skin) oxygen/carbon dioxide monitoring. A method of measuring the oxygen/carbon dioxide in the blood by attaching electrodes to the skin which contain heating coils to raise the skin temperature and increase blood flow at the surface. This is similar in support time to 94770 [end tidal CO2 procedure] assigned 40 RVUs. Therefore 40 RVUs will be assigned.

s. Ventilator services- The following services are considered a component of ventilator services and not separately reportable/assigned zero (0) RVUs and are bundled into the daily vent management service.

   a. Ambulation

   b. Endotracheal tube re-stabilization and positioning

   c. Extubation of Airway

   d. FRC determination during mechanical ventilation

   e. Maximal inspiratory and expiratory pressure (also bundled with Pulmonary Function Testing)

   f. Monitor cuff pressure/care

   g. Placement or change of in-line suction catheter

   h. Prone positioning

   i. Spontaneous breathing trial and/or screen

   j. Static pressure/volume loop (also bundled with Pulmonary Function Testing)

   k. Therapeutic ventilator maneuver (recruitment maneuver)

   l. Transport/MRI ventilator use during – invasive Mechanical Ventilation

   m. Ventilator circuit change – invasive mechanical ventilation

   n. Work of breathing

CPT Codes with Bundled Procedures

CPT codes from 2018 with a surgical component have been assigned a zero (0) RVU value. If a RES or PUL CPT becomes bundled with a surgical code or replaced with a surgical code, these procedures should be charged as Interventional Radiology/Cardiovascular (IRC) and the associated costs of the

procedure/service are to be reclassified to the IRC cost center. (This is minimal for Respiratory/Pulmonary Services.)

CPT Codes without an Assigned RVU Value

RVUs for new codes developed and reported by CMS after the 2018 reporting, must be developed "By Report". When assigning RVUs to these new codes, hospitals should use the RVU Assignment Protocol described above, where possible, using the most current AARC Uniform Reporting Manual. For codes that are not listed in the AARC Uniform Reporting Manual, hospitals should assign RVUs based on time and resource intensity of the services provided compared to like services in the department. Documentation of descriptions and the assignment of RVUs to codes not listed in Appendix D should always be maintained by the hospital.

Separate Procedures

These are codes that include the parenthetical statement "separate procedure". The inclusion of this statement indicates that the procedure can only be reported when it is performed stand-alone. A "separate procedure" should not be reported when performed along with another procedure in an anatomically related region through the same skin incision or orifice, or approach.

General Guidelines

The AMA CPT Code will be used as the identifier throughout the system. Assigned RVUs will be strictly tied to the CPT Code.

All RVUs are per CPT unless otherwise stated.

Standard supplies and other medical equipment are part of hospital room and board and are not separately reportable and should not be assigned separately.

Drugs are NOT a routine part of any Resp/Pulm examination. These drugs should NOT be included in the RVU of the exam and are to be ~~billed~~ reported separately through the pharmacy. Drugs should not be assigned an RVU.

CPT	Description	RVU [1]
31500	INTUBATION, ENDOTRACHEAL, EMERGENCY PROCEDURE	25
31502	TRACHEOTOMY TUBE CHANGE PRIOR TO ESTABLISHMENT OF FISTULA TRACT	22
31505	LARYNGOSCOPY, INDIRECT, DIAGNOSTIC (SEPARATE PROCEDURE)	0 See Procedure Assist
31720	CATHETER ASPIRATION (SEPARATE PROCEDURE); NASOTRACHEAL	15

STANDARD UNIT OF MEASURE REFERENCES
RESPIRATORY THERAPY & PULMONARY FUNCTION TESTING

CPT	Description	RVU [1]
33946	EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)/EXTRACORPOREAL LIFE SUPPORT (ECLS) PROVIDED BY PHYSICIAN; INITIATION, VENO-VENOUS	1820/day
33947	EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)/EXTRACORPOREAL LIFE SUPPORT (ECLS) PROVIDED BY PHYSICIAN; INITIATION, VENO-ARTERIAL	1820/day
33948	EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)/EXTRACORPOREAL LIFE SUPPORT (ECLS) PROVIDED BY PHYSICIAN; DAILY MANAGEMENT, EACH DAY, VENO-VENOUS	1440/day
33949	EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)/EXTRACORPOREAL LIFE SUPPORT (ECLS) PROVIDED BY PHYSICIAN; DAILY MANAGEMENT, EACH DAY, VENO-ARTERIAL	1440/day
36410	VENIPUNCTURE, AGE 3 YEARS OR OLDER, NECESSITATING THE SKILL OF A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL (SEPARATEPROCEDURE), FOR DIAGNOSTIC OR THERAPEUTIC PURPOSES (NOT TO BE USED FORROUTINE VENIPUNCTURE)	Report via Lab
36416	COLLECTION OF CAPILLARY BLOOD SPECIMEN (EG, FINGER, HEEL, EAR STICK)	Report via Lab
36600	ARTERIAL PUNCTURE, WITHDRAWAL OF BLOOD FOR DIAGNOSIS	15
36620	ARTERIAL CATHETERIZATION OR CANNULATION FOR SAMPLING, MONITORING OR TRANSFUSION (SEPARATE PROCEDURE); PERCUTANEOUS	30
92950	CARDIOPULMONARY RESUSCITATION (EG, IN CARDIAC ARREST)	80/ session
93463	PHARMACOLOGIC AGENT ADMINISTRATION (EG, INHALED NITRIC OXIDE,INTRAVENOUS INFUSION OF NITROPRUSSIDE, DOBUTAMINE, MILRINONE, OR OTHERAGENT) INCLUDING ASSESSING HEMODYNAMIC MEASUREMENTS BEFORE, DURING,AFTER AND REPEAT PHARMACOLOGIC AGENT ADMINISTRATION, WHEN PERFORMED(LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) NOTE: CATH LAB ONLY	46
93503	INSERTION AND PLACEMENT OF FLOW DIRECTED CATHETER (EG, SWAN-GANZ) FOR MONITORING PURPOSES	0 See Procedural Assistance

STANDARD UNIT OF MEASURE REFERENCES
RESPIRATORY THERAPY & PULMONARY FUNCTION TESTING

CPT	Description	RVU [1]
94002	VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUMEPRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; HOSPITAL INPATIENT/OBSERVATION, INITIAL DAY [This service includes all services provided to ventilator patients including but not limited to mobility, transport, spontaneous mechanics, patient/system checks, etc.]	250/day-adult, 300/day-Neonates
94003	VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUME PRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; HOSPITAL INPATIENT/OBSERVATION, EACH SUBSEQUENT DAY [This service includes all services provided to ventilator patients including but not limited to mobility, transport, spontaneous mechanics, patient/system checks, etc.]	250/day-adult, 300/day-Neonates
94004	VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUME PRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; NURSINGFACILITY, PER DAY	0
94005	HOME VENTILATOR MANAGEMENT CARE PLAN OVERSIGHT OF A PATIENT (PATIENTNOT PRESENT) IN HOME, DOMICILIARY OR REST HOME (EG, ASSISTED LIVING)REQUIRING REVIEW OF STATUS, REVIEW OF LABORATORIES AND OTHER STUDIES AND REVISION OF ORDERS AND RESPIRATORY CARE PLAN (AS APPROPRIATE),WITHIN A CALENDAR MONTH, 30 MINUTES OR MORE	0
94010	SPIROMETRY, INCLUDING GRAPHIC RECORD, TOTAL AND TIMED VITAL CAPACITY,EXPIRATORY FLOW RATE MEASUREMENT(S), WITH OR WITHOUT MAXIMAL VOLUNTARY VENTILATION	25
94011	MEASUREMENT OF SPIROMETRIC FORCED EXPIRATORY FLOWS IN AN INFANT OR CHILD THROUGH 2 YEARS OF AGE	30
94012	MEASUREMENT OF SPIROMETRIC FORCED EXPIRATORY FLOWS, BEFORE AND AFTER BRONCHODILATOR, IN AN INFANT OR CHILD THROUGH 2 YEARS OF AGE	38

STANDARD UNIT OF MEASURE REFERENCES
RESPIRATORY THERAPY & PULMONARY FUNCTION TESTING

CPT	Description	RVU [1]
94013	MEASUREMENT OF LUNG VOLUMES (IE, FUNCTIONAL RESIDUAL CAPACITY [FRC],FORCED VITAL CAPACITY [FVC], AND EXPIRATORY RESERVE VOLUME [ERV]) IN AN INFANT OR CHILD THROUGH 2 YEARS OF AGE	33
94014	PATIENT-INITIATED SPIROMETRIC RECORDING PER 30-DAY PERIOD OF TIME;INCLUDES REINFORCED EDUCATION, TRANSMISSION OF SPIROMETRIC TRACING,DATA CAPTURE, ANALYSIS OF TRANSMITTED DATA, PERIODIC RECALIBRATION AND REVIEW AND INTERPRETATION BY A PHYSICIAN OR OTHER QUALIFIED HEALTHCARE PROFESSIONAL	BY REPORT
94015	PATIENT-INITIATED SPIROMETRIC RECORDING PER 30-DAY PERIOD OF TIME;RECORDING (INCLUDES HOOK-UP, REINFORCED EDUCATION, DATA TRANSMISSION,DATA CAPTURE, TREND ANALYSIS, AND PERIODIC RECALIBRATION)	BY REPORT
94016	PATIENT-INITIATED SPIROMETRIC RECORDING PER 30-DAY PERIOD OF TIME;REVIEW AND INTERPRETATION ONLY BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL	0
94060	BRONCHODILATION RESPONSIVENESS, SPIROMETRY AS IN 94010, PRE- AND POST-BRONCHODILATOR ADMINISTRATION	37
94070	BRONCHOSPASM PROVOCATION EVALUATION, MULTIPLE SPIROMETRIC DETERMINATIONS AS IN 94010, WITH ADMINISTERED AGENTS (EG, ANTIGEN[S],COLD AIR, METHACHOLINE)	84
94150	VITAL CAPACITY, TOTAL (SEPARATE PROCEDURE)	18
94200	MAXIMUM BREATHING CAPACITY, MAXIMAL VOLUNTARY VENTILATION	12
94250	EXPIRED GAS COLLECTION, QUANTITATIVE, SINGLE PROCEDURE (SEPARATE PROCEDURE)	30
94375	RESPIRATORY FLOW VOLUME LOOP	0
94400	BREATHING RESPONSE TO CO2 (CO2 RESPONSE CURVE)	30
94450	BREATHING RESPONSE TO HYPOXIA (HYPOXIA RESPONSE CURVE)	30

STANDARD UNIT OF MEASURE REFERENCES
RESPIRATORY THERAPY & PULMONARY FUNCTION TESTING

CPT	Description	RVU [1]
94452	HIGH ALTITUDE SIMULATION TEST (HAST), WITH INTERPRETATION AND REPORT BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL;	45
94453	HIGH ALTITUDE SIMULATION TEST (HAST), WITH INTERPRETATION AND REPORT BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL; WITH SUPPLEMENTAL OXYGEN TITRATION	45
94610	INTRAPULMONARY SURFACTANT ADMINISTRATION BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL THROUGH ENDOTRACHEAL TUBE	30
94617	EXERCISE TEST FOR BRONCHOSPASM, INCLUDING PRE- AND POST-SPIROMETRY, ELECTROCARDIOGRAPHIC RECORDING(S), AND PULSE OXIMETRY	71
94618	PULMONARY STRESS TESTING (EG, 6-MINUTE WALK TEST), INCLUDING MEASUREMENT OF HEART RATE, OXIMETRY, AND OXYGEN TITRATION, WHEN PERFORMED	30
94621	PULMONARY STRESS TESTING; COMPLEX (INCLUDING MEASUREMENTS OF CO2 PRODUCTION, O2 UPTAKE, AND ELECTROCARDIOGRAPHIC RECORDINGS)	90
94640	PRESSURIZED OR NONPRESSURIZED INHALATION TREATMENT FOR ACUTE AIRWAY OBSTRUCTION FOR THERAPEUTIC PURPOSES AND/OR FOR DIAGNOSTIC PURPOSES SUCH AS SPUTUM INDUCTION WITH AN AEROSOL GENERATOR, NEBULIZER, METERED DOSE INHALER OR INTERMITTENT POSITIVE PRESSURE BREATHING (IPPB) DEVICE	480 per inpatient admission 40 per outpatient admission
94642	AEROSOL INHALATION OF PENTAMIDINE FOR PNEUMOCYSTIS CARINII PNEUMONIATREATMENT OR PROPHYLAXIS	60
94644	CONTINUOUS INHALATION TREATMENT WITH AEROSOL MEDICATION FOR ACUTE AIRWAY OBSTRUCTION; FIRST HOUR	34

STANDARD UNIT OF MEASURE REFERENCES
RESPIRATORY THERAPY & PULMONARY FUNCTION TESTING

CPT	Description	RVU [1]
94645	CONTINUOUS INHALATION TREATMENT WITH AEROSOL MEDICATION FOR ACUTE AIRWAY OBSTRUCTION; EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) MAX 4	28
94660	CONTINUOUS POSITIVE AIRWAY PRESSURE VENTILATION (CPAP), INITIATION AND MANAGEMENT	120/day
94662	CONTINUOUS NEGATIVE PRESSURE VENTILATION (CNP), INITIATION AND MANAGEMENT	120/day
94664	DEMONSTRATION AND/OR EVALUATION OF PATIENT UTILIZATION OF AN AEROSOL GENERATOR, NEBULIZER, METERED DOSE INHALER OR IPPB DEVICE	15/day
94667	MANIPULATION CHEST WALL, SUCH AS CUPPING, PERCUSSING, AND VIBRATION TO FACILITATE LUNG FUNCTION; INITIAL DEMONSTRATION AND/OR EVALUATION	30
94668	MANIPULATION CHEST WALL, SUCH AS CUPPING, PERCUSSING, AND VIBRATION TO FACILITATE LUNG FUNCTION; SUBSEQUENT [This includes services provided by the Inexsufflator – Cough Assist and other products providing the same function.]	25
94669	MECHANICAL CHEST WALL OSCILLATION TO FACILITATE LUNG FUNCTION, PER SESSION	30
94680	OXYGEN UPTAKE, EXPIRED GAS ANALYSIS; REST AND EXERCISE, DIRECT, SIMPLE	75
94681	OXYGEN UPTAKE, EXPIRED GAS ANALYSIS; INCLUDING CO2 OUTPUT, PERCENTAGE OXYGEN EXTRACTED	90
94690	OXYGEN UPTAKE, EXPIRED GAS ANALYSIS; REST, INDIRECT (SEPARATE PROCEDURE)	60
94726	PLETHYSMOGRAPHY FOR DETERMINATION OF LUNG VOLUMES AND, WHEN PERFORMED,AIRWAY RESISTANCE	19
94727	GAS DILUTION OR WASHOUT FOR DETERMINATION OF LUNG VOLUMES AND, WHEN PERFORMED, DISTRIBUTION OF VENTILATION AND CLOSING VOLUMES	19
94728	AIRWAY RESISTANCE BY IMPULSE OSCILLOMETRY	15

STANDARD UNIT OF MEASURE REFERENCES
RESPIRATORY THERAPY & PULMONARY FUNCTION TESTING

CPT	Description	RVU [1]
94729	DIFFUSING CAPACITY (EG, CARBON MONOXIDE, MEMBRANE) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	20
94750	PULMONARY COMPLIANCE STUDY (EG, PLETHYSMOGRAPHY, VOLUME AND PRESSURE MEASUREMENTS)	30
94760	NONINVASIVE EAR OR PULSE OXIMETRY FOR OXYGEN SATURATION; SINGLE DETERMINATION	8
94761	NONINVASIVE EAR OR PULSE OXIMETRY FOR OXYGEN SATURATION; MULTIPLE DETERMINATIONS (EG, DURING EXERCISE)	30
94762	NONINVASIVE EAR OR PULSE OXIMETRY FOR OXYGEN SATURATION; BY CONTINUOUS OVERNIGHT MONITORING (SEPARATE PROCEDURE)	30
94770	CARBON DIOXIDE, EXPIRED GAS DETERMINATION BY INFRARED ANALYZER	40/day
94772	CIRCADIAN RESPIRATORY PATTERN RECORDING (PEDIATRIC PNEUMOGRAM), 12-24HOUR CONTINUOUS RECORDING, INFANT	34
94774	PEDIATRIC HOME APNEA MONITORING EVENT RECORDING INCLUDING RESPIRATORYRATE, PATTERN AND HEART RATE PER 30-DAY PERIOD OF TIME; INCLUDES MONITOR ATTACHMENT, DOWNLOAD OF DATA, REVIEW, INTERPRETATION, ANDPREPARATION OF A REPORT BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL	0
94775	PEDIATRIC HOME APNEA MONITORING EVENT RECORDING INCLUDING RESPIRATORY RATE, PATTERN AND HEART RATE PER 30-DAY PERIOD OF TIME; MONITORATTACHMENT ONLY (INCLUDES HOOK-UP, INITIATION OF RECORDING AND DISCONNECTION)	By Report
94776	PEDIATRIC HOME APNEA MONITORING EVENT RECORDING INCLUDING RESPIRATORY RATE, PATTERN AND HEART RATE PER 30-DAY PERIOD OF TIME; MONITORING,DOWNLOAD OF INFORMATION, RECEIPT OF TRANSMISSION(S) AND ANALYSES BY COMPUTER ONLY	0

STANDARD UNIT OF MEASURE REFERENCES
RESPIRATORY THERAPY & PULMONARY FUNCTION TESTING

CPT	Description	RVU [1]
94777	PEDIATRIC HOME APNEA MONITORING EVENT RECORDING INCLUDING RESPIRATORY RATE, PATTERN AND HEART RATE PER 30-DAY PERIOD OF TIME; REVIEW,INTERPRETATION AND PREPARATION OF REPORT ONLY BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL	0
94780	CAR SEAT/BED TESTING FOR AIRWAY INTEGRITY, NEONATE, WITH CONTINUAL NURSING OBSERVATION AND CONTINUOUS RECORDING OF PULSE OXIMETRY, HEART RATE AND RESPIRATORY RATE, WITH INTERPRETATION AND REPORT; 60 MINUTES	60
94781	CAR SEAT/BED TESTING FOR AIRWAY INTEGRITY, NEONATE, WITH CONTINUAL NURSING OBSERVATION AND CONTINUOUS RECORDING OF PULSE OXIMETRY, HEARTRATE AND RESPIRATORY RATE, WITH INTERPRETATION AND REPORT; EACH ADDITIONAL FULL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	30
94799	ALTERNATIVE GAS THERAPY The administration of gases or mixtures of gases other than the traditional administration of oxygen or medical air. Administration requires procuring special equipment, special expertise, and additional time in providing this gas and systems to patients. Examples of these gases are Helium, Helium oxygen measures, Carbon dioxide and mixtures, and Nitrogen gas mixtures excluding Nitric Oxide.	120/day
94799	BEDSIDE PULMONARY MECHANICS Used for spontaneously breathing, non-vented patients, as a diagnostic measurement of respiratory muscle strength, volumes, and capacities. Includes, not limited to negative inspiratory force, tidal volume, and minute volumes. May have more than one session per day; each session may include multiple different measurements.	15
94799	CONTINUOUS NEBULIZATION-NON-BRONCHODILATOR Used for continuous nebulization of non-bronchodilator medications, includes pulmonary vasodilator medications, antibiotics, or any non-bronchodilator nebulized medication administered.	250/day

STANDARD UNIT OF MEASURE REFERENCES
RESPIRATORY THERAPY & PULMONARY FUNCTION TESTING

CPT	Description	RVU [1]
94799	CONTINUOUS AEROSOL MIST W/ OR W/OUT OXYGEN The initial application of equipment to supply and maintain a continuous aerosol mist, with or without increased oxygen concentration (FIO2), to a patient, using a face mask, tracheostomy mask, T-piece, hood, or other device. Includes the periodic evaluation of the system supplying and maintaining a continuous aerosol mist with or without increased oxygen (FIO2) to a patient. The aerosol may be heated or cool. Daily oxygen is bundled into this service.	30/day
94799	GENERATION OF NON-EMERGENT NIV PATIENT COMPLIANCE STUDY This activity describes the evaluation, application, and monitoring of a patient, using a non-invasive portable ventilator, as a means in determining oxygenation/ventilation requirements during resting, ambulation, and walking/exercise to quantify the required ventilation needs with daily life activities.	15
94799	HIGH FLOW OXYGEN THERAPY Heated, humidified high flow nasal cannula (HFNC, aka: HFO, HFT) that can deliver up to 100% heated and humidified oxygen at a flow rate that meets or exceeds patient demand	120/day
94799	INHALED NITRIC OXIDE Therapeutic gas administration for the treatment of Pulmonary Hypertension and other related conditions in patients who have this condition or related disease processes primarily in newborns and adults who exhibit signs of Pulmonary Hypertension. May also be used to treat reperfusion injury as in patients who have received heart and/or lung transplants	250/day
94799	COMPREHENSIVE PATIENT ASSESSMENT The process of gathering and evaluating data from a patient's complete medical record, consultations, physiological monitors and bedside observations (that does not lead to the immediate administration of a treatment). This must be specifically ordered and may only be charged once per day.	20/day
94799	MANUAL VENTILATION Intermittent manual compression of a gas-filled reservoir bag to force gases into a patient's lungs to maintain and support oxygenation and carbon dioxide elimination during apnea or hypoventilation. Can't be reported with ventilator and rapid response.	15/qtr hr
94799	MINI BRONCHO ALVEOLAR LAVAGE (BAL) This activity describes the collection of a non-bronchoscopic bronchoalveolar lavage to obtain fluid specimen for the diagnosis of ventilator associated pneumonia.	30

STANDARD UNIT OF MEASURE REFERENCES
RESPIRATORY THERAPY & PULMONARY FUNCTION TESTING

CPT	Description	RVU [1]
94799	NASOPHARNGEAL TUBE CARE A curved flexible endotracheal tube to be slotted down one nostril to open a channel between the nostril and nasopharynx, to sit behind the tongue, that can be used in an emergency (egg, unconscious patient), or for long-term purposes to create a patient airway.	~~10~~ 0
94799	OXYGEN THERAPY The initial application and periodic monitoring of equipment supplying and maintaining continuous increased oxygen concentration (FIO2) to a patient using a cannula, simple oxygen mask, non-rebreather mask or enturi-type mask. This excludes high flow oxygen therapy and cannot be reported with Continuous Aerosol therapy.	20/day
94799	RAPID RESPONSE Used when respiratory therapy is part of a multidisciplinary team of clinicians who bring critical care expertise and interventions directly to patients with early signs of deterioration. Use ONCE per rapid response event. DO NOT USE in combination with Cardiopulmonary Resuscitation. Regardless of number of therapists present	30
94799	TRACH TUBE CARE The routine care of a tracheostomy tube and tracheostomy site. Not reportable for ventilator patients.	20
94799	TRANSCUTANEOUS MONITORING Transcutaneous (existing, applied, or measured across the depth of the skin) oxygen/carbon dioxide monitoring. A method of measuring the oxygen/carbon dioxide in the blood by attaching electrodes to the skin which contain heating coils to raise the skin temperature and increase blood flow at the surface	40/day
94799	Bedside Sleep Apnea Screening The application of an Impedance Monitoring system to assess a patient's ventilatory pattern with periodic evaluation of patient	30
~~94799~~	~~Nasopharyngeal airway~~	~~0~~
94799	UNLISTED PULMONARY SERVICE OR PROCEDURE	BY REPORT
94799	Bedside Procedure Assist- Used for assistance during separate complex bedside procedures performed by authorized prescribers (physicians, PAs, NPs). Examples include, not limited to, bedside laryngoscopy/bronchoscopy/ endoscopy/ lung biopsy, chest tube insertion, bedside percutaneous trach, A-line insertion, peripherally inserted central catheter (PICC), thoracentesis, cricothyrotomy, central line insertion, hemodynamic monitoring/measurements; or other invasive diagnostic or therapeutic, or emergency procedure.	30
95012	NITRIC OXIDE EXPIRED GAS DETERMINATION	15

STANDARD UNIT OF MEASURE REFERENCES
RESPIRATORY THERAPY & PULMONARY FUNCTION TESTING

CPT	Description	RVU [1]
99406	SMOKING AND TOBACCO USE CESSATION COUNSELING VISIT; INTERMEDIATE,GREATER THAN 3 MINUTES UP TO 10 MINUTES	10
99407	SMOKING AND TOBACCO USE CESSATION COUNSELING VISIT; INTENSIVE, GREATER THAN 10 MINUTES	20
99464	ATTENDANCE AT DELIVERY (WHEN REQUESTED BY THE DELIVERING PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL) AND INITIAL STABILIZATION OF NEWBORN	60
G0237	THERAPEUTIC PROCEDURES TO INCREASE STRENGTH OR ENDURANCE OF RESPIRATORY MUSCLES, FACE TO FACE, ONE ON ONE, EACH 15 MINUTES (INCLUDES MONITORING)	15
G0238	THERAPEUTIC PROCEDURES TO IMPROVE RESPIRATORY FUNCTION, OTHER THAN DESCRIBED BY G0237, ONE ON ONE, FACE TO FACE, PER 15 MINUTES (INCLUDES MONITORING)	15
G0239	THERAPEUTIC PROCEDURES TO IMPROVE RESPIRATORY FUNCTION OR INCREASE STRENGTH OR ENDURANCE OF RESPIRATORY MUSCLES, TWO OR MORE INDIVIDUALS (INCLUDES MONITORING)	15
G0424	PULMONARY REHABILITATION, INCLUDING EXERCISE (INCLUDES MONITORING), ONE HOUR, PER SESSION, UP TO TWO SESSIONS PER DAY	18

STANDARD UNIT OF MEASURE REFERENCES
LEUKOPHERESIS

Account Number	Cost Center Title
7760	Leukopheresis

Leukopheresis Relative Values as developed by the Johns Hopkins Hospital, reproduced below, shall be used to determine the units related to the output of the Leukopheresis cost center.

Procedure	Unit Value
Leukopheresis Run	
Granulocytes	15.6
Other Pheresis Runs	
Random Platelets	1.0
Matched Platelets	10.9
Therapeutic	5.0
Special	4.0

STANDARD UNIT OF MEASURE REFERENCES
LABOR AND DELIVERY

Account Number	Cost Center Title
7010	Labor and Delivery Service

Labor and Delivery Service

The Labor and Delivery Relative Value Units were developed by a task force which included clinical and financial representatives of Maryland hospitals and HSCRC staff. These relative value units will be used as the standard unit of measure related to the output of the Labor and Delivery Revenue Center.

All time reflects standard of 1 RVU=15 minutes of direct RN care. Charges made to Labor and Delivery RVUs must reflect entire procedure or event occurring in the Obstetrical suite without duplication, support or charges to other areas using RVUs, minutes, or hours per patient day at the same time. As an example a short stay D&C cannot be charged RVUs plus OR minutes; a sonogram cannot be charged RVUs to Labor and Delivery and to Radiology. Each institution should designate where a procedure is to be charged based on where that procedure is performed. For any Labor and Delivery OR suite procedure, RVUs or Minutes may be charged, but not both.

Primary Obstetrical Procedures:

These procedures include physical assessment, ~~and~~ pregnancy history, and vital signs. Delivery procedures are excluded. RVUs are assigned on the basis of RN time only in relation to these procedures. Charges for these Obstetrical charges (See section to follow entitled: L & D Observation/Triage services.)

1RVU=15 minutes of direct RN care

Procedure	RVUs
Amniocentesis – Diagnostic	3
Biophysical Profile with NST	5
Biophysical Profile w/o NST	4
Cervical Cerclage	10
Dilation & Curettage (D&C)	9
Dilation and Evacuation (D&E)	9
Doppler Flow Evaluation	1
External Cephalic Versions	10
*Minor OR procedure, emergent or non-emergent, w/o delivery	8
*Major OR procedure, emergent or non-emergent, w/o delivery	38
Non Stress Test, Fetal	5
Oxytocin Stress Test	5
Periumbilical Blood Sampling (PUBS)	18(+4w/multiples)
Periumbilical Blood Sampling (PUBS) double set up w/OR	2
Ultrasound, OB (performed and read by Obstetrics personnel only)	By Report

STANDARD UNIT OF MEASURE REFERENCES
LABOR AND DELIVERY

* The classification of minor and major procedures is related to the complexity of the case and the nursing work load required for patient care. The lists below are examples of procedures in each category, but the classification is not limited to these examples.

Minor:	Major:
Cerclage insertion or removal	Bladder repair
Incision and Drainage (I&D)	Bowel repair
Needle membrane	Hernia repair
Tubal ligation	Hysterectomy
Wound care	Oopherectomy

* "Minor" surgery is any invasive operative procedure in which only skin or mucous membranes and connective tissue is resected, e.g., vascular cutdown for catheter placement, implanting pumps in subcutaneous tissue. Also included are procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar in combination with a "minor" surgical procedure, e.g., the placement of electrodes into the CNS through reflected skin and a burr hole in the cranium, so long as the dura is not resected.

* "Major" surgery is any invasive operative procedure in which extensive resection is performed, e.g., a body cavity is entered, organs are removed, or normal anatomy is significantly altered. In general, if a mesenchymal barrier is opened (pleurum, peritoneum, meninges) or an extensive orthopedic procedure is involved, the surgery is considered "major". For surgical procedures that do not clearly fall in the above categories, the chance for significant inadvertent infection of the surgical site is to be a primary consideration.

The definition of Emergent and Non-emergent is based on timing also known as the “decision to incision time”. An emergent procedure is performed within 30 minutes of the physician’s decision. A non-emergent procedure is performed after that 30 minute window has passed.

STANDARD UNIT OF MEASURE REFERENCES
LABOR AND DELIVERY

DELIVERY Procedures:

The following procedures are primarily inpatient services, however if any are performed on an outpatient basis hospitals should apply the most appropriate CPT codes.

Procedures: (SELECT ONLY ONE):	RVUs
Fetal Demise/Genetic Termination 2nd or 3rd Trimester	30
Fetal Demise/Genetic Termination 2nd or 3rd Trimester w/Epidural	36
Delivery outside the hospital, prior to arrival	12
Vaginal Delivery (No anesthesia, uncomplicated)	24
Vaginal Delivery w/Vacuum/Forceps Assistance	26
Vaginal Delivery w/Epidural Anesthesia	30
Vaginal Delivery w/Epidural w/Forceps/Vacuum Assistance	32
Vaginal Delivery after prior C-section (VBAC)	32
Cesarean Section, non-emergent	18
Cesarean Section, non-emergent w/minor surgery	20
Cesarean Section, non-emergent w/major surgery	31
Cesarean Section, Emergency	37
Cesarean Section, emergent w/minor surgery	39
Cesarean Section, emergent w/major surgery	61

OBSTETRICAL ADD ON TO DELIVERY Procedures:

These are procedures that are performed in addition to the core procedures listed above:

Procedure	RVUs
Amnioinfusion	6
Double Set-Up/Failed Forceps/Vacuum	2
Intrauterine Pressure Catheter Monitoring (IUPC)	2
Induction/Augmentation w/delivery	4
Multiple Birth: Twins	6
Multiple Birth: Triplets	9
Multiple Birth: Quads	12
Neonatal Resuscitation (APGAR < 6 @ 1 minute; PH < 7.2)	4

STANDARD UNIT OF MEASURE REFERENCES
LABOR AND DELIVERY

POSTPARTUM OBSTETRICAL SURGICAL Procedures:

The following procedures are listed to capture RVUs for postpartum obstetrical surgeries that occur after an episode of delivery, vaginal or cesarean section. Please refer to page 2 for the definition and examples of minor and major procedures.

Procedures (**SELECT ONLY ONE)**:

Surgery, Additional minor, non-emergent	8
Surgery, Additional major, non-emergent	19
Surgery, Additional minor, emergent	16
Surgery, Additional major, emergent	38

MISCELLANEOUS PROCEDURES

	RVUs
Circumcision (even if performed in Nursery)	3
Oocyte Retrieval	10
Gamete Intrafallopian Tube Transfer (GIFT)/Tubal Embryo Transfer	16

ASSESSMENT/TRIAGE and OBSERVATION Services:

Hospitals should determine the most appropriate level of Assessment/Triage, the use of Observation, and Maternal Intensive Care; then apply the most appropriate observation and/or evaluation and management code depending on the physician order.

	RVUs
Services:	
Assessment/Triage Services	1

Assessment/Triage services may include, but are not limited to performing a health and physical assessment, pregnancy history and vital signs.

	RVUs
Outpatient Maternal Observation	1 per hour (15 min direct RN time per hour)

Observation is a valid clinical service. The primary purpose of observation services in L&D is to determine whether the patient should be admitted as an inpatient. The service includes the use of a hospital bed and periodic monitoring, by the facility's nursing or other staff, deemed reasonable and necessary to evaluate the patient's condition to determine whether she should be admitted.

Outpatient Maternal Observation minutes should be rounded up to the nearest full hour. This should be interpreted to mean that 30 minutes = 0 RVUs, 31 minutes = 1 RVU, 75 minutes = 1 RVU, etc…

Some common examples of providing observation and triage services included but not limited to are:

1) Labor evaluation
2) Cervical ripening
3) Fetal monitoring
4) Motor Vehicle Accident
5) IV hydration

STANDARD UNIT OF MEASURE REFERENCES
LABOR AND DELIVERY

L & D MATERNAL INTENSIVE CARE (MIC) RVUs:

Outpatient Maternal Intensive Care	2 RVUs per hour (30 min direct RN time per hour)

This category is reserved for patients prior to delivery requiring on-going intensive nursing care. This category may be charged only during the period of intensive interventions. ~~(~~Note: Patients who have been admitted and require on-going intensive nursing care should be reported with the applicable inpatient care room and board rate and not Maternal Intensive Care.~~)~~ Examples of disease processes with designated pharmaceutical and or nursing interventions are listed below but the examples are not all inclusive.

Diagnoses:
Cardiac Disease
Bleeding Disorders
Disseminated Intravascular Coagulation (DIC)
Diabetes Mellitus
Hypertensive Disorder of Pregnancy (HDP)
Preterm labor
Multisystem Disorders
Asthma

Examples of pharmaceuticals and nursing care necessary for MIC include but are not limited to the following:

Pharmaceutical:
Magnesium Sulfate
Ritodrine
Terbutaline (repeated SQ doses)
Aminophylline
Insulin IV drip
Apresoline
Heparin Sulfate
Phenytoin Sodium (Dilantin)
Pitocin
Nifedipine
Labatalol
AZT drip
IVIG Drip

Nursing Care:
Blood Transfusions (> 2 units)
Nebulizer Therapy
Invasive Hemodynamic Monitoring
Conscious Sedation procedures
- a) PUBS
- b) Fetal surgery
- c) Fetal exchange transfusion

Ventilation Therapy
Labor/Delivery care on another unit

STANDARD UNIT OF MEASURE REFERENCES
INTERVENTIONAL RADIOLOGY/CARDIOVASCULAR

Account Number 7310

INTERVENTIONAL RADIOLOGY/CARDIOVASCULAR

Definition of IRC

The Interventional Cardiovascular Services (IVC) rate center is re-named Interventional Radiology/Cardiovascular to better reflect both interventional radiologic and interventional cardiovascular services. The Interventional Radiology/Cardiovascular Department provides special diagnostic, therapeutic, and interventional procedures that include the use of imaging techniques to guide catheters and other devices through blood vessels and other pathways of the body. When these procedures are performed in the operating room and charged with operating room minutes, hospitals may not charge IRC minutes in addition to operating room minutes. All Medical/Surgical supplies utilized in these cases will be billed for separately through the MedSurg Supplies (MSS) rate center.

Assigning RVUs

RVUs are assigned based either on the actual clock minutes it takes to perform the procedure—similar to the assignment of Operating Room minutes or the average minutes it takes to perform the procedure based on an annual time study. Procedures with a separately billable imaging component are assigned a single RVU for the imaging component. It is assumed that the costs associated with the imaging component are already included in the IRC rate center and therefore should not generate additional revenue. A single RVU is reported for the imaging component so that, when appropriate, an imaging CPT code can be included in the coding of the case. In practice, this means hospitals may want to assign in their charge description master a value of one, representing one RVU, to each imaging component associated with an interventional procedure.

Start and Stop Times

The definition of start and stop time for procedures performed in IRC mirrors the definition used in the operating room.
Starting time is:

- The beginning of the procedure if general anesthesia is not administered, or
- The beginning of general anesthesia or conscious sedation administered in the procedure room

Ending time is:

- Removal of the needle or catheter, if general anesthesia is not administered, or
- The end of general anesthesia.

Six hours of recovery time is included in the minute value. The time the anesthesiologist spends with the patient in the recovery room is not counted. Sheath removal and hemostasis is considered part of recovery and is not to be counted.

The cost of sedation and pain reducing drugs used to make a procedure more easily tolerated are not included in the IRC rate center. The time it takes to administer the drugs is accounted for in counting the procedure minutes. Revenue and expenses associated with the drug itself are billed and reported through the Pharmacy rate center.

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Account Number 6720

OVERVIEW: REPORTING STRUCTURE FOR CLINIC SERVICES

DEFINITION OF CLINIC SERVICES

Clinic Services include diagnostic, preventive, therapeutic, rehabilitative, and educational services provided to non-emergent outpatients in a regulated setting. On rare occasions, clinic services will be provided to inpatients (Examples and discussion are included later in this document.)

Surgical procedures, diagnostic tests and other services that are better described in a separate cost center, such as Delivery, EEG, EKG, Interventional Cardiology, Laboratory, Lithotripsy, Occupational Therapy, Operating Room, Physical Therapy, Radiation Therapy, Radiology, Speech Therapy, are to be reported in those specific rate centers.

Clinic services may include either one or both of the following two components: an evaluation and management (E/M) visit, and non-surgical procedures. To report an E/M visit and a procedure on the same day, the E/M service must be separately identifiable. The Medicare definition of separately identifiable is included in the Evaluation and Management section.

RVU ASSIGNMENT OF CLINIC VISITS

The relative value units (RVUs) for the evaluation and management portion of a clinic visit are based on a 5-point visit level scale, while the RVUs for non-surgical procedures are specified by procedure. The development of the RVU values for each component will be explained in more detail in subsequent paragraphs. Clinic procedures considered surgery are to be reported via operating room minutes. The definition of surgical procedures will be explained in more detail later in this section.

RVUs were assigned based on clinical care time (CCT), as described in the E/M section, with a rule of 5 minutes of CCT per 1 RVU. This same logic should be applied to any services that are “by report”.

PART 1: EVALUATION AND MANAGEMENT (E/M) COMPONENT

CLINICAL CARE TIME

The evaluation and management portion of the clinic visit is based on a 5-point visit level scale. The amount of clinical care time provided to the patient during the E/M portion of the visit determines the visit level. Clinical care time is the combined total amount of time that each non-physician clinician spends treating the patient. The time does not necessarily have to be face-to-face with the patient, but the patient must be present in the department. The time spent by physicians, and other –physician providers, who bill professionally for their services is not included. It is possible for

multiple clinic personnel to be providing CCT to the same patient simultaneously. Therefore, in a given time interval, the hospital may record and report CCT greater than the actual clock time that as elapsed.

Both direct and indirect patient care may be included in CCT. Direct patient care will always be included in CCT. Indirect patient care may be included when the skills of a clinician are required to provide the care. Direct patient care includes tasks or procedures that involve face-to-face contact with the patient. These tasks may include: specimen retrieval, administration of medications, family support, patient teaching, and transportation of patients requiring a nurse or other clinical personnel whose cost is assigned to the Clinic. Indirect patient care includes tasks or procedures that do not involve face-to-face contact with the patient, but are related to their care. These tasks may include: arranging for admission, calling for lab results, calling a report to another unit, documentation of patient care, and reviewing prior medical records.

EXAMPLES OF SERVICES INCLUDED IN E/M COMPONENT

The following are examples of services performed by nursing and other clinical staff that may be included in CCT provided during the E/M portion of a clinic visit. The list is not all-inclusive and is only meant as a guide.

- Patient evaluation and assessment
- Patient education and skills assessment
- Patient counseling
- Patient monitoring that does not require equipment or a physician order (different from observation)
- Skin and wound assessment
- Wound cleansing and dressing changes
- Application of topical medications
- Transporting a patient, when it requires the skill of a clinician
- Coordination of care and discharge planning that requires the skill of a clinician

EXAMPLES OF SERVICES EXCLUDED FROM E/M COMPONENT

Services that do not require the skills of a clinician should be excluded from CCT. Examples of excluded activities are listed below. The list is not all-inclusive and is only meant as a guide.

- Patient waiting time
- All time spent on the phone with a payer
- Time spent securing payment authorization
- Chart set-up, room preparation
- Appointment setting
- Calling in prescriptions and entering orders and/or charges

PROFESSIONAL SERVICES ONLY VISIT

In instances where a patient sees only an *outside provider*, the hospital may only report a Level one E/M visit regardless of the amount of time a patient spends with the outside provider. An outside provider is a physician or other provider who bills professionally and is not included on the hospital's wage and salary reporting schedule. A level one E/M visit may also be reported when a patient is seen by clinic personnel and CCT totals 1-10 minutes, as per the E/M visit level guidelines below.

INTERNAL GUIDELINES

The RVUs for each visit level remain the same across every clinic. However, each clinic within a hospital is expected to develop and maintain a set of internal guidelines to standardize the amount of CCT required to perform common E/M services in the particular clinic. Hospitals are expected to conduct in-service programs to assure that new and existing clinic staff understand the guidelines and apply them fairly and consistently. The over-riding consideration is that there must be a "reasonable" relationship between the intensity of resource use and the assigned visit level.

The clinic's internal guidelines should include a typical time range for all of the commonly performed services in that clinic. The time range allows for the circumstances of the visit and judgment of the clinician, while maintaining a degree of uniformity among clinicians. The guidelines are not expected to dictate a definitive time value for every service that could be performed in a clinic. Instead their purpose is to provide an average time frame for commonly performed procedures. The format and content are at the facility's discretion. For example, taking vital signs: 5 minutes.

VISIT LEVELS

The minutes and RVUs for each of the five levels of an E/M visit are:

	New/Established	Minutes	RVUs
Level 1	99201/99211	0–10	2
Level 2	99202/99212	11–25	4
Level 3	99203/99213	26–45	7
Level 4	99204/99214	46–90	15
Level 5	99205/99215	>90	18

Facility E/M visits are reportable only with the above codes.

NEW VS. ESTABLISHED

The 2000 Federal Register defines a new vs. an established patient by whether or not the patient has an established medical record. Patients with a previously established medical record are considered established whether or not it is their first visit to a specific clinic.

SEPARATELY IDENTIFIABLE

To ensure uniform reporting by all Maryland hospitals, it is important to recognize when an E/M visit should be reported separately from a procedure or other E/M services. This manual is not meant to provide guidance on how to bill services or to interpret Medicare rules. Medicare discusses the term "separately identifiable" in Program Memorandum Transmittals AA-00-40 and A-01-80. Providers who want additional guidance or examples may check with their Medicare Administrative Contractor or other payor representative.

PART II: SERVICES AND NON-SURGICAL PROCEDURES

Each section includes tables with CPT codes, descriptions, and RVU values. It is prefaced with any information, coding guidelines, etc. that were used in setting the RVUs for each area. This manual is not meant to give direction or interpretation to Medicare billing or coding rules. Moreover, it is the goal of every work group that recommends revisions to RVUs that the revised system be as impervious as possible to future changes in billing rules and correct coding guidelines.

BACKGROUND INFORMATION ON DRUG ADMINISTRATION SERVICES

This manual is not meant to give direction or interpretation to Medicare billing or coding rules. However, substantial information on the current coding guidelines for injections, transfusions, and infusions is being included here because of the frequent changes and clarifications to coding guidelines for these services. The information is included to document the rules in place at the time the RVUs were developed and to provide rationale for the relative values. The Clinic RVU work group assigned RVUs to transfusions, infusions, and related drug administrations with the following information in mind.

VASCULAR ACCESS DEVICES

There are several codes related to vascular access devices, however, only 36593, "declotting-thrombolytic agent of vascular access device or catheter", is routinely and frequently performed in clinics. It was assigned an RVU value of 9. The insertion of non-tunneled central venous catheters (36555 and 36556) are performed and reported more frequently in interventional cardiology than in clinics, although a few hospitals routinely perform those procedures in clinics. After considering the options, the group decided that RVUs for the insertion of non-tunneled central venous catheters

(36555 and 36556) in the clinic would be reported via operating room minutes. (See the Surgical Procedures section of this appendix for further information.) The remaining CPT codes related to vascular access devices (36557-36620) are routinely performed in the IVC or operating room suite, and therefore, should not be assigned clinic RVUs. Any of these procedures that are performed in the clinic will be reported through the operating room cost center.

INJECTIONS

Are injections billed per injection, or per drug?

After substantial discussion, the work group agreed that injectable drugs are charged per injection when splitting a dosage is ordered and documented. The following examples were cited for further clarification.

- *If two drugs are mixed into one syringe/injection based* on nursing guidelines or standards of practice (such as Phenagran and Demerol), one unit/injection should be billed.

- *If two drugs cannot be administered together and require separate injections, two units of service may be billed, but the documentation should denote that these were separately administered based on the time injected. (Note: hospitals should avoid split drugs just for the sake of billing twice.)*

- *If an order is written as "10 mg morphine" and staff titrates it as 2 mg x 5 separate injections before the pain is relieved-the facility still can bill only one unit.*

- *If an order is written as "10 mg of morphine" and staff titrates 2 mg x 5 injections with no relief, and then the doctor orders an "additional 6 mg of morphine" and staff titrates 2 more injections of 2 mg prior to pain relief (14 mg total now administered)-two units/injections may be billed (7 actual injections performed).*

- *If an order is written as "10 mg of morphine" and staff titrates 2 mg x 5 injections with no relief, and then the doctor orders "5 mg of Torodol" and staff injects all 5 mg with pain relief-2 injections may be billed (one for each drug).*

If an order is written for an IM injection of Gentamycin, 160 mg. And a nurse administers it in a split 80 mg. IM dose, it should be billed as one unit of 90772 (IM injection). If it was ordered to be titrated in two 80 mg. doses, it could be billed as two units of 9077288. Hospitals may have specific physician-approved hospital policies that specify circumstances under which a dose is titrated. For example, "if a patient weights less than X, titrate IM injections over X mg. into multiple injections of not more than X mg." In this case, charge and bill for each IM injection.

TRANSFUSIONS

Transfusion of blood or blood components (36430) will be internally stratified by the number of hours. Stratifying by the number of units transfused was rejected because the resources consumed in the transfusion of units vary by patient diagnosis and type of product. The first hour of transfusion is weighted heavier than subsequent hours to include the staff's time preparing and assessing the patient prior to and at the conclusion of the transfusion. The timing of the transfusion begins and ends with the start and stop of the transfusion, and/or resolution of any reaction to the blood product. Any fraction of the first hour can be reported as a full hour, subsequent hours are subject to simple rounding rules i.e., must be 30 minutes or more.

INFUSIONS

Infusion coding is currently divided into chemotherapy and non-chemotherapy, and first hour and each additional hour. The first hour of infusion is weighted heavier than subsequent hours to include the staff's time preparing, educating and assessing the patient prior to and at the conclusion of the infusion. The timing of the infusion begins and ends with the start and stop of the infusion. The treatment of a reaction to a chemotherapy infusion should not be included in the timing of the infusion. A hospital that believes time resolving a reaction should be accounted for may consider whether those services are separately identifiable and warrant an E/M code. Education including discussion of the management of side effects is included in the value of chemotherapy infusions.

For further clarification, providers are encouraged to consult with their Medicare Administrative Contractor or other payor representative.

DRUG ADMINISTRATION SERVICES

IMMUNIZATIONS

36430	Transfusion, blood or blood components, first hour (0-90 min)	12
36430	Transfusion, blood or blood components, two hours (91-150 min)	18
36430	Transfusion, blood or blood components, three hours (151-210 min)	24
36430	Transfusion, blood or blood components, four hours (211-270 min)	30
36430	Transfusion, blood or blood components, five hours (271-330 min)	36
36430	Transfusion, blood or blood components, six hours (331-390 min)	42
36430	Transfusion, blood or blood components, seven hours (391-450 min)	48
36430	Transfusion, blood or blood components, eight hours (451-510 min)	54
36591	Collection of blood specimen from a completely implantable venous Access device	6
36593	Declotting by thrombolytic agent of implanted VAD or cath	9

IMMUNIZATIONS

90465	Immuniz. <8 y/o, percut, intraderm, IM, subq, first	2
+90466	Immuniz. <8 y/o, ea. additional, per day	1
90467	Immuniz. <8 y/o, intranasal or oral, first	2
+90468	Immuniz. <8 y/o, intranasal or oral, ea. additional	1
90471	Immuniz. percut, intraderm, IM, subq, first	2
+90472	Immuniz. ea. Additional, per day	1
90473	Immuniz. intranasal or oral, first	2
+90474	Immuniz. intranasal or oral, ea. additional	1

NON-CHEMOTHERAPY INJECTIONS AND INFUSIONS

90760	IV infusion, hydration; initial, 31 minutes to 1 hour	12
+90761	IV infusion, hydration; ea add'l hr	6
90765	IV infusion, for therapy, prophylaxis, or diagnosis, initial, up to 1 hr	12
+90766	IV infusion, ea add'l hr	6
+90767	IV infusion, add'l sequential infusion up to one hour	6
+90768	IV infusion, concurrent infusion	1
90769	SubQ infusion for therapy or prophylaxis, initial, up to 1 hr, including pump set-up and establishment of subQ infusion site(s)	By Report
+90770	SubQ infusion for therapy or prophylaxis, ea add'l hr	By Report
+90771	SubQ infusion for therapy or prophylaxis, add'l pump set-up and establishment of new subQ infusion site(s)	By Report
90772	Therapeutic, prophylactic, or diagnostic injection, subQ, or IM	3
90773	Therapeutic, prophylactic, or diagnostic injection, intraarterial	By Report
90774	Therapeutic, prophylactic, or diagnostic injection, IV push, single or initial substance/drug	6
+90775	Therapeutic, prophylactic, or diagnostic injection, IV push, ea add'l IV push of a new substance/drug	3
+90776	Therapeutic, prophylactic, or diagnostic injection, ea add'l sequential IV push of the same substance/drug provided in a facility single or initial substance/drug	By Report
90779	Unlisted ther, prophyl, or dx IV or IA injection or infusion	By Report

CHEMOTHERAPY INFUSIONS

RVUs are "By Report" for several services that are performed infrequently within the state.

96401	Chemotherapy admin, subQ or IM, non-hormonal anti-neoplastic	6
96402	Chemotherapy admin, subQ or IM, hormonal anti-neoplastic	6
96405	Chemotherapy admin, intralesional, 1-7 lesions	By Report
96406	Chemotherapy admin, Intralesional, 8+ lesions	By Report
96409	Chemotherapy admin, IV push, single or initial substance/drug	6
+96411	Chemotherapy admin, IV push, ea add'l substance/drug	3
96413	Chemotherapy admin, IV infusion, up to one hour, single or initial	18
+96415	Chemotherapy, IV infusion, ea add'l hour	9
96416	Chemotherapy, IV infusion initiation of prolonged infusion, >8hrs, with port or implantable pump	By Report
+96417	Chemotherarpy, IV Infusion, ea add'l sequential infusion, up to 1 hr	9
96420	Chemotherapy, intra-arterial, push	By Report
96422	Chemotherapy, intra-arterial, infusion, up to 1 hr	By Report
+96423	Chemotherapy, intra-arterial infusion, ea add'l hr	By Report
96425	Chemotherapy, intra-arterial infusion, initiation of prolonged infusion,>8 hrs, with port or implantable pump	By Report
96440	Chemother into pleural cavity, w/ thoracentesis	By Report
96445	Chemo into peritoneal cavity, w peritoneocent.	By Report
96450	Chemo into CNS, intrathecal, w/ spinal puncture	By Report
96521	Refill and maintenance of portable pump	By Report
96522	Refill and maintenance of implantable pump	By Report
96523	Irrigation of implanted venous access device for drug delivery	3
96542	Chemo inject, subarach or intraventric, subq reserv.	By Report
96549	Unlisted chemotherapy procedure	By Report

PSYCHIATRY (EXCLUDES PARTIAL HOSPITALIZATION- PHP)

In instances where a patient only sees an outside provider who bills professionally, the hospital may only report two RVUs regardless of the amount of time a patient spends with the outside provider. Two RVUs corresponds to a level one E/M visit that is used to report the facility component of an E/M visit when a clinic patient is seen only by an outside provider. (*See Professional Services Only Visit under Part II: E/M Component.)* The following RVUs are to be assigned only when the service is performed by a non-physician provider who does not bill professionally for the service.

90791	Psychiatric diagnostic evaluation (no medical services)	12
90792	Psychiatric diagnostic evaluation (with medical services)	18
90785	Interactive complexity (add-on code)	By Report

Psychotherapy

90832	Psychotherapy, 30 minutes	6
90833	Psychotherapy, 30 minutes (add-on code to E&M code)	6
90834	Psychotherapy, 45 minutes	9
90836	Psychotherapy, 45 minutes (add-on code, to E&M code)	9
90837	Psychotherapy, 60 minutes	12
90838	Psychotherapy, 60 minutes (add-on code to E&M code)	12
90839	Psychotherapy for crisis, first 60 minutes	12
90840	Psychotherapy for crisis, each additional 30 minutes (add on code)	6
90853	Group Psychotherapy (other than that of multi-family)	3
90845	Psychoanalysis	By Report
90846	Family psychotherapy w/o patient	10
90847	Family psychotherapy w/ patient	10
90849	Multiple family group psychotherapy	By Report
90853	Group psychotherapy	3

Other

90865	Narcosynthesis for psychiatric diagnostic and therapeutic purposes	By Report
90870	Electroconvulsive therapy (ECT), single seizure. Performed and reported in OR	
90875	Individual psychophysiolog ther-biofdbk w/ psychotherapy, 20-30 min	6
90876	Individual psychophysiolog ther-biofdbk w/ psychotherapy, 45-50 min	10
90880	Hypnotherapy	By Report
90882	Environmental intervention for med management	By Report
90885	Psychiatric eval of records, reports & tests for diagnosis	By Report
90887	Interpret of psych or med exams & data to family	By Report
90889	Prep of report of pt status, hx, tx, or progress	By Report
90899	Unlisted psychiatric service or procedure	By Report

BIOFEEDBACK TRAINING

RVUs were left as “by report” as these services are not routinely performed in the Clinic setting.

These services are also reportable via the rehabilitation rate centers.

90901	Biofeedback training, any modality	By Report
90911	Biofeedback training, perineal muscles	By Report

OPHTHALMOLOGY

COMPREHENSIVE VS. INTERMEDIATE

In deciding whether to code an ophthalmologic exam as comprehensive vs. intermediate, the direction in the most recent CPT manual should be consulted. RVUs were set with the following distinction in mind: a comprehensive visit includes treatment, whereas, an intermediate visit does not.

92002	Ophthalmol svcs, medical exam, intermed, new pt.	4
92004	Ophthalmol svcs, medical exam, comprehensive, new pt.	6
92012	Ophthalmol svcs, medical exam, intermed, estab pt.	3
92014	Ophth svcs, medical exam, comprehensive, estab pt.	4
92015	Determination of refractive state	2
92018	Ophthal exam under gen anesth, complete	By Report
92019	Ophthal exam under gen anesth, limited	By Report
92020	Gonioscopy	By Report
92060	Sensorimotor exam, interp and report	9
92065	Orthoptic &/or pleoptic training w/ med. Direction	6
92070	Fitting of contact lens, include. Lens supply	By Report
92081	Visual field exam, w/ interp & report, limited	2
92082	Visual field exam, w/ interp & report, intermed.	4
92083	Visual field exam, w/ interp & report, extended	6
92100	Serial tonometry, w/ interp & report	By Report
92120	Tonography w/ interp & report	By Report
92130	Tonography w/ water provocation	By Report
92135	Scanning computerized ophthalmic diagnostic imaging, posterior seg, w/ interp & report, unilateral	4
92136	Ophthalmic biometry, partial coherence interferometry	By Report
92140	Provocative tests for glaucoma, w/ interp & report	By Report
92225	Ophthalmoscophy, extended, interp & report, initial	By Report
92226	Ophthalmoscophy, extended, interp & report, subsequent	By Report
92230	Fluorescein angioscopy, w/ interp & report	By Report
92235	Fluorescein angiography, w/ interp & report	4
92240	Indocyanine-green angiography, w/ interp & report	2
92250	Fundus photography w/ interp & report	2
92260	Ophthalmodynamometry	By Report

92265	Needle oculoelectromyography, w/interp & repor	By Report
92270	Electro-oculomyography, w/interp & report	By Report
92275	Electro-retinography, 2/interp & report	By Report
92283	Color vision exam, extended	By Report
92284	Dark adaptation exam w/interp & report	By Report
92285	External ocular photography, w/interp & report 3	
92286	Special anterior segment photography, w/interp & report	By Report
92287	Ant. Segment photo, w/fluorescein angiography	By Report
92499	Unlisted Ophthalmological service or procedure	By Report

CARDIAC REHABILITATION

RVUs for caridac rehab were based on the principle of one RVU per five minutes of clinical care time, with the assumptions that services are usually provided in a group setting with a staff to patient ratio of 1:3, and sessions last 60-75 minutes.

93797	Physician services for cardiac rehab, without monitoring	0
93798	Physician services for cardiac rehab, continuous monitoring	5

ALLERGY TESTING/IMMUNOTHERAPY

RVUs were left as “by report” as these services are not routinely performed in the hospital setting.

95004	Percutaneous tests w/ allergenic extracts, immed type reaction, incl test interp & report by physician, specify # of tests	By Report
95010	Percutaneous tests, w/ drugs, biological, venom, immed. rxn	By Report
95015	Intracutaneous tests, w/ drugs, biologicals, venom, immed. rxn	By Report
95024	Intracutaneous/intradermal tests, w/ allergenic extracts, immed. Rxn, incl test interp & report by physician, specify # of tests	By Report
95027	Intracutaneous/intradermal tests, w/ allergenic extracts, airborne, immed. Rxn, incl test interp & report by physician, specify # of tests	By Report
95028	Intracutaneous tests, allergenic extracts, delayed rxn, + reading	By Report
95044	Patch or application tests	By Report
95052	Photo patch tests	By Report
95056	Photo tests	By Report
95060	Ophthalmic mucous membrane tests	By Report
95065	Direct nasal mucous membrane tests	By Report
95070	Inhalation bronchial challenge, w/ histamine or methacholine	By Report
95071	Inhalation bronchial challenge, w/ antigens or gases	By Report
95075	Ingestion challenge, sequential and incremental	By Report
95180	Rapid desensitization procedure, ea hour	By Report
95199	Unlisted allergy/clinical immunologic service or procedure	By Report

ENDOCRINOLOGY

RVUs were left as "by report" as these services are not routinely performed in the hospital setting.

95250	Glucose monitoring, up to 72 hours by continuous recording	By Report

PSYCHOLOGICAL TESTING

Some of the following CPTs may also be reported via the speech language pathology (STH) rate center using the RVUs defined in that rate center.

96101	Psyc Testing per hour of MD or Ph.D time, both face-to-face time to administer tests & interp & report prep time	12
96102	Psyc Testing w/ qualified health care professional interp & report, admin by tech, per hr of tech time, face-to-face	By Report
96103	Psyc Testing admin by computer, w/ qualified health care professional interp & report	By Report
96105	Assessment of aphasia12	
96110	Developmental testing	By Report
96111	Developmental testing, extended	By Report
96116	Neurobehavioral status exam	12
96118	Neropsych testing, per hr of MD or Ph.D, both face-to face time to administer tests & interp & report prep time	By Report
96119	Neuropsychological testing battery, admin. by technician, per hour	By Report
96120	Neuropsychological testing battery, admin. by computer, per hour	By Report
96125	Standardized cognitive performance testing, per hr, both Face-to-face time admin tests & interp & report prep time	By Report

PHOTODYNAMIC THERAPY/DERMATOLOGY

RVUs were left as "by report" as these services are not routinely performed in the hospital setting.

96567	Photodynamic therapy, external application of light	By Report
+96570	Photodynamic therapy, endoscopic application of light, 30 min	By Report
+96571	Photodynamic therapy, endoscopic, ea additional 15 min	By Report
96900	Actinotherapy	By Report
96902	Microscopic exam of hair–telogen and anagen counts	By Report
96910	Photochemotherapy, tar & UVB or petrolatum & UVB	By Report
96912	Photochemotherapy, psoralens & UVB	By Report
96913	Goeckerman &/or PUVA, severe, 4-8 hrs, direct superv.	By Report

96920	Laser treatment, <250 cm²	By Report
96921	Laser treatment, 250-500 cm²	By Report
96922	Laser treatment, > 500 cm²	By Report
96999	Unlisted special dermatological service or procedure	By Report

MEDICAL NUTRITION THERAPY

These services are currently not a facility benefit for Medicare purposes, but are routinely performed in the hospital clinic setting.

97802	Medical nutrition therapy, Individual, initial, ea 15 min	3
97803	Medical nutrition, Individual, re-assess, ea 15 min	3
97804	Medical nutrition, group, re-assess, ea 30 min	4
G0270	Medical nutrition therapy, Individual, ea 15 min	3
G0271	Medical nutrition therapy, group, ea 30 min	4

ACUPUNCTURE AND CHIROPRACTIC

RVUs were left as "by report" as these services are not routinely performed in the hospital setting.

97810	Acupuncture, 1 or more needles, 15 min	By Report
+97811	Acupuncture, 1 or more needles, addl 15 min	By Report
97813	Acupunct, 1 or more needle, w/elect. Stim, 15 min	By Report
+97814	Acupunct, 1 or more needle, w/ elect. Stim, addl 15 min	By Report
98925	Osteopathic manipulative trmt (OMT); 1-2 regions	By Report
98926	Osteopathic manipulative trmt (OMT); 3-4 regions	By Report
98927	Osteopathic manipulative trmt (OMT); 5-6 regions	By Report
98928	Osteopathic manipulative trmt (OMT); 7-8 regions	By Report
98929	Osteopathic manipulative trmt (OMT); 9-10 regions	By Report
98940	Chiropractic manipulation, spinal 1-2 regions	By Report
98941	Chiropractic manipulation, spinal 3-4 regions	By Report
98942	Chiropractic manipulation, spinal 5 regions	By Report
98943	Chiropractic manip, extraspinal 1 or more regions	By Report

DIABETES SELF MANAGEMENT TRAINING

G0108	Diabetes self management, Individual, 30 min.	6
G0109	Diabetes self management, group, 30 min.	3

SMOKING CESSATION

99406	Smoking/tobacco-use cessation counseling; intermediate, >3-10 min	2
99407	Smoking/tobacco-use cessation counseling; intensive, >10 min	9

ALCOHOL AND/OR SUBSTANCE (OTHER THAN TOBACCO) ABUSE

99408Alcohol and/or substance abuse structured screening and brief intervention services; 15-30 min	By Report
99409Alcohol and/or substance abuse structured screening and brief intervention services; >30 min	By Report

GASTROENTEROLOGY

All GI services (codes 91000-91299) will be reported through the operating room center. (See the Surgical Procedure section for more information.)

WOUND CARE

No new assignments were made for services performed in a wound care clinic. The following codes are not reportable in Clinic because they are already assigned in the Physical Therapy cost center: 97597, 97598, 97602, 97605, 97606, 0183T. The decision to use 1104X codes to describe excisional debridement should be made based on guidance from your Medicare Administrative Contractor or other payor representative.

PART III: SURGICAL PROCEDURES

Any surgical procedures performed in a clinic should be reported via the operating room cost center, and associated surgical costs allocated to the operating room rate center (excluding the exceptions listed in more detail below). Surgical procedures are defined as all procedures corresponding to CPT codes from 10000 to 69999 (surgery) and 91000 to 91299 (gastroenterology).

A few rate centers include a limited number of surgical procedures with CPT codes between 10000 and 69999 that have already been assigned RVUs relative to other procedures in that cost center. For the most part, the RVU values and reporting of these procedures will remain unchanged. The procedures and how they should be reported are:

- *Clinic*-Specimen Collection via VAD (CPT 36591), Declotting (CPT 36593), and Blood Transfusions (CPT 36430) have been assigned Clinic RVUs, and should be reported as clinic revenue.

  Delivery-Non-Stress Tests, amniocentesis, external versions, cervical cerclages, dilation and curettage/evacuation and curettage, hysterectomies, deliveries, etc. Continue to report via DEL by assigned RVUs.

Interventional Cardiology-certain IVC procedures have surgical CPT codes are defined in the IVC rate center with RVUs. Hospitals should continue to report using those IVC RVUs

- until instructed otherwise.

- *Laboratory*-Venipunctures/Capillary punctures. These procedures are considered to be part of the E/M component of a clinic visit. If a hospital chooses to code and report them separately in the clinic, the RVU is zero. If a phlebotomist comes to the clinic to do the procedure, the revenue and expenses are allocated to LAB.

- *Lithotripsy*-Procedures will continue to be reported in the LIT cost center as the number of procedures.

- *Occupational and Physical therapy*-Splinting, Strapping and Unna Boot application (CPT codes 29105-29590) continue to report with assigned PT/OT RVUs

- *Radiation Therapy*-Stereotactic Radiosurgery (61793). Continue to report with assigned RAT RVUs.

- *Speech Therapy*-Laryngoscopy (31579). Continue to report via STH by assigned RVUs.

- *Therapeutic apheresis*-Continue to report through LAB; RVUs are by report.

Non-physicians may perform procedures that will be reported as operating room revenue. The HSCRC acknowledged that it is appropriate for non-physicians to generate operating room minute charges as long as the clinician is providing services within the scope of his or her practice standards.

DOCUMENTING START AND STOP TIMES FOR SURGICAL PROCEDURES PERFORMED IN CLINIC

The definition of stop and start time for surgical procedures performed in clinics is the same definition as that used in the operating room Chart of Accounts that states:

> *Surgery minutes is the difference between starting time and ending time defined* as follows: *Starting time is the beginning of anesthesia administered in the operating room or the beginning of surgery if anesthesia is not administered or if anesthesia is administered in other than the operating room. Ending time is the end of the anesthesia or surgery if anesthesia is not administered. The time the anesthesiologist spends with the patient in the recovery room is not to be counted.*

Clinicians need to document procedure stop and start times in the medical record, unless the hospital is using average times. It is not necessary to keep a log similar to the one kept in the Operating Room (OR) to document the minutes of each procedure. Unlike in the OR, clinic staff may enter and leave the room during a procedure. This does not affect the calculation of procedure minutes. Please

reference additional information in this section regarding reporting of actual minutes (included vs. excluded minutes).

As an alternative to reporting actual minutes, hospitals may report procedures using average times that are "hard coded". To report average procedure times, hospitals should conduct time studies to find the average time it takes to perform common procedures and periodically verify these average times. Please reference additional information in this section regarding reporting of average minutes (included vs. excluded minutes).

ACTIVITIES INCLUDED IN PROCEDURE TIME

As stated above, the definition of procedure start and stop times for surgical procedures performed in the clinic is the same as the definition of procedure start and times for procedures performed in the operating room. However, for surgical procedures performed in the clinic, some activities that are integral to the procedure may not be typically thought of as included in the time of the procedure. The following lists of included and excluded activities are examples to guide the decision of which activities to include and exclude from the timing of surgical procedures performed in clinics. These lists are not all-inclusive but should be used as a guide when reporting minutes for these services.

INCLUDED ACTIVITIES

When the following activities are integral to a procedure, the time it takes to perform the activity should be included in the procedure time. These services are all above and beyond the actual performance of the surgical service, i.e. "cut to close". Many of these examples apply directly to wound care but should also be applied to all surgical procedures performed in the clinic. The overriding consideration is that the minutes associated with the procedure along with the minutes associated with clinical care time spent preparing the recovering the patient are reportable surgical minutes.

- Positioning of the patient in preparation for the procedure
- Removal of dressing/casting/Unna boot (i.e. whatever covers the wound)
- Cleansing of wound
- Wound measurement and assessment
- Applications of topical/local anesthetic
- Application of topical pharmaceuticals and dressing post procedure
- Monitored time when waiting for anesthetic to become effective
- Taking vital signs
- Monitored time when waiting for cast to dry

Monitored time post procedure when waiting for recovery from anesthetic

EXCLUDED ACTIVITIES

The time it takes to perform the following activities should not be included in the procedure time.

- Waiting time in general
- Teaching
- Non-monitored time when waiting for topical and/or local anesthetic to become effective
- Non-monitored time when waiting for cast to dry
- Non-monitored time post procedure when waiting for recovery from anesthetic

PART IV: MISCELLANEOUS INFORMATION

COUNTING CLINIC VISITS

The definition of a clinic visit follows the logic of the definition of a referred ambulatory visit. See Section 500 Reporting Instructions page 017 Schedule V2B columns 1 to 3. A patient who is seen in a clinic and receives an E/M service and/or non-surgical procedure is counted for one clinic visit. A patient who is seen in a clinic and receives a surgical procedure is counted as a surgery visit. A patient who is seen in a clinic and receives an E/M service plus a surgical procedure is counted as two visits-clinic and surgery. A patient receiving E/M services and/or non-surgical procedures in two different clinics is counted as two visits. Patients who are seen twice at the same clinic at two different times on one day for therapeutic or treatment protocol reasons are counted as having two visits. However, patients who are seen in the same clinic at two different times on one day because of scheduling difficulties would be counted as one visit. More information on counting visits is included in Part III: Surgical Procedures under the Same Day Surgery section and in Section 500 of this manual-Reporting Instructions for Schedule OVS.

STANDARD UNIT OF MEASURE REFERENCES
AMBULANCE SERVICES- REBUNDLED

Account Number	Cost Center Title
6800	Ambulance Services-Rebundled

The Ambulance Service-Rebundled relative value units listed below were developed by the Health Services Cost Review Commission. They will be used as the standard unit of measure to determine the charges for round-trip ambulance services for hospital inpatients from the hospital to the facility of a third party provider of a non-physician diagnostic or therapeutic services.

Basic Ambulance Service

Service	Relative Value Units
Base Charge	112.5
Per Mile	1.5
Downtown - Per Hour	37.5
Overtime Premium (Night, Weekend, etc.)	15

Advance Ambulance Service

Service	Relative Value Units
Base Charge	225
Per Mile	3.0
Downtime - Per Hour	75
Overtime Premium (Night, Weekend, etc.)	30

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY

ACCOUNT NUMBER	COST CENTER TITLE
7550	Speech Therapy

The descriptions of codes in this section of Appendix D were obtained from the 2003 edition of the Current Procedural Terminology (CPT) manual, and the 2003 edition of the Healthcare Common Procedure Coding System (HCPCS). Some of these codes are time-based; for example, 97110, "Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility," while other codes are non-time based; for example, code 96110, "Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report." The review committee felt that the current system could be improved by converting all the codes to time-based. The codes could then be used in increments of 15 minutes with the total time, and therefore charge, dependent on the complexity and tolerance of the patient. This rationale was used in the revision of the Physical and Occupational Therapy appendices, and applied to Speech, would maintain consistency across the rehabilitation disciplines.

The amount of time counted is time spent evaluating and treating the patient. This could include time spent reviewing medical records in the presence of the patient (where you may ask for clarification or additional information from the patient), but not time spent writing a report after the session with the patient is concluded. With the exception of a few codes that are described in the CPT manual in increments of one hour, the review committee assigned all Relative Value Units (RVU's) in this section of Appendix D based on 15-minutes increments. **The 15-minute increments used in this Appendix D are subject to the Medicare 8 minute rule.**

Converting non-tie based CPT codes to a time basis requires that the hospital's Charge Description Master (CDM) be set up with the most likely time multiples of a test to avoid confusion in billing payors who may not expect to see multiple units of a non-time-based service being provided. As an example, billing 96110 (described as non-time-based) at an assumed rate per unit of $5.00, the CDM could read as follows:

CPT Code	Description	Unit	CMD#	Total RVU	Total Price
96110	**Developmental testing; limited - 15 min.**	**1**	**xxx16**	**9**	**$ 45.00**
96110	**Developmental testing; limited - 30 min.**	**1**	**xxx17**	**18**	**$ 90.00**
96110	**Developmental testing; limited - 45 min.**	**1**	**xxx18**	**27**	**$135.00**
96110	**Developmental testing; limited - 60 min.**	**1**	**xxx19**	**36**	**$180.00**

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY

As a comparison, billing 97110 (described as time-based), the CDM would read as follows:

CPT Code	Description	Unit	CMD#	Total RVU	Total Price
97110	**Therapeutic procedure - 15 min/ea.**	**1**	**xxx26**	**6**	**$30.00**

If this service were provided for 45 minutes, the therapist would specify a quantity (unit) of 3 and not 1. The facilities CDM/Revenue system would extend the RVU to 18 and the Total Price to $90.00.

The committee referenced the RVU's found in the 2003 Medicare Fee Schedule for Speech-Language Pathologists & Audiologists as presented by the American Speech-Language Hearing Association to assist in determining the relative appropriateness of each procedure's RVU.
Other considerations:

1. Routine Supply cost is included in the HSCRC rate per RVU.
2. Non-routine supply (such as TEP, passey-muir speaking valve) costs are billable as M/S Supplies.
3. Durable Medical Equipment (DME) for Inpatient services is billable as M/S Supplies. However, DME provided to Outpatients are not regulated by HSCRC, and all applicable payor DME billing requirements would apply.
4. The CPT codes reviewed account for the majority of services provided in ST. There are some CPT codes not listed and new codes may be added in the future. These codes should be considered as "by report" by the individual institution. (Note: "By report" means the HSCRC has not assigned a RVU to the specific test/procedure. Should the facility provide the service, the facility is to develop an RVU consistent with other comparable ST services performed within the department and contact the HSCRC to report the use of the procedure along with the logic for the RVU assignment).
5. CPT codes are in a process of constant revision and as such, providers should review their institution's use of CPT codes and stay current with proper billing procedures.
6. The RVU's listed in this section of Appendix D are time-based. The time increments are in 15-minute multiples. HSCRC expects providers to round up/down for services, when not provided in exactly a 15-minute multiple. For example services that are:
   a. 8 to 22 minutes = 15 minutes,
   b. 23 to 37 minutes = 30 minutes,
   c. 38 to 52 minutes = 45 minutes,
   d. 53 to 67 minutes = 60 minutes, etc.

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY

7. Billable time is spent evaluating and treating the patient. Time spent for set-up, documentation of service, conference, and other non-patient contact is not reportable or billable.
8. It is expected and essential that all appropriate clinical documentation be prepared and maintained to support services provided.

CPT Code	Description	RVU
NON-TIME-BASED CODES THAT BECOME TIME-BASED		
31579	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy *(per HSCRC: each 15 minutes).*	25
92506	Evaluation of speech, language, voice communication, auditory processing, and/or aural rehabilitation status. *(per HSCRC: each 15 minutes).*	12

CPT Code	Description	RVU
NON-TIME-BASED CODES THAT BECOME TIME-BASED		
92507	Treatment of speech, language, voice communication and/or auditory processing disorder (includes aural rehabilitation); individual. *(per HSCRC: each 15 minutes).*	6
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); *(per HSCRC: each 15 minutes).*	
	Groups of two, three, or four	3 per patient
	Groups of five or more	2 per patient
92526	Treatment of swallowing dysfunction and/or oral function for feeding. *(per HSCRC: each 15 minutes).*	6
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech. *(per HSCRC: each 15 minutes).*	12
92605	Evaluation for prescription of non-speech-generating augmentative and alternative communication device. *(per HSCRC: each 15 minutes).*	12

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY

CPT Code	Description	RVU
NON-TIME-BASED CODES THAT BECOME TIME-BASED		
92606	Therapeutic service(s) for the use of non-speech generating device, including programming and modification. *(per HSCRC: each 15 minutes).*	6
92609	Therapeutic services for the use of speech generating device, including programming and modification. *(per HSCRC: each 15 minutes).*	6
92610	Evaluation of oral and pharyngeal swallowing function. *(per HSCRC: each 15 minutes).*	12
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording. *(per HSCRC: each 15 minutes).*	17
92612	Flexible fiberooptic endoscopic evaluation of swallowing by cine or video recording. (If flexible fiberoptic or endoscopic evaluation of swallowing is performed without cine or video recording. Use 92700). *(per HSCRC: each 15 minutes).*	22
92614	Flexible fiberoptic endosopic evaluation, laryngeal sensory testing by cine or video recording. *(per HSCRC: each 15 minutes).*	19
92616	Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording. *(per HSCRC: each 15 minutes).*	24
92700	Flexible fiberoptic endoscopic evaluation of swallowing without cine or video recording. *(per HSCRC: each 15 minutes).*	22
92700	Unlisted otorhinological services or procedures, *(per HSCRC: each 15 minutes).*	by report

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY

CPT Code	Description	RVU
NON-TIME-BASED CODES THAT BECOME TIME-BASED		
96110	Developmental testing; limited (e.g. Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report. *(per HSCRC: each 15 minutes).*	9
97150	Therapeutic procedure(s), group *(per HSCRC: each 15 minutes; supplemental HSCRC definition: swallow therapeutic procedure(s)*	
	Groups of two, three, or four	3 per patient
	Groups of five or more	2 per patient

CPT Code	Description	RVU
TIME-BASED CODES		
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour.	48
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to face with the patient; each additional 30 minutes. *(List separately in addition to code for primary procedure.)*	24
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g. by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour.	48
96111	Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, e.g. Bayley Scales of Infant Development) with interpretation and report, per hour.	48
96115	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g. acquired knowledge, attention memory, visual spatial abilities, language functions, planning) with interpretation and report, per hour.	48

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY

CPT Code	Description	RVU
TIME-BASED CODES		
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility.	6
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities. *(Supplemental HSCRC definition: includes DPNS)*	6
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes.	7
97532	Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (One-on-one) patient contact by the provider, each 15 minutes.	5
97703	Checkout for orthotic/prosthetic use, established patient, each 15 minutes	5

STANDARD UNIT OF MEASURE REFERENCES
AUDIOLOGY

ACCOUNT NUMBER	COST CENTER TITLE
7580	Audiology

The descriptions in this section of Appendix D were obtained from the 2003 edition of the Current Procedural Terminology (CPT) manual, and the 2003 edition of the Healthcare Common Procedure Coding System (HCPCS).

It was the objective of the review committee to maintain RVU consistency among Physical Therapy, Occupational Therapy, Speech Therapy, and Audiology in terms of RVU value and a time-based approach. The review committee was able to achieve this consistency in assigning RVU values to the audiology codes, but decided that some codes specifically codes associated with Vestibular ENG (92541–92547), and codes for tests generally considered add-ons to a standard audiometry evaluation (92561–92577) should remain non-time based. CPT code 95920, intraoperative neurophysiology testing was already described in one-hour increments. The remaining codes were converted to time based codes with 15-minute increments. **The 15-minute increments used in this Appendix D are subject to the Medicare 8 minute rule.** For CPT code 95920, intraoperative neurophysiology testing, measured in one-hour increments, any partial hour of service is rounded up or down, and reported in full hours.

The decision to convert non-time based CPT codes to a time basis, created a possible billing concern where payors may not expect to see multiple units of a service being provided. As a solution to that concern, the review committee suggested that hospitals' Charge Description Master (CDM) be set up with the most likely time multiples of a test, but that the unit will always show "1." Using the example of (a non-time based) 92579 and using an assumed rate per unit of $5.00, the CDM (four CDM numbers are used) could read as follows:

CPT Code	Description		Unit	CMD#	Total RVU	Total Price
92579	VRA	15 min.	1	xxx16	12	$60.00
92579	VRA	30 min.	1	xxx17	24	$120.00
92579	VRA	45 min.	1	xxx18	36	$180.00
92579	VRA	60 min.	1	xxx19	48	$240.00

As a comparison, below is a CDM example of a procedure that is CPT time based.

CPT Code	Description	Unit	CMD#	Total RVU	Total Price
95920	Intraop. Neurophys. Test-60/min/ea	1	xxx26	24	$120.00

STANDARD UNIT OF MEASURE REFERENCES
AUDIOLOGY

To assist the committee in its effort to determine the relative appropriateness of each procedure's RVU; the committee made reference to the RVUs found in the 2003 Medicare Fee Schedule for Speech-Language Pathologists & Audiologists as presented by the American Speech-Language Hearing Association.

Other Considerations:

1. Routine Supply cost is included in the HSCRC rate per RVU.
2. Non-routine supply costs are billable as M/S Supplies.
3. Durable Medical Equipment (DME) for Inpatient services is billable as M/S Supplies. However, DME provided to Outpatients are not regulated by HSCRC, and all applicable payor DME billing requirements would apply.
4. The CPT codes reviewed account for the majority of services provided in Audiology. There are some CPT codes not listed and new codes may be added in the future. These codes should be considered as "by report" by the individual institution.

   NOTE: "By Report" means the HSCRC has not assigned a RVU to the specific test or procedure. Should the facility provide the service, the facility is to develop a RVU; which is to be consistent with other comparable Audiology Services performed within the department. The facility is responsible for contacting the HSCRC to report the use of the procedure and the logic for the RVU assignment.
5. CPT codes are in a process of constant revision and as such, providers should review their institution's use of CPT codes and stay current with proper billing procedures.
6. The RVU's listed in this section of Appendix D are time based. The time increments are in 15-minute multiples. HSCRC expects providers to round up/down for services, when not provided in exactly a 15-minute multiple. For example services that are:

   a. 8 to 22 minutes = 15 minutes,
   b. 23 to 37 minutes = 30 minutes
   c. 38 to 52 minutes = 45 minutes,
   d. 53 to 67 minutes = 60 minutes, etc.

7. Time increments used in this section of Appendix D are for direct patient time. Direct patient time is reportable/billable. Time spent for set-up, documentation of service, conference, and other non-patient contact is not reportable/billable.

8. It is expected and essential that all appropriate clinical documentation be prepared and maintained to support services provided.

CPT Code	Description	RVU
NON-TIME BASED THAT REMAIN NON-TIME BASED CODES		
92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	14
92542	Positional nystagmus test, minimum of 4 positions, with recording	14
92543	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording	8
92544	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording	12
92545	Oscillating tracking test, with recording	12
92546	Sinusoidal vertical axis rotational testing	21
92547	Use of vertical electrodes (List separately in addition to code for primary procedure	12
92561	Bekesy audiometry, diagnostic	7
92562	Loudness balance test, alternative binaural or monaural	4
92563	Tone decay test	4
92564	Short increment sensitivity index (SISI)	5
92565	Stenger test, pure tone	4
92567	Tympanometry (impedance testing)	5
92568	Acoustic reflex testing	4

STANDARD UNIT OF MEASURE REFERENCES
AUDIOLOGY

CPT Code	Description	RVU
NON-TIME BASED THAT REMAIN NON-TIME BASED CODES		
92569	Acoustic reflex decay test	4
92571	Filtered speech test	4
92572	Staggered spondaic word test	1
92573	Kinbard test	4
92575	Sensorineural acuity level test	3
92576	Synthetic sentence identification test	5
92577	Stenger test, speech	7
CPT Code	**Description**	**RVU**
NON-TIME BASED THAT BECOME TIME BASED CODES		
92510	Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing therapeutic services) with or without speech processor programming *(per HSCRC: each 15 minutes)*	20
92516	Facial nerve function studies (e.g. Electroneuronography) *(per HSCRC: each 15 minutes)*	9
92548	Computerized dynamic posturography *(per HSCRC: each 15 minutes)*	39
92551	Screening test, pure tone, air only *(per HSCRC: each 15 minutes)*	Non-reportable
92552	Pure tone audiometry (threshold); air only *(per HSCRC: each 15 minutes)*	5
92553	Pure tone audiometry (threshold); air and bone *(per HSCRC: each 15 minutes)*	7

STANDARD UNIT OF MEASURE REFERENCES
AUDIOLOGY

CPT Code	Description	RVU
NON-TIME BASED THAT BECOME TIME BASED CODES		
92555	Speech audiometry threshold *(per HSCRC: each 15 minutes)*	4
92556	Speech audiometry threshold: with speech recognition *(per HSCRC: each 15 minutes)*	6
92557	Comprehensive audiometry threshold evaluation & speech recognition (92553 & 92556 combined) *(per HSCRC: each 15 minutes)*	12
92559	Audiometric testing of groups *(per HSCRC: each 15 minutes)*	Non-reportable
92560	Bekesy audiometry, screening *(per HSCRC: each 15 minutes)*	Non-reportable
92579	Visual reinforcement audiometry (VRA) *(per HSCRC: each 15 minutes)*	12
92582	Conditioning play audiometry *(per HSCRC: each 15 minutes)*	12
92583	Select picture audiometry *(per HSCRC: each 15 minutes)*	9
92584	Electrocochleagraphy *(per HSCRC: each 15 minutes)*	25
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive *(per HSCRC: each 15 minutes)*	21
92586	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited *(per HSCRC: each 15 minutes)*	18

STANDARD UNIT OF MEASURE REFERENCES
AUDIOLOGY

CPT Code	Description	RVU
NON-TIME BASED THAT BECOME TIME BASED CODES		
92586	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited (supplemental HSCRC description: Universal newborn hearing screen program) *(per HSCRC: each 15 minutes)*	6
92587	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products) *(per HSCRC: each 15 minutes)*	14
92587	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products) (supplemental HSCRC description: Universal newborn hearing screen program) *(per HSCRC: each 15 minutes)*	5
92588	Evoked otoacustic emissions; comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies) *(per HSCRC: each 15 minutes)*	16
92589	Central auditory function tests(s) (specify) *(per HSCRC: each 15 minutes)*	5
92596	Ear protector attenuation measurements *(per HSCRC: each 15 minutes)*	6
92601	Diagnostic analysis of cochlear implant, patient under 7 years of age; with programming *(per HSCRC: each 15 minutes)*	33
92602	Diagnostic analysis of cochlear implant, patient under 7 years of age; with subsequent programming *(per HSCRC: each 15 minutes)*	23
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming *(per HSCRC: each 15 minutes)*	23

STANDARD UNIT OF MEASURE REFERENCES
AUDIOLOGY

CPT Code	Description	RVU
NON-TIME BASED THAT BECOME TIME BASED CODES		
92604	Diagnostic analysis of cochlear implant, age 7 years or older; with subsequent programming (per HSCRC: each 15 minutes)	15
95925	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs (per HSCRC: each 15 minutes)	11
69210	Removal impacted cerumem (separate procedure), one or both ears (per HSCRC: each 15 minutes)	6
CPT Code	**Description**	**RVU**
TIME BASED CODES - (direct one to one patient contact)		
95920	Intraoperative neurophysiologic testing, per hour (List separately in addition to code for primary procedure)	24

ACCOUNT NUMBER	COST CENTER TITLE
7210	Laboratory Services

Approach

The descriptions of codes in this section of Appendix D were obtained from the 2014 edition of the Current Procedural Terminology (CPT) manual, and the 2014 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning relative value units (RVU's) to laboratory codes, an effort was made to maintain consistency across laboratory sections. RVU assignments were developed considering Medicare fee schedule, technician time, reagent costs, and supply costs. Future assignments of RVU's should take existing assignments to similar CPT codes into consideration as well as the Medicare fee schedule, technician's time, reagent costs, and supply costs, the methodology used in performing the test. Since the cost of supplies for each test was considered when the RVU's were developed, hospitals may not bill separately for any laboratory supplies.

CPT Codes without an Assigned RVU Value

By Report Some CPT codes in the appendix are rarely used or have significant range in reagent supply costs and have not been assigned RVUs; they are labeled "by report". In addition, new CPT codes may be added in the years following this revision that will not have assigned RVUs. In the case a laboratory performs a test that does not have assigned RVUs, or a test that is not listed, the lab will select an appropriate CPT code and assign a reasonable value based on the above criteria (existing assignments to similar CPT codes, technician's time, reagent and supply costs, and the methodology used in performing the test). The laboratory reporting such tests to the HSCRC must maintain adequate documentation of the rationale used in assigning the RVU. In the case of a CPT code covering multiple tests with varying resources, the hospital is allowed to assign different RVU values as long as they maintain the documentation of the rationale.

Non-Regulated; Professional Services
CPT codes that describe the interpretation of results are considered professional, not technical services and are valued at zero RVUs, or labeled "non-regulated". Professional services are considered physician services, not regulated hospital services, and should not be reported to the HSCRC.

Professional Component of Service Referred to Outside Laboratory
According to the *Medicare Claims Processing Manual,* a clinical diagnostic laboratory may refer a specimen to an independent laboratory (one separate from a physician's office or hospital) for testing. When the hospital obtains laboratory services for patients under arrangements with clinical laboratories or other hospital laboratories, only the originating hospital can bill for the arranged services.

By providing the services under arrangement, it is as if the initiating laboratory has performed the service themselves; therefore, can bill for the complete service provided (including those codes stating "with interpretation"). Also from Medicare, "where a referring laboratory prepares a specimen before transfer to a reference laboratory these preparatory services are considered integral part of the testing process and the costs of such services are included in the charge for the total testing service."

For example, a specimen is collected at the hospital, prepared and sent out to the reference laboratory for testing and interpretation. The reference laboratory has an arrangement with the hospital to provide such services and bills the hospital appropriately. The reference laboratory does not bill the patient or the patient's insurance. The hospital bills the patient/insurance for the testing that has been completed. In this appendix, services, such as 88291, that include both a professional and technical component and are typically performed by an outside laboratory are labeled "By Report."

Non-Regulated; Autopsy Service (CPT Codes 88000-88099)
Autopsy, CPT code 88020, is labeled "not reportable"-meaning no value may be reported to the HSCRC for this service. Do not report Autopsy RVU's to the HSCRC.

General Advice

- The HSCRC system is a revenue reporting and payment system; it does not dictate billing rules. Hospitals should adhere to the billing requirements of CMS and exhibit good billing practices as defined by the OIGs Model Compliance Plan.
- The RVU assigned to a test will be the same regardless of whether the analysis is performed at the hospital's laboratory or sent to another laboratory.
- Additional RVUs have not been allotted for STAT testing or for specimen dispatch; this is regarded as overhead expense.
- The RVUs are assigned per reported test, do not bill double the RVU's when a test is run in multiple times on the same sample.
- If a procedure has multiple CPT codes, the hospital may report all applicable CPT codes.
- No RVUs have been allotted for calculated tests such as INR, albumin/globin ratios, etc.
- Simple confirmatory testing should not generate additional reported RVUs. For example, sulfosalicylic acid used to confirm abnormal protein from urine dipstick would not warrant additional RVUs.
- More complex reflex testing that is performed based on initial test results would generate additional RVU's. Reflex testing to a more definitive assay includes such things as: anti-body panel following a positive anti-body screen; IgM anti-hepatitis A after a positive anti-hepatitis A; Western blot testing after a positive HIV anti-body assay; phase contrast platelet count used to test a low automated platelet count. Hospitals must obtain an additional physician's order or follow established policies for reflex testing.

- Regarding CMS/AMA Panels, the hospital laboratory should bill tests as a defined panel even if the tests are ordered individually.
- Do not use a code with a general or miscellaneous description when a specific code is available.
- Phlebotomy is a billable laboratory procedure. In order to bill for this service, the lab must perform the phlebotomy and report all expenses such as personnel and supplies associated with this service.
- Point of Care Testing is also a billable laboratory procedure. Revenue and expenses for point of care testing must be reported as a laboratory service.
- Lab testing cannot be billed as a supply charge; a laboratory CPT code must be used.

- Therapeutic apheresis has been moved from the laboratory rate center to the clinic rate center.

- Bone and Tissue have moved from the laboratory rate center to the supply rate center.

Regulated vs. Unregulated Laboratory Services

HSCRC rules govern inpatient services as defined by Medicare, and outpatient services performed at the hospital. Any sample collected on regulated hospital premises is part of this regulated system and must be reported when the patient is still an inpatient or presents as an outpatient. If a patient is discharged a test ordered through the laboratory system is considered regulated within the first 14 days post-discharge for Medicare patients and at discharge for all other patients.

This includes samples referred to other reference labs. Under Medicare guidelines, when a hospital provides and/or refers laboratory services for patients under arrangements with clinical laboratories or other hospital laboratories, only the originating hospital can bill for the arranged services (per the Medicare Claims Processing Manual). By providing the services under arrangement, it is as if the initiating laboratory has performed the service, and can therefore bill for the complete service provided.

Samples received by a hospital laboratory from other sources, e.g., doctors' offices, other laboratories, are not part of HSCRC regulated activity. Similarly, samples that are collected or tested by hospital employees stationed away from hospital property are not regulated. The costs associated with these services should not be included in regulated expenses reported to the HSCRC.

Blood Bank

Blood Products are described by HCPCS codes. In establishing RVU's for the new HCPCS codes, individual values for existing basic blood products (whole blood, red blood cells, fresh frozen plasma, and platelets) were combined with individual values for existing manipulations to blood products (washing, rejuvenation, leukoreduction, irradiation, etc.) to build the corresponding RVUs for the new HCPCS Codes.

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CPT Code	Description	RVU

Venous/Capillary

36415	Collection of venous blood by venous puncture	8
	[see also G0001]	
36416	Capillary blood collect (eg, finger, heel, ear stick)	6
	[see also G0001]	

Therapeutic Apheresis

36511	Therapeutic apheresis-WBC	0
36512	Therapeutic apheresis-RBC	0
36513	Therapeutic apheresis-platelets	0
36514	Therapeutic apheresis-Plasma	0

Organ or Disease Oriented Panels

80047	Basic Metabolic panel (calcium, ionized)	11
80048	Basic Metabolic panel (with Calcium)	11
80050	General Health Panel	Depends on tests
80051	Electrolyte panel	8
80053	Comprehensive metabolic panel(with C02, AST)	15
80055	Obstetric Panel	Depends on tests
80061	Lipid panel	19
80069	Renal function panel	12
80074	Acute Hepatitis Panel	90
80076	Hepatic Function Panel (with Total Protein)	11

Drug Testing

80100	Drug screen, multiple classes	By report
80101	Drug screen, each drug or class	8
80102	Drug confirmation	25
80103	Tissue prep for drug analysis	By report
80104	Drug screen, multiple drug classes other than chromatographic method, each procedure	By Report

Therapeutic Drug Assays

CPT Codes	Description	RVU
80150	Amikacin, assay	15
80152	Amitriptyline	30
80154	Benzodiazepines	30
80155	Caffeine	15
80156	Carbamazepine, total	15
80157	Carbamazepine, free	15
80158	Cyclosporine	20
80159	Clozapine	30
80160	Desipramine	30
80162	Digoxin	15
80164	Dipropylacetic acid (valproic acid)	15
80166	Doxepin	30
80168	Ethosuximide	15
80169	Everolimus	30
80170	Gentamicin	15
80171	Gabapentin	15
80172	Gold	40
80173	Haloperidol	30
80174	Imipramine	30
80175	Lamotrigine	15
80176	Lidocaine	15
80177	Levatiracetam	15
80178	Lithium	15
80180	Mycophenolate (Mycophenolic Acid)	20
80182	Nortriptyline	30
80183	Oxcarbazepine	15
80184	Phenobarbital	15
80185	Phenytoin, total	15
80186	Phenytoin, free	15
80188	Primidone	30

CPT Codes	Description	RVU
80190	Procainamide	15
80192	Procainamide with metabolites	30
80194	Quinidine	15
80195	Sirolimus	30
80196	Salicylate	15
80197	Tacrolimus	30
80198	Theophylline	15
80199	Tiagabine	30
80200	Tobramycin	15
80201	Topiramate	15
80202	Vancomycin	15
80203	Zonisamide	15
80299	Quantitation of drug not specified	By report

Evocative/Suppression Testing

80400	ACTH stimulation panel, adrenal insufi.	30
80402	ACTH stimulation panel, 21 hydro insuff.	100
80406	ACTH stim panel, 3 beta-hydroxy insuff	80
80408	Aldosterone suppression eval panel	80
80410	Calcitonin stimul panel	90
80412	Corticotropic releas horm stim panel	270
80414	Chorionic gonad stim panel, testosterone	90
80415	Estradiol response panel	90
80416	Renin stimulation panel, renal vein	90
80417	Renin stimulation panel, peripheral vein	30
80418	Pituitary evaluation panel	608
80420	Dexamethasone supression panel	94
80422	Glucagon tolerance panel, insulinoma	57

CPT Code	Description	RVU
80424	Glucagon tolerance panel, pheochrom	180
80426	Gonadotropin hormone panel	160
80428	Growth hormone stimulation panel	128
80430	Growth hormone suppression panel	140
80432	Insulin induced C-peptide suppression	110
80434	Insulin tolerance panel, ACTH insuff	101
80435	Insulin tolerance panel, GH deficiency	180
80436	Metyrapone Panel	80
80438	TRH stimulation panel, 1 hour	45
80439	TRH stimulation panel, 2 hour	60
80440	TRH stimulation panel, hyperprolactin	60

Consultations (Clinical Pathology)

80500	Clinical pathology consultation; limited	0
80502	Clinical pathology consultation; comprehensive	0

Urinalysis

81000	Urinalysis, nonauto, w/scope	9
81001	Urinalysis, auto, w/scope	9
81002	Urinalysis, nonauto w/o scope	4
81003	Urinalysis, auto, w/o scope	4
81005	Urinalysis, qualitative or semiquant	9
81007	Urine bacteria screen, non-culture	4
81015	Microscopic exam of urine only	5
81020	Urinalysis, glass test	By report
81025	Urine pregnancy test, visual color comparison	10
81050	Urine, timed, volume measurement	2
81099	Unlisted urinalysis procedure	By report

Chemistry

CPT Code	Description	RVU
81161	DMD (dystrophin) (eg. Duchenne/Becker muscular dystrophy) deletion analysis and duplication analysis if performed	By Report
81200	ASPA gene analysis, common variants	By Report
81201	ASPC gene analysis, full gene sequence	By Report
81202	APC gene analysis, known familial variance	By Report
81203	APC gene analysis, duplication/deletion variants	By Report
81205	BCKDHB gene analysis, common variants	By Report
81206	BCR/ABL1 tranlocation analysis; major breakpoint qual or quant	By Report
81207	BCR/ABL1 tranlocation analysis; minor breakpoint qual or quant	By Report
81208	BCR/ABL1 tranlocation analysis; other breakpoint qual or quant	By Report
81209	BLM gene analysis, 2281 del6ins7 variant	By Report
81210	BRAF, gene analysis, V60E variant	By Report
81211	BRCA1, BRCA gene analysis; full sequence analysis and common duplication/deletion variance in BRCA	By Report
81212	184del AG, 5385insC, 617dellT variants	By Report
81213	Uncommon duplication/deletion variants	By Report
81214	BRCA1 gene analysis, full sequence and common duplication/deletion variants	By Report
81215	Known familial variant	By Report
81216	BRCA2 gene analysis, full sequence analysis	By Report
81217	Known familial variant	By Report
81220	CFTR gene analysis; common variants	By Report
81221	Known familial variant	By Report
81222	Duplication/deletion variants	By Report
81223	Full gene sequence	By Report
81224	Introl 8 poly-T analysis	By Report
81225	CYP2C19, gene analysis, common variants	By Report
81226	CYP2D6, gene analysis, common variants	By Report
81227	CYP2C9, gene analysis, common variants	By Report
81228	Cytogenomic contitutional microarray analysis; interrogation of genomic regions for copy number variants	By Report
81229	Interrogation of genomic regions for copy number and single nucleotide polymorphism variants of chromosomal abnormalities	By Report

CPT Code	Description	RVU
81235	EGFR gene analysis, common variants	By Report
81240	F2 gene analysis, 20210G>A variant	By Report
81241	F5 gene analysis, Leiden variant	By Report
81242	FANCC gene analysis, common variant	By Report
81243	FMR1 gene analysis; evaluation to detect abnormal alleles	By Report
81244	FMR1 gene analysis; characterization of alleles	By Report
81245	FLT3 gene analysis, internal tandem duplication variants	By Report
81250	G6PC gene analysis, common variants	By Report
81251	GBA gene analysis, common variants	By Report
81252	GJB2 gene analysis, full gene sequence	By Report
81253	GJB2 gene analysis, known familial variants	By Report
81254	GJB6 gene analysis, common variants	By Report
81255	HEXA gene analysis, common variants	By Report
81256	HFE gene analysis, common variants	By Report
81257	HBA1/HBA2, gene analysis, for common deletions or variant	By Report
81260	IKBKAP gene analysis, common variants	By Report
81261	IGH@, gene rearrangement analysis to detect abnormal clonal population(s); amplified methodology	By Report
81262	IGH@, gene rearrangement analysis to detect abnormal clonal population(s); direct probe methodology	By Report
81263	IGH@, variable region somatic mutation analysis	By Report
81264	IGK@, gene rearrangement analysis, evaluation to detect abnormal clonal population	By Report
81265	Comparative analysis using Short Tandem Repeat markers; patient and comparative specimen	By Report
+81266	Comparative analysis using Short Tandem Repeat markers; each additional specimen	By Report
81267	Chimerism analysis, post transplantation specimen, includes comparison to previously performed baseline analyses, without cell selection	By Report
81268	Chimerism analysis, post transplantation specimen, includes comparison to previously performed baseline analyses; with cell selection	By Report
81270	JAK2 gene analysis, p. Val617Phe variant	By Report

CPT Code	Description	RVU
81275	KRAS gene analysis, variants in codons 12 and 13	By Report
81280	Long QT syndrome gene analysis; full sequence analysis	By Report
81281	Long QT syndrome gene analysis; known familial sequence variant	By Report
81282	Long QT syndrome gene analysis; duplication/deletion variants	By Report
81287	MGMT (o-6 methylguaninej-DNA methyltransferase) (eg, glioblastoma multiforma), methylation analysis	By Report
81290	MCOLN1 gene analysis, common variants	By Report
81291	MTHFR gene analysis, common variants	By Report
81292	MLH1 gene analysis; full sequence analysis	By Report
81293	MLH1 gene analysis; known familial variants	By Report
81294	MLH1 gene analysis; duplication/deletion variants	By Report
81295	MSH2 gene analysis; full sequence analysis	By Report
81296	MSH2 gene analysis, known familial variants	By Report
81297	MSH2 gene analysis; duplication/deletion variants	By Report
81298	MSH6 gene analysis, full sequence analysis	By Report
81299	MSH6 gene analysis; known familial variants	By Report
81300	MSH6 gene analysis; duplication /deletion variants	By Report
81301	Microsatellite instability analysis of markers for mismatch repair deficiency, if performed	By Report
81302	MECP2 gene analysis; full sequence analysis	By Report
81303	MECP2 gene analysis; known familial variant	By Report
81304	MECP2 gene analysis; duplication/deletion variant	By Report
81310	NPM1 gene analysis, exon 12 variants	By Report
81315	PML/RARalpha translocation analysis; common breakpoints, qualitative or quantitative	By Report
81316	PML/RARalpha translocation analysis; single breakpoint, qualitative or quantitative	By Report
81317	PMS2 gene analysis; full sequence analysis	By Report
81318	PMS2 gene analysis; known familial variant	By Report
81319	PMS2 gene analysis, duplication deletion variant	By Report

CPT Code	Description	RVU
81321	PTEN gene analysis; full sequence analysis	By Report
81322	PTEN gene analysis, known familial variant	By Report
81323	PTEN gene analysis; duplication/deletion variant	By Report
81324	PMP22 gene analysis; full sequence analysis	By Report
81325	PMP22 gene analysis; known familial variant	By Report
81326	PMP22 gene analysis; duplication/deletion variant	By Report
81330	SMPD1 gene analysis, common variants	By Report
81331	SNRPN/UBE3A methylation analysis	By Report
81332	SERPINA1, gene analysis, common variants	By Report
81340	TRB@, gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology	By Report
81341	TRB@, gene rearrangement analysis to detect abnormal clonal population(s); using direct probe methodology	By Report
81342	TRG@, gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	By Report
81350	UGT1A1, gene analysis, common variants	By Report
81355	VKORC1, gene analysis, common variants	By Report
81370	HLA Class I and II typing, low resolution; complete	By Report
81371	HLA Class I and II typing, low resolution; one focus	By Report
81372	HLA Class I typing, low resolution; complete	By Report
81373	HLA Class I typing, low resolution, one locus	By Report
81374	HLA Class I typing, low resolution, one antigen equivalent	By Report
81375	HLA Class II typing, low resolution; HLA-DRB1/3/4/5 and- DQB1	By Report
81376	HLA Class II typing, low resolution; one locus	By Report
81377	HLA Class II typing, low resolution; one antigen equivalent, each	By Report
81378	HLA Class I and II typing, high resolution, LA-A, -B, -C and -DRB1	By Report
81379	HLA Class I typing, high resolution; complete	By Report
81380	HLA Class I typing, high resolution; one focus	By Report

CPT Code	Description	RVU
81381	HLA Class I typing, high resolution; one allele or allele group	By Report
81382	HLA Class II typing, high resolution; one locus, each	By Report
81383	HLA Class II typing, high resolution; one allele or allele group each	By Report
81400	Molecular pathology procedure, Level 1	By Report
81401	Molecular pathology procedure, Level 2	By Report
81402	Molecular pathology procedure, Level 3	By Report
81403	Molecular pathology procedure, Level 4	By Report
81404	Molecular pathology procedure, Level 5	By Report
81405	Molecular pathology procedure, Level 6	By Report
81406	Molecular pathology procedure, Level 7	By Report
81407	Molecular pathology procedure, Level 8	By Report
81408	Molecular pathology procedure, Level 9	By Report
81479	Unlisted molecular pathology procedure	By Report
81500	Oncology, biochemical assays of two proteins, utilizing serum, with menopausal status, algorithm reported as a risk score	By Report
81503	Oncology, biochemical assays of five proteins, utilizing serum, algorithm reported as a risk score	By Report
81504	Oncology (tissue or origin), microarray gene expression profiling of >2000 genes, utilizing formalin-fixed paraffin embedded tissue, algorithm, reported as tissue similarity scores	By Report
81506	Endocrinology, biochemical assays of seven analytes, utilizing serum of plasma, algorithm reporting a risk score	By Report
81507	Fetal aneuploidy (trisomy 21, 18, and 13) DNA dequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy.	By Report
81508	Fetal congenital abnormalities, biochemical assays of two proteins, utilizing maternal serum, algorithm reported as a risk score	By Report
81509	Fetal congenital abnormalities, biochemical assays of three proteins, utilizing maternal serum, algorithm reported as a risk score	By Report

CPT Code	Description	RVU
81510	Fetal congenital abnormalities, biochemical assays of three analytes, utilizing maternal serum, algorithm reported as a risk score	By Report
81511	Fetal congenital abnormalities, biochemical assays of four analytes, utilizing maternal serum, algorithm reported as a risk score	By Report
81512	Fetal congenital abnormalities, biochemical assays of five analytes, utilizing maternal serum, algorithm reported as a risk score	By Report
81599	Unlisted multianalyte assay with alorithmic analysis	By Report
82000	Acetaldehyde, blood	19
82003	Acetaminophen	15
82009	Keytone body(s); qualitative	5
82010	Keytone body(s); quantitative	13
82013	Acetylcholinesterase assay	30
82016	Acylcarnitines; qualitative	50
82017	Acylcarnitines; quantitative	130
82024	Adrenocorticotropic hormone (ACTH)	30
82030	Adenosine, 5- monophosphate, cyclic	25
82040	Albumin, serum	2
82042	Albumin urine/other, quantitative	10
82043	Microalbumin, urine, quantitative	15
82044	Microalbumin, semiquant. (Reagent strip)	5
82045	Microalbumin, semiquant, ischemia modified	By Report
82055	Alcohol (ethanol) except breath	15
82075	Alcohol (ethanol) breath	20
82085	Aldolase	15
82088	Aldosterone	25
82101	Alkaloids, urine, quantitative	By Report
82103	Alpha -I-antitrypsin, total	15
82104	Alpha- I-antitrypsin phenotype	40
82105	Alpha- fetoprotein, serum	15
82106	Alpha- fetoprotein; amniotic	15
82107	Alpha- fetoprotein; AFP-L3 fraction isoform and total AFP	By Report
82108	Aluminum	40

CPT Codes	Description	RVU
82120	Amines, vaginal fluid, qualitative	30
82127	Amino acids, single, qualitative	30
82128	Amino acids, multiple, qualitative, each specimen	30
82131	Amino acids, single, quantitative, each specimen	60
82135	Aminolevulinic acid, delta (ALA)	26
82136	Amino acids, 2–5 amino acids, quantitative	120
82139	Amino acids, 6 or more, quantitative	150
82140	Ammonia	20
82143	Amniotic fluid scan	120
82145	Amphetamine or metamphetamine	25
82150	Amylase	6
82154	Androstanediol glucuronide	47
82157	Androstenedione	25
82160	Androsterone assay	25
82163	Angiotensin II	20
82164	Angiotensin II converting enzyme (ACE)	20
82172	Apolipoprotein	15
82175	Arsenic	40
82180	Ascorbic acid (Vitamin C), blood	25
82190	Atomic absorption spec, each analyta	40
82205	Barbiturates, not elsewhere specified	25
82232	Beta-2 microglobulin	15
82239	Bile acids, total	25
82240	Bile acids, cholylglycine	25

CPT Codes	Description	RVU
82247	Bilirubin, total	6
82248	Bilirubin, direct	6
82252	Bilirubin, fecal, qualitative	8
82261	Biotinidase, each specimen	75
82270	Blood, occult; feces, 1–3 simultaneous deterim	5
	[see also G0107 for screening]	
82271	Blood, occult, other sources, qualitative	4
82272	Blood, occult, qual, feces, single specimen	4
82274	Blood, occult, immunoassay, 1–3 determinations	25
82286	Bradykinin	10
82300	Cadmium	40
82306	Calcifediol (25-OH Vitamin D-3)	15
82308	Calcitonin	30
82310	Calcium, total	2
82330	Calcium, ionized	15
82331	Calcium, infusion test	By Report
82340	Calcium, urine quantitative, timed spec	10
82355	Calculus (stone) qualitative analysis	40
82360	Calculus (stone) quant. Assay, chemical	40
82365	Calculus (stone) infrared spectroscopy	40
82370	Calculus (stone) x-ray diffraction	By Report
82373	Carbohydrate deficient transferrin	By Report

CPT Codes	Description	RVU
82374	Carbon dioxide (bicarbonate)	2
82375	Carbon monoxide (carboxyhemo) quantitative	20
82376	Carbon monoxide, qualitative	20
82378	Carcinoembryonic antigen (CEA)	25
82379	Carnitine (total and free), quantitative	150
82380	Carotene	25
82382	Catecholamines, total urine	30
82383	Catecholamines, blood	30
82384	Catecholamines, fractionated	90
82387	Cathepsin-D	80
82390	Ceruloplasmin	15
82397	Chemiluminescent assay	15
82415	Chloramphenicol	30
82435	Chloride, blood	2
82436	Chloride, urine	10
82438	Chloride, other source	10
82441	Chlorinated hydrocarbons, screen	17
82465	Cholesterol, serum or whole blood, total	4
82480	Cholinesterase, serum	15
82482	Cholinesterase, RBC	15
82485	Chondroitin B sulfate, quantitative	33
82486	Chromatography, qualitative; column, nos	20
82487	Chromatography, paper, 1 dimensional	By Report
82488	Chromatography, paper, 2 dimensional	By Report

CPT Codes	Description	RVU
82489	Chromatography, thin layer, nos	By Report
82491	Chromatography, quantitative; column, nos	30
82492	Chromatography, quant; column, multiple analytes	30
82495	Chromium	40
82507	Citrate	15
82520	Cocaine or metabolite	25
82523	Collagen crosslinks	25
82525	Copper	25
82528	Corticosterone	25
82530	Cortisol, free	30
82533	Cortisol, total	15
82540	Creatine	8
82541	Column chromatography/mass spec. qual, nos	20
82542	Column chrom/mass spec., quant, single phase	30
82543	Column chrom/mass spec., quant, isotope, single	100
82544	Column chrom/mass spec., quant, isotope, mult.	120
82550	Creatine kinas (CK), (CPK), total	6
82552	Creatine kinase isoenzymes	25
82553	Creatine kinase, MB fraction only	15
82554	Creatinine kinase, isoforms	25
82565	Creatinine, blood	2
82570	Creatinine, other source	10
82575	Creatinine, clearance	12
82585	Cyrofibrinogen	14

CPT Codes	Description	RVU
82595	Cyroglobulin, qualitative or semi-quant.	14
82600	Cyanide	29
82607	Cyanocobalamin (Vitamin B-12)	15
82608	Cyanocobalamin unsaturated binding capacity	23
82610	Cystatin C	50
82615	Cystine and homocystine, urine, qualitative	20
82626	Dehydroepiandrosterone (DHEA)	15
82627	Dehydroepiandrosterone - sulfate (DHEA-S)	15
82633	Desoxycorticostertone, 11-	25
82634	Deoxycortisol, 11-	25
82638	Dibucaine number	30
82646	Dihydrocodeinone	By Report
82649	Dihydromorphinone	By Report
82651	Dihydrotestosterone (DHT)	25
82652	Dihydroxyvitamin D, I, 25-	25
82654	Dimethadione	22
82656	Elastase, pancreatic, fecal qual or semiquant	By Report
82657	Enzyme activity in cells, nos, nonradioactive	40
82658	Enzyme activity in cells, radioactive substrate	100
82664	Electrophoretic technique, nos	25
82666	Epiandrosterone	25
82668	Erythropoietin	15
82670	Estradiol	15
82671	Estrogens; fractionated	25
82672	Estrogens; total	25

CPT Codes	Description	RVU
82677	Estriol	15
82679	Estrone	25
82690	Ethchlorvynol	24
82693	Ethylene glycol	15
82696	Etiocholanolone	25
82705	Fats/lipids, feces, qualitative	15
82710	Fats/lipids, feces, quantitative	40
82715	Fecal fat differential, quantitative	By Report
82725	Fatty acids, nonesterified	20
82726	Very long chain fatty acids	120
82728	Ferritin	15
82731	Fetal fibronectin, cervicoaginal, semi-quant.	175
82735	Fluoride	25
82742	Flurazepam	25
82746	Folic acid, serum	15
82747	Folic acid, RBC	15
82757	Fructose, semen	75
82759	Galactokinase, RBC	34
82760	Galactose	19
82775	Galactose-I-phosphate uridyl transferase, quant	107
82776	Galactose-I-phosphate uridyl transferase, screen	18
82777	Galectin-3	15
82784	Gammaglobulin, IgA, IgD, IgG, IgM, each	15
82785	Gammaglobulin IgE	15
82787	Immunoglobulin subclasses, (IgG 1, 2, 3, or 4) each	15

CPT Codes	Description	RVU
82800	Gases, blood, pH only	15
82803	Gases, blood, any of pH, pCO_2, PO_2, CO_2, HCO_3	31
82805	Blood gases with O_2 Saturation by direct meas.	31
82810	Blood gases, O_2 sat only, direct measurement	31
82820	Hemoglobin-oxygen affinity	31
82930	Gastric acid analysis, includes pH if performed, each specimen	By Report
82938	Gastrin, after secretin stimulation	15
82941	Gastrin assay	15
82943	Glucagon	25
82945	Glucose, body fluid, other than blood	4
82946	Glucagon tolerance test	By Report
82947	Glucose, quantitative, blood	4
82948	Glucose, blood, reagent strip	4
82950	Glucose, post glucose dose (includes glucose)	4
82951	Glucose tolerance test, 3 specimens	15
82952	GTT-additional specimens>3	4
82953	Glucose, tolbutamide tolerance test	8
82955	Glucose-6-phosphate dehydrogenase; quant.	15
82960	G6PD enzyme, screen	10
82962	Glucose blood test, monitoring device	8
82963	Glucosidase, beta	39
82965	Glutamate dehydrogenase	12
82975	Glutamine (glutamic acid amide)	30

CPT Code	Description	RVU
82977	Glutamyltransferase, gamma (GGT)	2
82978	Glutathione	15
82979	Glutathione reduatase, RBC	20
82980	Glutethimide	25
82985	Glycated protein	15
83001	Gonadotropin (FSH)	15
83002	Gonadotropin (LH)	25
83003	Growth hormone, human (HGH)	32
83008	Guanosine monophosphate (GMP) cyclic	34
83009	H. Pylori, blood test for urease activity, non-radioactive	By Report
83010	Haptoglobin, quantitative	15
83012	Haptoglobin, phenotypes	By Report
83013	Helicobacter pylori; unease activity, non-radioact	20
83014	Helicobacter, drug admin. and sample collection	By Report
83015	Heavy metal (arsenic, barium, mercury, etc.) screen	25
83018	Heavy metal, quantitative, each	30
83020	Hemoglobin fract. And quant., electrophoresis	25
83021	Hemoglobin fract. And quan.; chromatography	25
83026	Hemoglobin, copper sulfate method	By Report
83030	Hemoglobin, F (fetal), chemical	15
83033	Hemoglobin, F (fetal), qualitative	15
83036	Hemoglobin, glycosylated (A1C)	20
83037	Hemoglobin, glycosylated (A1C), device for home use	10
83045	Methemoglobin, qualitative	15

CPT Code	Description	RVU
83050	Methemoglobin, quantitative	20
83051	Hemoglobin, plasma	12
83055	Sulfhemoglobin, qualitative	5
83060	Sulfhemoglobin, quantitative	20
83065	Hemoglobin thermolabile	4
83068	Hemoglobin unstable, screen	13
83069	Hemoglobin urine	4
83070	Hemosiderin, qualitative	8
83071	Hemosiderin, quantitative	By Report
83080	b-Hexosaminidase	15
83088	Histamine	24
83090	Homocystine	30
83150	Homovanillic acid (HVA)	30
83491	Hydroxycorticosteroids, 17-(17-OHCS)	30
83497	Hydroxyindolactetic acid, 5-(HIAA)	30
83498	Hydroxyprogesterone, 17-d	35
83499	Hydroxyprogesterone, 20-	35
83500	Hydroxyproline, free	60
83505	Hydroxyproline, total	60
83516	Immunoassay, non-infec. Disease; multi. Step	25
83518	Immunoassay, non-infec. Disease; single step (reagent strip)	15
83519	Immunoassay, analyte, quant, RIA	25
83520	Immunoassay, not otherwise specified	By Report
83525	Insulin, total	15

CPT Code	Description	RVU
83527	Insulin, free	15
83528	Instrinsic factor	25
83540	Iron	6
83550	Iron binding capacity	12
83570	Isocitric dehydrogenase (IDH)	25
83582	Ketogenic steroids, fractionation	60
83586	Ketosteroids, 17-(17-KS) total	60
83593	Ketosteroids, fractionation	21
83605	Lactic acid	20
83615	Lactate dehydrogenase (LD, LDH)	4
83625	LD, LDH isoenzymes, separation and quant	25
83630	Lactoferrin, fecal; qualitative	By Report
83631	Lactoferrin, fecal; quant	By Report
83632	Lactogen, human placental (HPL)	60
83633	Lactose, urine; qualitative	15
83634	Lactose, urine; quantitative	15
83655	Lead	25
83661	Fetal lung maturity, lecithin-sphingomyelin (L/S) ratio	120
83662	Fetal lung maturity, foam stability	8
83663	Fetal lung maturity, fluorescence polarization	25
83664	Fetal lung maturity, lamellar body density	50
83670	Leucine aminopetidase (LAP)	25
83690	Lipase	8
83695	Lipoprotein (a)	25

CPT Codes	Description	RVU
83698	Lipoprotein-associated phospholipase A2	By Report
83700	Lipoprotein, blood; electrophoresis and quantitation	25
83701	Lipoprotein, blood; electrophor, high res fract. & quant.	50
83704	Lipoprotein, blood; electrophor, quant of particle	50
83718	Lipoprotein direct meas. HDL. Cholest.	15
83719	Lipoprotein, direct meas. VLDL cholest.	25
83721	Lipoprotein direct meas. LDL cholest.	15
83727	Leuteinizing releasing factor (LRH)	25
83735	Magnesium	6
83775	Malate dehydrogenase	25
83785	Manganese	25
83788	Mass spectrometry, tandem, nos, qualitative, ea spec	30
83789	Mass spectrometry, tandem, nos, quantitative, ea spec	40
83805	Meprobamate	30
83825	Mercury, quantitative	25
83835	Metanephrines	30
83840	Methadone	30
83857	Methemalbumin	10
83858	Methsuximide	15
83861	Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity	By Report
83864	Mucopolysaccharides, acid; quantitative	33
83866	Mucopolysaccharides screen	11
83872	Mucin, synovial fluid (Ropes test)	9
83873	Myelin basic protein, CSF	60

CPT Codes	Description	RVU
83874	Myoglobin	20
83876	Myeloperoxidase (MPO)	By Report
83880	Natriuretic peptide	30
83883	Nephelometry, not specified	15
83885	Nickel	40
83887	Nicotine	37
83915	Nucleotidase 5-	15
83916	Oligoclonal immunoglobulin (bands)	25
83918	Organic acids, total quantitative, each specimen	125
83919	Organic acids, qualitative, each specimen	40
83921	Organic acid, single quantitative	40
83925	Opitates	25
83930	Osmolality, blood	10
83935	Osmolality, urine	10
83937	Osteocalcin (bone gla protein)	15
83945	Oxalate	15
83950	Oncoprotein, HER-2/neu	33
83951	Oncoprotein; des-gamma-carboxy-prothrombin (DCP)	8
83970	Parathyroid hormone	15
83986	ph, body fluid, except blood	8
83987	pH; exhaled breath condensate	8
83992	Phencyclidine (PCP)	15
83993	Calprotectin, fecal	By Report
84022	Phenothiazine	30
84030	Phenylalanine (PKU), blood	20

CPT Code	Description	RVU
84035	Phenylketones, qualitative	8
84060	Phosphatase, acid; total	15
84061	Phosphatase, forensic exam	By Report
84066	Phosphatase, acid; prostatic	15
84075	Phosphatase, alkaline	2
84078	Phosphatase, alkaline, heat stable only	10
84080	Phosphatase, alkaline, isoenzymes	25
84081	Phosphatidylglycerol	120
84085	Phosphogluconate, 6-, dehydrogenase, RBC	39
84087	Phosphohexose isomerase	16
84100	Phosphorus inorganic (phosphate)	2
84105	Phosphorus inorganic (phosphate), urine	10
84106	Porphobilinogen urine; qualitative	12
84110	Porphobilinogen urine; quantitative	13
84112	Placental alpha microglobulin-1 (PAMG-1), cervicovaginal secretion, qualitative	44
84119	Porphyrins, urine; qualitative	16
84120	Porphyrins, quantitation + fractionation	35
84126	Porphyrins, feces; quantitative	30
84127	Porphyrins, feces; qualitative	16
84132	Potassium, serum	4
84133	Potassium, urine	10
84134	Prealbumin	15
84135	Pregnanediol	25
84138	Pregnanetriol	25

CPT Codes	Description	RVU
84140	Pregnenolone	25
84143	17-hydroxypregnenolone	25
84144	Progesterone	15
84145	Procalcitonin (PCT)	150
84146	Prolactin	20
84150	Prostaglandin, each	39
84152	Prostate specific antigen (PSA); complexed	25
84153	Prostate specific antigen (PSA); total	20
84154	Prostate specific antigen (PSA); free	25
84155	Protein; total, except refractometry; serum	2
84156	Protein; total, except refractometry; Urine	10
84157	Protein; total, except refractometry; other source	10
84160	Protein; total, refractometric	4
84163	Pregnancy associated plasma protein-A (PAPP-A)	By Report
84165	Protein; electrophoretic fractionation + quant.	25
84166	Protein; electrophoretic fract + quan., other fluids with concentration	25
84181	Western blot, interpretation and report	60
84182	Western blot + Immunol. Probe for band ident.	75
84202	Protoporphyrin, RBC; quantitative	54
84203	Protoporphyrin, RBC; screen	14
84206	Proinsulin	120
84207	Pyridoxal phosphate (Vitamin B-6)	50
84210	Pyruvate	30
84220	Pyruvate kinase	15

CPT Codes	Description	RVU
84228	Quinine	31
84233	Receptor assay, estrogen	75
84234	Receptor assay, progesterone	75
84235	Receptor assay, endocrine, other	75
84238	Receptor assay, non-endocrine (eg, acetylcholine)	75
84244	Renin	15
84252	Riboflavin (Vitamin B-2)	25
84255	Selenium	40
84260	Serotonin	30
84270	Sex hormone binding globulin (SHBG)	25
84275	Sialic acid	24
84285	Silica	37
84295	Sodium; serum	2
84300	Sodium; urine	10
84302	Sodium, other source	10
84305	Somatomedin	15
84307	Somatostatin	25
84311	Spectrophotometry, analyte nos	25
84315	Specific gravity (except urine)	4
84375	Sugars, chromatographic (TLC/paper)	By Report
84376	Sugars (mono-, di-, oligo) single qual, each spec	8
84377	Sugars, multiple qualitative, each specimen	8
84378	Sugars, single quantitative, each specimen	4
84379	Sugars, multiple quantitative, each specimen	4

CPT Codes	Description	RVU
84392	Sulfate, urine	42
84402	Testosterone, free	15
84403	Testosterone, total	15
84425	Thiamine (Vitamin B-1)	49
84430	Thiocyanate	15
84431	Thromboxane metabolite(s), including thromboxane if performed, urine	25
84432	Thyroglobulin	25
84436	Thyroxine, total	15
84437	Thyroxine, requiring elution (neonatal)	By Report
84439	Thyroxine, free	15
84442	Thyroid binding globulin (TBG)	15
84443	Thyroid stimulating hormone (TSH)	15
84445	Thyroid stimulating immune globulins (TSI)	25
84446	Tocopherol alpha (vitamin E)	30
84449	Transcortiin (cortisol binding globulins)	25
84450	Transferase, aspartate amino (AST)(SGOT)	2
84460	Transferase, alanine amino (ALT)(SGPT)	2
84466	Transferrin	15
84478	Triglycerides	2
84479	Thyroid hormones (T3 or T4) uptake (THBR)	15
84480	Triiodothyronine T3, total (TT-3)	15
84481	Triiodothyronine, free (FT-3)	15
84482	Triiodothyronine, reverse	15
84484	Troponin, quantitative	25

CPT Codes	Description	RVU
84485	Trypsin, duodenal fluid	40
84488	Trypsin, feces qualitative	40
84490	Trypsin, feces, quantitative, 24 hr.	By Report
84510	Tyrosine	16
84512	Troponin, qualitative	8
84520	Urea nitrogen; quantitative	2
84525	Urea nitrogen; semi-quant (reagent strip)	4
84540	Urea nitrogen; urine	10
84545	Urea nitrogen; clearance	12
84550	Uric acid; blood	2
84560	Uric acid; other source	10
84577	Urobilinogen, feces, quantitative	22
84578	Urobilinogen, urine, qualitative	5
84580	Urobilinogen, qualitative, timed specimen	22
84583	Urobilinogen, urine, semiquantitative	By Report
84585	Vanillylmandelic acid (VMA), urine	30
84586	Vasoactive Intestinal Peptide (VIP)	25
84588	Vasopressin (antidiuretic hormone, ADH)	25
84590	Vitamin A	30
84591	Vitamin, not otherwise specified	50
84597	Vitamin K	25
84600	Volatiles (dichlor, alcohol, methanol, etc)	30
84620	Xylose absorption test	30
84630	Zinc	25

CPT Codes	Description	RVU
84681	C-peptide	15
84702	Gonadotropin, chorionic (hCG) quant.	24
84703	Gonadotropin, chorionic (hCG) qualitative	10
84704	Gonadotropin, chorionic (hCG) free beta chain	By Report
84830	Ovulation tests, visual method for LH	By Report
84999	Unlisted chemistry procedure	By Report

Hematology and Coagulation

85002	Bleeding time	15
85004	Blood count, automated differential	4
85007	Blood count, manual differential	10
85008	Blood count, manual exam w/o diff.	5
85009	Blood count, differential WBC, buffy coat	15

CPT Codes	Description	RVU
85013	Blood count, spun microhematocrit	5
85014	Blood count, other than spun hematocrit (Hct)	4
85018	Hemoglobin (Hgb)	4
85025	Hemogram + plt ct. + auto complete diff (CBC)	10
85027	Hemogram and platelet ct. automated	8
85032	Manual cell count, each	10
85041	Blood count, RBC only	4
85044	Reticulocyte count, manual	10
85045	Reticulocyte count, automated	10
85046	Blood count, reticulocytes, hemoglobin conc.	16
85048	Blood ct, automated WBC	4
85049	Platelet, automated	4
85055	Reticulated platelet assay	8
85060	Blood smear, physician interp and report	0
85097	Bone marrow, smear interpretation	0
85130	Chromogenic substrate assay	60
85170	Clot retraction	6
85175	Clot lysis time, whole blood dilution	6
85210	Clotting; factor II, prothrombin, specific	60
85220	Clotting; factor V, labile factor	60
85230	Clotting; factor VII (proconvertin stable factor)	60
85240	Clotting; factor VIII, (AHG), one stage	60
85244	Clotting; factor VIII related antigen	60
85245	Clotting; factor VIII, VW factor, ristocetin cofact	60

CPT Codes	Description	RVU
85246	Clotting; factor VIII, VW factor antigen	60
85247	Von Willebrand's factor, multimetric analysis	120
85250	Clotting; factor IX (PTC or Christmas)	60
85260	Clotting; factor X (Stuart-Prower)	60
85270	Clotting; factor XI (PTA)	60
85280	Clotting; factor XII (Hageman)	60
85290	Clotting; factor XIII (fibrin stabilizing)	60
85291	Clotting factor XIII, screen solubility	25
85292	Clotting prekallikrein assay (Fletcher factor)	50
85293	High MW kininogen (Fitzgerald factor)	50
85300	Clotting inhibitors; antithrombin III, activity	19
85301	Clotting inhibitors; antithrombin III, antigen assay	17
85302	Protein C, antigen	60
85303	Protein C, activity	60
85305	Protein S, total	60
85306	Protein S, free	50
85307	Activated Protein C (APC) resistance assay	60
85335	Factor inhibitor test	60
85337	Thrombomodulin	50
85345	Coagulation time, Lee and White	15
85347	Coagulation time activated	15
85348	Coagulation time, other methods	15
85360	Euglobulin lysis	8
85362	Fibrin degradation products, semiquantitative	15

CPT Codes	Description	RVU
85366	Fibrin degradation products, paracoagulation	15
85370	Fibrin degradation products, quantitative	15
85378	Fibrin degradation prod, D-dimer; qual or semiquant	15
85379	Fibrin degradation prod, D-dimer; quantitative	15
85380	Fibrin degradation prod, D-dimer; ultrasensitive	15
85384	Fibrinogen; activity	9
85385	Fibrinogen; antigen	16
85390	Fibrinolysins screen, interpretation and report	60
85396	Coagulation/fibrinolysis (viscoelastic clot)	60
85397	Coagulation and fibrinolysis, functional activity, not otherwise specified, each analyte	70
85400	Fibrinolytic factors & inhibitors, plasmin	20
85410	Fibrinolytic; alpha 2 antiplasmin	50
85415	Fibrinolytic; plasminogen activator	50
85420	Plasminogen, except antigenic assay	23
85421	Plasminogen, antigen assay	16
85441	Heinz bodies; direct	10
85445	Heinz bodies; induced	10
85460	Hemoglobin fetal, Kleihauer-Betke	23
85461	Hemoglobin, fetal, rosette	15
85475	Hemolysin, acid	8
85520	Heparin assay	23
85525	Heparin neutralization	50
85530	Heparin-protamine tolerance	50
85536	Iron stain, peripheral blood	10
85540	Leukocyte alkaline phospatase with count	20

CPT Codes	Description	RVU
85547	Mechanical fragility, RBC	20
85549	Muramidase	33
85555	Osmotic fragility, RBC; unincubated	21
85557	Osmotic fragility, RBC; incubated	21
85576	Platelet; aggregation (in vitro), each agent	60
85597	Phospholipid neutralization; platelet	50
85598	Phospholipid neutralization; hexagonal phospholipid	50
85610	Prothrombin time	8
85611	Prothrombin time, substitutions, each	24
85612	Russell viper venom time, undiluted	12
85613	Russell viper venom, diluted	15
85635	Reptilase test	20
85651	Sedimentation rate, RBC, non-automat	6
85652	Sedimentation rate, automated	5
85660	RBC sickle cell test	10
85670	Thrombin time, plasma	10
85675	Thrombin time titer	15
85705	Thromboplastin inhibition, tissue	15
85730	Thromboplastin time, partial (PTT)	8
85732	Thromboplastin time, substitutions, fract, each	24
85810	Viscosity	25
85999	Unlisted hematol and coag procedure	By Report

Immunology

86000	Agglutinins; febrile, each antigen	20
86001	Allergen specific lgG, each allergen	By Report

CPT Codes	Description	RVU
86003	Allergen specific lgE, quantitative or semi-quant, each	15
86005	Allergen specific lgE qualitative, multiallergen scr	25
86021	Antibody identification, leukocyte antibodies	40
86022	Antibody identification, platelet antibodies	50
86023	Platelet assoc. Immunoglobulin assay	40
86038	Antinuclear antibodies, (ANA)	15
86039	Antinuclear antibodies, titer	28
86060	Antistreptolysin O titer	25
86063	Antistreptolysin O screen	12
86077	Physician; diff crossmatch and/or eval AB, interp/report	0
86078	Physician; investigation transfusion reaction, interp/report	0
86079	Physician; auth for deviation from standard procedures	0
86140	C-reactive protein	15
86141	C-reactive protein; high sensitivity (hsCRP)	16
86146	Beta 2 Glycoprotein I antibody, each	20
86147	Cardiolipin (phospholipid) antibody, each Ig class	20
86148	Anti-phosphatidylserine antibody	20
86152	Cell enumeration using immunologic selection and identifcation in fluid specimen;	By Report
86153	Cell enumeration using immunologic selection and identifcation in fluid specimen; physician interpretation and report when required	By Report
86155	Chemotaxis assay, specific method	40
86156	Cold agglutinin screen	13
86157	Cold agglutinin titer	26
86160	Complement; antigen each component	25
86161	Complement; funct activ, each component	25
86162	Complement; total hemolytic (CH50)	25
86171	Complement fixation tests, each antigen	15

CPT Codes	Description	RVU
86185	Counterimmunoelectrophoresis, each antigen	20
86200	Cyclic citrullinated peptide (CCP), antibody	25
86215	Deoxyribonuclease, antibody	21
86225	DNA antibody, native or double stranded	31
86226	DNA antibody, single stranded	31
86235	Extractable nuclear antigen, antibody (RNP,JOI)	28
86243	Fc receptor	72
86255	Fluorescent antibody; screen, ea antibody	15
86256	Fluorescent antibody; titer, ea antibody	28
86277	Growth hormone, human (HGH), antibody	30
86280	Hemagglutination inhibition (HAI)	13
86294	Immunoassay, tumor ant, qual/semiquant (bladder tumor)	33
86300	Immunoassay, tumor antigen, quant CA 15-3	33
86301	Immunoassay, tumor antigen, quant CA 19-9	33
86304	Immunoassay, tumor antigen, quant CA 125	33
86305	Human epididymis protein 4	135
86308	Heterophile antibodies, screening	8
86309	Heterophile antibodies, titer	10
86310	Heterophile antibodies, titer after absorption	12
86316	Immunassay, tumor antigen; other, quant, each	33
86317	Immunassay, infect agent antibody, quant, NOS	25
86318	Immunassay, infect agent antibody, qual, single step	15
86320	Immunoelectrophoresis serum	35
86325	Immunoelectrophoresis, other fluid w conc	39
86327	Immunoelectrophoresis (two dimension)	50

CPT Codes	Description	RVU
86329	Immunodiffusion, nos	8
86331	Immunodiffusion gel.qual (Ouchterlony) each	19
86332	Immune complex assay	36
86334	Immunofixation electrophoresis	40
86335	Immunofixation electrophoresis, other fluids	44
86336	Inhibin A	24
86337	Insulin antibodies	37
86340	Instrinsic factor antibody	35
86341	Islet cell antibodies	20
86343	Leukocyte histamine release (LHR)	20
86344	Leukocyte phagocytosis	34
86352	Cellular function assay involving stimulation and detection of biomarker	77
86353	Lymphocyte transformation, induced blastogenesis	77
86355	B cells, total count	50
86356	Mononuclear cell antigen, quantitative, not otherwise specified, each antigen	50
86357	Natural killer cells, total count	50
86359	T cells, total count	50
86360	T cells, absolute CD4, CD8 and ratio	100
86361	T cell, absolute CD4 count	50
86367	Stem cells (CD34), total count	50
86376	Microsomal antibidies (thyroid, liver) each	22
86378	Migration inhibitory factor (MIF)	28
86382	Neutralization test, viral	50
86384	Nitrobllue tetrazolium dye (NTD)	50
86386	Nuclear Matrix Protein 22, qualitative	By Report
86403	Particle agglutination; screen, each antibody	15
86406	Particle aggluination titer, each antibody	30

CPT Codes	Description	RVU
86430	Rheumatoid factor, qualitative	8
86431	Rheumatoid factor, quantitative	10
86480	Tuberculosis test, cell mediated-gamma interferon antigen	35
86481	Tuberculosis test, cell mediated immunity antigen response measurement; enumeration of gamma interferon-producing t-cells in cell suspension	40
86485	Skin test; candida	By Report
86486	Skin test; unlisted antigen, each	By Report
86490	Skin test; coccidioidomycosis	By Report
86510	Skin test; histoplasmosis	By Report
86580	Skin test; tuberculosis, intradermal	By Report
86590	Streptokinase antibody	17
86592	Syphilis test; qualitative (eg, VDRL, RPR, ART)	8
86593	Syphilis test; quantitative	10
86602	Actinomyces antibody	33
86603	Adenovirus, antibody	33
86606	Aspergillus antibody	33
86609	Bacterium, not specified, antibody	33
86611	Bartonella, antibody	33
86612	Blastomyces, antibody	33
86615	Bordetella antibody	33
86617	Borrelia burgdorferi (Lyme) confirmatory (WB)	60
86618	Borrelia burgdorferi (Lyme) antibody	25
86619	Borrelia (relapsing fever) antibody	33
86622	Brucella, antibody	33
86625	Campylobacter; antibody	33

CPT Codes	Description	RVU
86628	Candida antibody	33
86631	Chlamydia, antibody	20
86632	Chlamydia, IgM antibody	20
86635	Coccidioides, antibody	33
86638	Coxiella Burnetii (Q fever) antibody	33
86641	Cryptococcus antibody	47
86644	CMV antibody	15
86645	CMV antibody, IgM	25
86648	Diphtheria antibody	33
86651	Encephalitis, California, antibody	47
86652	Encephalitis, Eastern equine, antibody	47
86653	Encephalitis, St. Louis, antibody	47
86654	Encephalitis, Western equine, antibody	47
86658	Enterovirus (cox, echo, polio) antibody	40
86663	Epstein-Barr (EB) virus; EA antibody	33
86664	Epstein-Barr (EB) virus; EBNA antibody	33
86665	Epstein-Barr (EB) VCA antibody	47
86666	Ehrlichia, antibody	33
86668	Francisella tularensis antibody	47
86671	Fungus, not specified, antibody	By Report
86674	Giardia lamblia antibody	25
86677	Helicobacter pylori antibody	25
86682	Helminth, not elsewhere spec. antibody	33
86684	Haemophilus influenza, antibody	47

CPT Codes	Description	RVU
86687	HTLV I, antibody	33
86688	HTLV II, antibody	33
86689	HTLV or HIV antibody confirmatory (WB), antibody	75
86692	Hepatitis, delta agent, antibody	33
86694	Herpes simplex, nonspec type, antibody	25
86695	Herpes simplex, type I, antibody	25
86696	Herpes simplex, type 2, antibody	25
86698	Histoplasma, antibody	20
86701	HIV-1, antibody	25
86702	HIV-2, antibody	33
86703	HIV-1/HIV-2, single assay, antibody	25
86704	Hep B core antibody (HBcAb); total	20
86705	Hep B core antibody; IgM	20
86706	Hepatitis B surface antibody (HbsAB)	20
86707	Hepatitis Be antibody (HbeAB)	20
86708	Hepatitis A antibody (HAAb); total	20
86709	Hepatitis A antibody; IgM	20
86710	Influenza virus antibody	30
86711	Antibody; JC Virus	20
86713	Legionella antibody	20
86717	Leishmania antibody	20
86720	Leptospira antibody	20
86723	Listeria monocytogenes antibody	20
86727	Lymphocytic choriomeningitis antibody	20
86729	Lymphogranuloma Venereum antibody	20

CPT Codes	Description	RVU
86732	Mucormycosis antibody	20
86735	Mumps antibody	20
86738	Mycoplasma antibody	20
86741	Nisseria meningitidis antibody	20
86744	Nocardia; antibody	20
86747	Parvovirus antibody	30
86750	Plasmodiium (malaria); antibody	25
86753	Protozoa, not elsewhere specified; antibody	By Report
86756	Respiratory syncytial virus; antibody	25
86757	Rickettsia antibody	20
86759	Rotavirus; antibody	25
86762	Rubella antibody	15
86765	Rubeola; antibody	20
86768	Salmonella antibody	60
86771	Shigella antibody	20
86774	Tetanus; antibody	25
86777	Toxoplasma; antibody	25
86778	Toxoplasma, IgM; antibody	25
86780	Antibody; Treponema pallidum	17
86784	Trichinella; antibody	20
86787	Varicella-zoster antibody	20
86788	Antibody; West Nile Virus IgM	20
86789	Antibody; West Nile Virus	20
86790	Virus, not specified; antibody	By Report
86793	Yersinia; antibody	20
86800	Thyroglobulin antibody	25

CPT Codes	Description	RVU
86803	Hepatitis C antibody	25
86804	Hepatitis C antibody; confirmatory test	100
86805	Lymphocytotoxicity assay, w titration	75
86806	Lymphocytotoxicity assay, without titration	50
86807	Cytotoxic percent reactive antibody (PRA), std method	100
86808	Cytotoxic precent reactive antibody (PRA), quick method	47
86812	HLA typing, A, B, or C, single antigen	45
86813	HLA typinig, A, B, or C, multiple antigens	125
86816	HLA typing DR/DQ, single antien	115
86817	HLA typing DR/DQ, multiple antigens	230
86821	Lymphocyte culture, mixed (MLC)	150
86822	Lymphocyte culture, primed (PLC)	150
86825	Human leukocyte antigen crossmatch, non-cytotoxic; first serum sample or dilution	442
86826	Human leukocyte antigen crossmatch, non-cytotoxic; each additional serum sample or dilution	By Report
86828	Antibody to human leukocyte antigens, solid phase assays; qualitative assessment of presence or absence of antibody to HLA Class I and Class II HLA antigens	By Report
86829	Antibody to human leukocyte antigens, solid phase assays; quantitative assessment of presence or absence of antibody to HLA Class I and Class II HLA antigens	By Report
86830	Antibody to human leukocyte antigens, solid phase assays; antibody identification by qualitative panel using complete HLA phenotypes HLA Class I	140

CPT Codes	Description	RVU
86831	Antibody to human leukocyte antigens, solid phase assays; antibody identification by qualitative panel using complete HLA phenotypes HLA Class II	140
86832	Antibody to human leukocyte antigens, solid phase assays; high definition qualitative panel for identification of antibody specificities, HLA Class I	140
86833	Antibody to human leukocyte antigens, solid phase assays; high definition qualitative panel for identification of antibody specificities, HLA Class II	140
86834	Antibody to human leukocyte antigens, solid phase assays; semi-quantitative panel, HLA class I	By Report
86835	Antibody to human leukocyte antigens, solid phase assays; semi-quantitative panel, HLA class II	By Report
86849	Unlisted immunology procedure	By Report

Transfusion Medicine

86850	Antibody screen, RBC ea technique	12
86860	Antibody elution, RBC, each elution	20
86870	Antibody ident, RBC antibodies, ea panel	30
86880	Coombs test, direct, ea antiserum	8
86885	Coombs test, indirect, qualitative, ea antiserum	12
86886	Coombs test, indirect titer, ea antiserum	32
86890	Autologous bld, collect, proc, store; predeposited	170
86891	Autologous intra or post operative salvage	525
86900	Blood typing, ABO	4
86901	Blood typing, Rh(D)	4
86902	Blood typing; antigen testing of donor blood using reagent serum,each antigen test	15
86904	Blood typing, antigen screen, using patient serum, per unit	12
86905	Blood typing, RBC antigens, other than ABO, Rh, each	15
86906	Blood typing, Rh phenotyping, complete	30
86910	Blood typing, paternity, per individual	64
86911	Blood typing, paternity, each additional antigen system	30
86920	Compatibility test each unit, immediate spin	8
86921	Compatibility test, incubation technique	1
86922	Compatibility, antiglobulin technique	10
86923	Compatibility test, electronic	6
86927	Fresh frozen plasma, thaw, each unit	4
86930	Fresh blood, prepare/freeze, each unit	80
86931	Frozen blood, thaw, each unit	120
86932	Frozen blood, prepare/freeze/thaw, each unit	240
86940	Hemolysins/agglutinins; auto screen, each	13
86941	Hemolysins/agglutinins, incubated	18
86945	Irradiation of blood prod, each unit	80
86950	Leukocyte transfusion	600

CPT Codes	Description	RVU
86960	Volume reduction of blood/product, each unit	20
86965	Pooling of platelets or blood products	20
86970	Pretreatment of RBC's incubate with chem, each	31
86971	Pretreatment of RBC's incubate with enzymes, each	31
86972	Pretreatment by density gradient	31
86975	Pretreatment of serurm, inc with drugs, each	31
86976	Pretreatment of serum by dilution	31
86977	Pretreatment of serum, incub with inhititors, each	31
86978	Pretreatment of serum, by diff RBC absorption, each	100
86985	Splitting of blood or blood prod each unit	20
86999	Unlisted transfusion medicine procedure	By Report

Microbiology

CPT Codes	Description	RVU
87001	Small animal inoculation, w/observation	100
87003	Small animal inoculation and dissection, w/ observation	150
87015	Specimen concentration (any type), for infectious agents	20
87040	Blood culture-bact, isol, presumpt. ident, aero w/wo anaero	40
87045	Stool culture-Salmonella and Shigella, pres. Ident., aero	30
87046	Stool culture for additional pathogens, ea plate, aero	10
87070	Culture, bacteria, source exc. Blood, urine, stool, aero	40
87071	Culture, aerobic, quant, exc blood, urine, stool	40
87073	Culture, anaerobic, quant, exc blood urine, stool	40
87075	Culture, anaerobic, quant, any source	40
87076	Definitive identification, anaerobic	10
87077	Definitive identification, aerobic	10
87081	Culture, bacterial screen	20
87084	Culture w colony estimate, density chart	20
87086	Urine culture, colony count	20
87088	Urine culture, isol, presump.identification	10
87101	Fungus culture, presump. identification skin/hair/nail, isol	25
87102	Fungus culture, presump. Ident, other source exc blood	25
87103	Fungus culture, presump. Identification, blood	30

CPT Codes	Description	RVU
87106	Fungi, definitive identification, each yeast	10
87107	Fungi, definitive identification, each mold	10
87109	Culture, Mycoplasma, any source	31
87110	Culture, Chlamydia, any source	31
87116	Culture, Tubercule or other; isolation, ultipl.ident	60
87118	Mycobacteria, definitive ident, each isolate	76
87140	Culture typing, fluorescent method, each antiserum	20
87143	Culture typing, GLC or HPLC method	40
87147	Culture typing, immunologic, per antiserum	20
87149	Culture typing, ident by nucleic acid probe	25
87150	Culture typing; identification by nucleic acid (DNA or RNA) probe, amp probe tech, per culture or isolate, ea org probed	25
87152	Culture ident by pulse field gel typing	68
87153	Culture typing; identification by nucleic acid sequencing method, each isolate	By Report
87158	Culture typing, other methods	10
87164	Dark field exam any source, includes collection	25
87166	Dark field exam any source, w/o collection	25
87168	Macroscopic exam, arthropod	20
87169	Macroscopic exam, parasite	20
87172	Pinworm exam, cellophane tape prep	6
87176	Homogenization, tissue, for culture	150
87177	Ova and parasite, dir.smear, conc.and ident	40
87181	Susceptibility, agar dil. Each agent (grad.strip)	10
87184	Susceptibility, up to 12 disks, per plate	10
87185	Susceptibility, enzyme detection, per enzyme	5
87186	Susceptibility, MIC or breakpoint, multi, per plate	10
87187	Susceptibility, MLC, per plate (add to primary MIC)	10

CPT Codes	Description	RVU
87188	Susceptibility, macrobroth dilution, each agent	10
87190	Susceptibility (mycobacteria), proportion, each agent	15
87197	Serum bactericidal titer (Schlicter)	45
87205	Smear, primary source, bact, fung, cells	20
87206	Smear, fluor or acid fast, bact, fung, cells, etc.	20
87207	Smear, stain for inclusion bodies or parasites.	15
87209	Smear, complex special stain for ova & parasites	10
87210	Smear, wetmount, infect. Agents (eg: KOH, India Ink)	8
87220	Tissue exam (KOH) for fungi, ectoparasites, mites	15
87230	Toxin or antitoxin assay, tissue cult. (eg: C, diff toxin)	30
87250	Virus isol, egg/animal inoculation, observ+dissection	100
87252	Virus tissue culture, inoculation, observ, CPE ident	100
87253	Virus tissue cult, addit. Studies or ID, each isolate	25
87254	Virus isolation, shell vial, incl ident, IF stain, each virus	30
87255	Virus isol, incl ID by non-immuno method non-cyto effect	60
87260	Adenovirus antigen, immunofluorescent technique	25
87265	Bordetella pertussis/parapertussis antigen, IFA	25
87267	Enterovirus, direct fluroscent antibody (DFA)	25
87269	Giardia, antigen, primary source, IFA	25
87270	Chlamydia trachomatis antigen, IFA	25
87271	Cytomegalovirus dir. Fluorescent antibody (DFA)	25
87272	Cryptosporidium antigen, IFA	25
87273	Herpes simplex virus type 2, primary source, IFA	25
87274	Herpes simplex virus type 1, primary source, IFA	25

CPT Codes	Description	RVU
87275	Influenza B virus antigen, primary source, IFA	25
87276	Influenza A virus antigen, primary source, IFA	25
87277	Legionella micdadei antigen, primary source, IFA	25
87278	Legionella pneumophila antigen, IFA	25
87279	Parainfluenza virus, each type, antigen, IFA	25
87280	Respiratory syncytial virus antigen, IFA	25
87281	Peumocystis carinii antigen, IFA	25
87283	Rubeola antigens IFA	25
87285	Treponema pallidum antigen, IFA	25
87290	Varicella zoster virus antigen, IFA	25
87299	Infectious agent antigen, nos, IFA	25
87300	Infectious agent AG, IFA, each polyvalent antisera	25
87301	Adenovirus 40/41 antigen, EIA, multi step	25
87305	Infectious agent antigen detection by enzyme immunoassay technique, qual or semiquant mult step meth; Aspergillus	25
87320	Chlamydia trachomatis antigen, EIA	25
87324	Clostridium difficile toxin(s) antigen, EIA	25
87327	Cryptococcus neoformans antigen, EIA	25
87328	Crytosporidum antigen, EIA	25
87329	Giardia antigen, EIA	25
87332	Cytomegalovirus antigen, EIA	25
87335	E. coli 0157 antigen, EIA	25
87336	Entamoeba histolytica dispar group, EIA	40
87337	Entoamoeba histolytica group, EIA	40
87338	Helicobacter pylori, stool	30
87339	Helicobacter pylori, EIA	25

CPT Codes	Description	RVU
87340	Hepatitis B surface antigen (HbsAg), EIA	25
87341	Hepatitis B surface antigen (HbsAG) neutralization	25
87350	Hepatitis Be antigen (HbsAg), EIA	20
87380	Hepatitis, Delta agent antigen EIA	25
87385	Histoplasma capsullatum antigen, EIA	40
87389	Infectious agent antien detection by enzyme immunoassay technique, qual or semiquant mult step meth; HIV-1 antigen w/HIV-1 & HIV-2 antibodies, single result	25
87390	HIV-1 ag, EIA	40
87391	HIV-2 ag, EIA	40
87400	Influenza, A or B, each	40
87420	Respiratory syncytial virus ag, EIA	25
87425	Rotavirus ag, EIA	25
87427	Shiga-like toxin ag, EIA	25
87430	Streptococcus Group A antigen, EIA	25
87449	Infectious agent ag nos, multiple step, each organism	By Report
87450	Infectious agent ag nos, single step, each organism	By Report
87451	Infectious agent ag, multi step, each antiserum	25
87470	Bartonella, DNA, dir probe	120
87471	Bartonella DNA, amp probe	120
87472	Bartonella DNA, quantification	160
87475	Borrelia burgdorferi, dna, dir probe	120
87476	Borrelia burgdorferi, DNA, amp probe	120
87477	Borrelia burgdorferi, DNA, quantification	160
87480	Candida, DNA dir probe	120
87481	Candida, DNA, amp, probe	120
87482	Candida, DNA, quant	160

CPT Codes	Description	RVU
87485	Chlamydia pneumoniae, DNA, dir probe	120
87486	Chlamydia pneumoiuae, DNA, amp probe	120
87487	Chlamydia pneumoniae, DNA, quant	160
87490	Chlamydia trachomatis, DNA, dir probe	45
87491	Chlamydia trachomatis, DNA, amp probe	45
87492	Chlamydia trachomatis, DNA, quant	160
87493	Infectious agent detection by nucleic acid; Clostridium difficile, toxin genes, amp probe tech	120
87495	Cytomegalovirus, direct probe	120
87496	Cytomegalovirus, amp probe	120
87497	Cytomegalovirus, quantification	160
87948	Infectious agent detection by nucleic acid; enterovirus, reverse transcription and amp probe tech	120
87500	Vancomycin resistance, amp probe tech	120
87501	influenza virus, reverse trans and amp probe tech, ea type	160
87502	influenza virus for mult types, multiplex reverse trans and amp probe tech, first 2 types or sub-types	160
87503	influenza virus for mult types, ultiplex reverse trans and amp probe tech, ea addl influenza virus type beyond 2	By Report
87510	Gardnerella vaginalis, DNA, dir probe	120
87511	Gardnerella vaginalis, DNA, amp probe	120
87512	Gardnerella vaginalis, DNA, quantification	160
87515	Hepatitis B virus, DNA, dir probe	120
87516	Hepatitis B virus, DNA, amp probe	120
87517	Hepatitis B virus, DNA, quantification	160
87520	Hepatitis C, DNA, direct probe	140
87521	Hepatitis C, DNA, amp probe	140
87522	Hepatitis C, DNA, quantification	160
87525	Hepatitis G, DNA, direct probe	120
87526	Hepatitis G, DNA, amp probe	120
87527	Hepatitis G, DNA, quantification	160
87528	Herpes simplex virus, DNA, direct probe	120
87529	Herpes simplex virus, DNA, amp probe	120
87530	Herpes simplex virus, DNA, quantification	160

CPT Codes	Description	RVU
87531	Herpes virus-6, DNA, direct probe	120
87532	Herpes virus-6, DNA, amp probe	120
87533	Herpes virus-6, DNA, quantification	160
87534	HIV-1, DNA, direct probe	120
87535	HIV-1, DNA, amp probe	120
87536	HIV-1, DNA, quantification	160
87537	HIV-2, DNA, direct probe	120
87538	HIV-2, DNA, amp probe	120
87539	HIV-2, DNA, quantification	160
87540	Legion pneumo, DNA, direct probe	120
87541	Legion pneumo, DNA, amp probe	120
87542	Legion pneumo, DNA quantification	160
87550	Mycobacteria, DNA, direct probe	120
87551	Mycobacteria, DNA, amp probe	120
87552	Mycobacteria, DNA quantification	160
87555	M. tuberculosis, DNA direct probe	120
87556	M. tuberculosis, DNA, amp probe	120
87557	M. tuberculosis, DNA quantification	160
87560	M. avium-intracellulare, DNA, direct probe	120
87561	M. avium-intracellulare, DNA amp probe	120
87562	M. avium-intracellulare, DNA quantification	160
87580	Mycoplasma pneumoniae, DNA, direct probe	120
87581	Mycoplasma pneumoniae, DNA, amp probe	120
87582	Mycoplasma pneumoniae, DNA quantification	160

CPT Codes	Description	RVU
87590	N. gonorrhoeae, DNA direct probe	45
87591	N. gonorrhoeae, DNA, amp direct probe	45
87592	N. gonorrhoeae, DNA quantification	160
87620	Human papillomavirus, DNA, direct probe	120
87621	Human papillomavirus, DNA, amp probe	120
87622	Human papillomavirus, DNA quantification	160
87631	Respiratory virus, multiplex reverse transcription and amp probe tech, mult types or subtypes, 3-5 targets	60
87632	Respiratory virus, multiplex reverse transcription and amp probe tech, mult types or subtypes, 6-11 targets	120
87633	Respiratory virus, multiplex reverse transcription and amp probe tech, mult types or subtypes, 12-25 targets	180
87640	Staphylococcus aureus, amplified probe tech	120
87641	Staphylococcus aureus, methicillin resistant, amp probl tech	120
87650	Streptococcus Group A DNA, direct probe	120
87651	Streptococcus Group A DNA, amp probe	120
87652	Streptococcus Group A DNA, quantification	160
87653	Streptococcus, group B, amp probe tech	120
87660	Trichomonas vaginalis, DNA, direct probe	45
87661	Infectious agent detection by nucleic acid (DNA or RNA); trichomonas vaginalis, amplified probe technique	45
87797	Infectious agent, nucleic acid, nos, direct probe, eaorg.	120
87798	Infectious agent, nucleic acid, amp probe, nos, each org.	120
87799	Infectious agent nucleic acid, nos, quant	160
87800	Infectious agent, DNA, multiple orgs, direct probe	120
87801	Infectious agent, DNA, multiple orgs, amplified probe	120
87802	Immunoassay, direct optical, Strep Gr B	25
87803	Immunoassay, direct optical, C. Difficile toxin A	25
87804	Immunoassay, direct optical, Influenza	25
87807	Immunoassay, respiratory syncytial virus	25
87808	Infectious agent antigen detection by immunoassay w/direct optical obv; Trichomonas vaginalis	25
87809	Infectious agent antigen detection by immunoassay w/direct optical obv; adenovirus	25
87810	Immunoassay, direct optical Chalamydia trachomatis	25

CPT Codes	Description	RVU
87850	Immunoassay, direct optical, N-gonorrhoeae	25
87880	Immunoassay, direct optical, Strep Crr. A	25
87899	Immunoassay, direct optical, nos	25
87900	Infectious agent drug susceptibility phenotype prediction	By Report
87901	Genotype by nucleic acid, HIV, RT and Protease	340
87902	Genotype by nucleic acid, Hepatitis C	340
87903	Phenotype, HIV, DNA, drug resistance, up to 10 drugs	340
87904	Phenotype, HIV, DNA, each additional drug, 1–5 (add on)	340
87905	Infectious agent enzymatic activity other than virus	By Report
87906	Infectious agent genotype analysis by nucleic acid; HIV-1 other region	By Report
87910	Infectious agent genotype analysis by nucleic acid; cytomegalovirus	By Report
87912	Infectious agent genotype analysis by nucleic acid; Hepatitis B virus	By Reoprt
87999	Unlisted microbiology procedure	By report

Anatomic Pathology

88000	Necropsy, gross exam only, without CNS	0*unbillable Code
88005	Necropsy, gross exam only, with brain	0*unbillable Code
88007	Necropsy, gross exam only, with brain and spinal cord	0*unbillable Code
88012	Necropsy, gross exam only, infant with brain	0*unbillable Code
88014	Necropsy, gross exam only, stillborn or newborn with brain	0*unbillable Code
88016	Necropsy, gross exam only, macerated stillborn	0*unbillable Code
88020	Necropsy gross and microscopic; without CNS	0*unbillable Code
88025	Necropsy gross and microscopic; with brain	0*unbillable Code
88027	Necropsy gross and microscopic; with brain and spinal cord	0*unbillable Code
88028	Necropsy gross and microscopic; infant with brain	0*unbillable Code
88029	Necropsy gross and microscopic; stillborn or newborn with brain	0*unbillable Code
88036	Necropsy, limited, gross and/or microscopic; regional	0*unbillable Code
88037	Necropsy, limited, gross and/or microscopic; single organ	0*unbillable Code
88040	Necropsy; forensic exam	0*unbillable Code
88045	Necropsy, coroners call	0*unbillable Code
88099	Unlisted necropsy procedure	0*unbillable Code

Cytopathology

88104	Cytopath, Fluid/Wash/Brush, Sm + interp	30
88106	Cytopath, filter meth only, interpretation	70
88108	Cytopath, smear + conc, interpret	70
88112	Cytopath, selective cellular enhancement	100
88120	Cytopath, in situ hybridization, urinary tract specimen w/morophometric analysis, 3-5 molecture probes each specimen; manual	By Report
88121	Cytopath, in situ hybridization, urinary tract specimen w/morophometric analysis, 3-5 molecture probes each specimen; using computer assisted tech	By Report
88125	Cytopath, forensic (eg, sperm)	20
88130	Sex chromatin ident. (Barr bodies)	20
88140	Sex chromatin ident, peripheral blood	20
88141	Cytopath, cerv/vag interp by physician	20
88142	Cytopath, cerv/vag thin layer, cytotech	40
88143	Cytopath, man scr and re-screen, phys suprv	50
88147	Cytopath, cerv/vag, auto screen, phys suprv	20
88148	Cytopath, auto screen w manual re-screen	50
88150	Cytopath, slides, cerv/vag, man scr, phys suprv	20
88152	Cytopath cerv/vag, man scr, comput re-screen	40
88153	Cytopath, slides, man scr, rescr, phys suprv	30

CPT Codes	Description	RVU
88154	Cytopath, slides, man scr, comp rescr, review, phys sup	50
88155	Cytopath cerv/vag, hormonal evaluation (add on)	22
88160	Cyto smears, other, screen & interp	30
88161	Cyto, prep, screening & interpretation	70
88162	Cyto, Extended study > 5 slides, mult. Stains	75
88164	Cytopath, slides, cerv/vag, TBS, man scr, phys sup	20
88165	Cyto, slides, cervvag, TBS, man scr, rescr phys sup	30
88166	Cyto, slides, TBS, man scr, comp rescr, phys suprv	40
88167	Cyto, slides, TBS, man scr, comp rescr, cell select	55
88172	FNA, immediate adequacy of specimen	60
88173	FNA, interpretation and report	90
88174	Cyto, auto thin prep & scr, phys sup	By Report
88175	Cyto, auto thin prep & scr, man rescr	By Report
88177	immediate cytohisto study to determine adequacy for diagnosis, each add'l eval episode, same site	30
88182	Flow cytometry, cell cycle or DNA analysis	150
88184	Flow cytometry, cell surface, TC only	50
88185	Flow cytometry, cell surface, TC only, ea addl marker	50
88187	Flow cytometry, interpretation, 2–8 markers	0
88188	Flow cytometry, interpretation, 9–15 markers	0
88189	Flow cytometry, interpretation, 16 or more markers	0
88199	Unlisted cytopathology procedure	By Report

Cytogenetic Studies

88230	Tissue culture, lymphocyte	100
88233	Tissue culture, skin or solid tissue biopsy	200
88235	Tissue culture, amniotic fluid or chorionic villus	150
88237	Tissue culture, bone marrow, blood cells	150

CPT Codes	Description	RVU
88239	Tissue culture, solid tumor	250
88240	Cryopreservation, freeze, store, each cell line	50
88241	Thawing, expansion, frozen cells, each aliquot	100
88245	Chromosome anal, breakage, (SCE) 20–25 cells	320
88248	Chromosome anal, breakage, 50–100 cells, 2kary	400
88249	Chromosome anal, 100 cells, clastogen stress	465
88261	Chromosome anal, 5 cells, 1 kary, banding	125
88262	Chromosome count: 15–20 cells, 2 kary, banding	320
88263	Chromosome analysis: 45 cells, 2 kary, banding	400
88264	Chromosome analysis, 20–25 cells	400
88267	Chromosome anal, amn fl/chorion villus, 15 cells, 1 kary	300
88269	Chromosome anal, in situ for amn fluid, 6–12 colonies	300
88271	Cytogenetics, Molecular, DNA probe, each (FISH)	50
88272	Cytogenetics, Molecular, chrom in situ hyb, 3–5 cells	150
88273	Cytogenetics, Molecular; chrom in situ hyb, 10–30 cells	175
88274	Cytogenetics, Molec, interphase in situ hyb, 25–99 cells	200
88275	Cytogenetics, Molec, interphase in situ hyb, 100–300 cells	230
88280	Chromosome analysis, add karyotypes, each study	20
88283	Chromosome anal, additional banding technique	75
88285	Chromosome anal, additional cells counted, each study	20
88289	Chromosome anal, additional high resolution study	100
88291	Cytogenetics and Mol. cytogenetics, interp and report	By Report
88299	Unlisted Cytogenetic Study	By Report

Surgical Pathology

CPT Codes	Description	RVU
88300	Surg path, level I gross exam only	20
88302	Surg path, level II gross & microscopic	25
88304	Surg path level III gross & microscopic	40
88305	Surg path level IV gross & microscopic	60
88307	Surg path, level V gross & microscopic	100
88309	Surg path, level VI gross & microscop	125
88311	Decalcification procedure (add on)	5
88312	Special stains, Grp I (eg, Gridley, AFB, Methenamine) ea	15
88313	Special stains, Group II (eg, iron, trichrome), ea	10
88314	Histochemical staining w frozen section(s)	30
88319	Determinative histochem. ID enzyme constituents	50
88321	Consultation report, referred slides	non-regulated
88323	Consultation report, referred material w slide preparation	non-regulated
88325	Consultation, comprehensive, referred materials	non-regulated
88329	Pathology consultation, during surgery	20
88331	Path consult with frozen section(s), single specimen	30
88332	Path consult, each additional block frozen sections	5
88333	Path consult, cyto exam, initial site	50
88334	Path consult, cyto exam, ea addl site	30
88342	Immunohistochemistry, each antibody	60
88343	Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear, each additional separately idenfiable antibody per slide (list separately in addition to code for primary procedure)	60
88346	Immunofluorscent, direct method, ea antibody	60
88347	Immunofluorescent study, indirect method, ea antibody	80
88348	Electron microscopy, diagnostic	400

CPT Codes	Description	RVU
88349	Electron microscopy, scanning	400
88355	Morphometric analysis, skeletal muscle	By Report
88356	Morphometric analysis, nerve	By Report
88358	Morphometric analysis, tumor	By Report
88360	Tumor IHC quant or semi quant., ea antibody, manual	75
88361	Tumor IHC; quant or semi-quant, computer assist	90
88362	Nerve teasing preparations	By Report
88363	Exam and selection of retrieved archival tissue for mol analysis	By Report
88365	Tissue in situ hybridization, interpretation & report	By Report
88367	Morphometric analysis, in situ hybridization each probe; using computer-assisted tech	By Report
88368	Morphometric analysis, in situ hybridization each probe; manual	By Report
88371	Protein analysis of tissue by WB, interpret. & report	60
88372	Protein analysis, WB, Immun probe for band ident, each	75
88375	Optical endomicroscopic image, interp & report, each endo session	By Report
88380	Microdissection (mechanical, laser capture)	By Report
88381	Microdissection; manual	By Report
88387	Macroscopic exam, dissection and prep of tissue for non-micro analytical studies; each tissue prep	By Report
88388	Macroscopic exam, dissection and prep of tissue for non-micro analytical studies; in conjunction w/touch imprint, intraop consult, or frozen section, each tissue prep	By Report
88399	Unlisted surgical pathology procedure	By Report

Transcutaneous Procedures

CPT Codes	Description	RVU
88720	Bilirubin, total, transcutaneous	By Report
88738	Hemoglobin (Hcg), quantitative, transcutaneous	By Report
88740	Hemoglobin (Hcg), quantitative, transcutaneous, per day; carboxyhemoglobin	By Report
88741	Hemoglobin (Hcg), quantitative, transcutaneous, per day; methemoglobin	By Report
88749	Unlisted in vivo	By Report

Other Procedures

89049	Caffeine Halothane test for malignant hyperthermia...	By Report
89050	Cell count, body Fluids, except blood	20
89051	Cell count, body fluids, exc bld with differential count	25
89055	Leukocyte assessment, fecal, qual or semiquant	5
89060	Crystal identification by microscopy (except urine)	15
89125	Fat stain, feces, urine, or respiratory secretions	15
89160	Meat fibers, feces	8
89190	Nasal smear for eosinophils	8
89220	Sputum, obtain, aerosol induced technique	By Report
89230	Sweat collection by iontophoresis	30
89240	Unlisted misc. pathology test	By Report

Reproductive Medicine Procedures

CPT Codes	Description	RVU
89250	Culture of oocyte(s)/embryo(s), <4 days	By Report
89251	Culture of oocyte(s)/embryo(s) with co-culture of oocytes	By Report
89253	Assisted embryo hatching, microtechniques	By Report
89254	Oocyte identification from follicular fluid	By Report
89255	Preparation of embryo for transfer	By Report
89257	Sperm identification from aspiration	By Report
89258	Cryopreservation; embryo(s)	By Report
89259	Cryopreservation; Sperm	By Report
89260	Sperm isolation; simple prep for insemination	By Report
89261	Sperm isolation; complex prep	By Report
89264	Sperm identification from testis tissue	By Report
89268	Insemination of oocytes	By Report
89272	Extended culture of oocytes/embryos 4–7 days	By Report
89280	Assisted oocyte fertilization, </= 10 oocytes	By Report
89281	Assisted oocyte fertilization, greater than 10 oocytes	By Report
89290	Biopsy, oocyte, microtechnique, </= 5 embr.	By Report
89291	Biopsy, oocyte, microtechnique, > 5 embr.	By Report
89300	Semen analysis, presence + motility, incl Huhner	8
89310	Semen analysis, motility and count, not incl Huhner	14
89320	Semen anal, complete (vol. count, motility + differential)	29
89321	Semen anal, presence and/or motility of sperm	By Report
	[see also G0027]	
89322	Semen analysis; volume count, motility and differential using strict morphologic criteria	0
89325	Sperm antibody test	17
89329	Sperm evaluation, hamster penetration	50
89330	Sperm/cervical mucous penetration test	23
89331	Sperm evaluation, for retrograde ejaculation, urine	By Report
89335	Cryopreservation, reprod. Tissue, testicular	By Report
89342	Storage, (per year): embryo(s)	By Report
89343	Storage, (per year): sperm/semen	By Report

CPT Codes	Description	RVU
89344	Storage, reproductive tissue, testic/ovarian	By Report
89346	Storage, oocyte	By Report
89352	Thawing of cryopreserved; embryo(s)	By Report
89353	Thawing of cryopreserved; semen/sperm	By Report
89354	Thawing of cryopreserved; reprod tissue	By Report
89356	Thawing of cryopreserved; oocytes, ea aliquot	By Report
89358	Unlisted reproductive medicine lab proc	By Report

Therapeutic Phlebotomy

99195	Therapeutic Phlobotomy	50

New Technology

0023T	HIV Virtual Phenotype	By Report

HCPCS - Level II

CPT Codes	Description	RVU
G0027	Semen analysis; presence and/or motility [see 89321]	By Report
G0107	CA screen; fecal blood test [see 82270]	5
G0123	Screen cytopath, auto thin prep, phys superv [see 88142]	By Report
G0124	Screen cytopath, auto thin prep, phys interp [see 88141]	By Report
P2038	Mucoprotein, blood	By Report
P3000	Screening Pap, by technician	Based on method
P3001	Screening Pap, interp by physician [See 88141]	By Report
Q0111	Wet mounts, incl vaginal, cervical, and skin prep	10
Q0112	All potassium hydroxide preps	15
Q0113	Pinworm exam	6
Q0114	Fern test	10
Q0115	Post-coital direct, qual exam, vag or cerv mucous	14

Addendum I

Blood Products	RVU value
Whole Blood	135
Red Blood Cells	90
Fresh Frozen Plasma	40
Platelet, Concentrated	55
Platelet, Pheresed	460

Manipulations	RVU value
Washing*	70
Freezing (80 and deglycerolization (90)	170
Aliquot and splitting (RBCs)	20
Irradiation	80
Leukoreduction RBC	55
Leukoreduction platelet, pheresed	40
Leukoreduction platelet, concentrate, per unit	5
CMV tested	20
Plasma cyroprecipitate reduced	10
Irradiation per platelet concentrate	10
HLA-matching, A, B, C, multiple	125
Autologous/Directed	125

*Freezing and deglycerolization includes washing.

HCPCS Code	Description	RVU value
P9010	Whole Blood for transfusion, per unit (non autologous)	135
P9010	Whole Blood for transfusion, per unit (autologous)	260
P9011	Blood (split unit), specify amount (for Pediatrics)	110
P9012	Cryoprecipitate, ea unit	35
P9016	RBC leukoreduced, ea unit (non autologous)	145
P9016	RBC leukoreduced, ea unit (autologous)	270
P9017	Fresh frozen plasma (sgl donor), frozen 8 hrs of collect, ea (non autologous)	40
P9017	Fresh frozen plasma (sgl donor), frozen 8 hrs of collect, ea (autologous)	165
P9019	Platelets, ea unit	55
P9020	Platelet rich plasma, ea unit	By Report
P9021	RBC, ea unit (non autologous)	90
P9021	RBC, ea unit (autologous)	215
P9022	RBC, washed, ea unit (non autologous)	160
P9022	RBC, washed, ea unit (autologous)	285

P9023	Plasma, multi-donor, solvent/detergent treated, froz, ea	120
P9031	Platelets, leukoreduced, ea unit	60
P9032	Platelets, irradiated, ea unit	65
P9033	Platelets, leukoreduced, irradiated, ea unit	70
P9034	Platelets, pheresis, ea unit	460
P9035	Platelets, pheresis, leukoreduced, ea unit	500
P9036	Platelets, pheresis, irradiated, ea unit	540
P9037	Platelets, pheresis, leukoreduced, irradiated, ea unit	580
P9038	RBC, irradiated, ea unit (non autologous)	170
P9038	RBC, irradiated, ea unit (autologous)	295
P9039	RBC, deglycerolized, ea unit (non autologous)	260
P9039	RBC, deglycerolized, ea unit (autologous)	385
P9040	RBC, leukoreduced, irradiated, ea unit (non autologous)	225
P9040	RBC, leukoreduced, irradiated, ea unit (autologous)	350
P9044	Plasma, cryoprecipitate reduced, ea unit	50
P9050	Granulocytes, pheresis, ea unit	600
P9051	Whole blood or RBC, Leuko reduced, CMV-neg, ea unit	165
P9052	Plt, HLA-matched leukored, apheresis/pheresis, ea unit	625
P9053	Plt, pheresis, leukoreduced, CMV-neg, irradiated, ea unit	600
P9054	Whole bld or RBC, leukoreduced, froz, degly/washed, ea	315
P9055	Plt, leukoreduced, CMV-neg, apheresis/pheresis, ea unit	520
P9056	Whole Blood, leukoreduced, irradiated, ea unit (non autologous)	270
P9056	Whole Blood, leukoreduced, irradiated, ea unit (autologous)	395
P9057	RBC, froz, degly/washed, leukored, irradiated, ea unit (non autologous)	395
P9057	RBC, froz, degly/washed, leukored, irradiated, ea unit (autologous)	520
P9058	RBC, leukoreduced, CMV-neg, irradiated, ea unit	245
P9059	FFP, frozen w/in 8-24 hrs of collection, ea unit	40
P9060	FFP, donor retested, ea unit	By Report

SANDARD UNIT OF MEASURE REFERENCES
EMERGENCY SERVICES

Account Number	Cost Center Title	Cost Center Code
6710	Emergency Services	EMG

EMG

HSCRC abbreviation for Emergency Department

EMTALA

Emergency Medical Screening Examination mandated by the Emergency Medical Treatment & Labor Act (EMTALA) to be provided to every person who seeks emergency care.

Relative Value Units (RVUs)

A standard unit of measure. A unique value or weight assigned to a specific service, e.g., number of visits for a particular hospital unit.

The RVUs for this cost center are based on resource consumption. Each facility is expected to develop, retain, and maintain Internal Guidelines, which identify the resources consumed. These resources may include but are not limited to time, staff intervention, complexity, patient severity, etc. The facility's Internal Guidelines are to be used for the purpose of maintaining Service Level reporting consistency among patients receiving comparable or similar treatment/care/resource consumption; and for patients who receive greater (or lesser) treatment/care/resource consumption to be assigned an appropriately higher (or lesser) Service Level.

General Guidelines

1. There is a direct relationship between the amounts of EMG resources consumed by a patient and the Service Level assigned to the patient.
2. The facility will prepare, record, and maintain appropriate documentation to support and justify the Service Level assigned. If a service or task is not documented, then that service or task cannot be included in the determination of the Service Level assignment. Patients are not to be charged, nor RVUs reported for a service or task that is not documented. Physician services are not to be included in the determination of Service Levels.
3. The facility's Internal Guidelines may not be totally inclusive or explanatory. It is recognized that the circumstance of the visit and the Service Level selected will involve a degree of clinical judgment and patient acuity. It is recommended that each facility's Internal Guidelines include an analysis of resource use and the services provided by EMG staff. The format and content are at the facility’s discretion.
4. Charges for EMG services are a by-product of all expenses and RVUs assigned to the EMG department. Ancillary services can be provided within the EMG area (e.g.,

laboratory, radiology, respiratory, etc.). If the cost of providing an ancillary service in the EMG is assigned to the ancillary center, regulated charges for that ancillary service must be included as a separate line item in the patient bill. However, if the cost associated with an ancillary service is assigned to the EMG department (e.g., an EMG registered nurse or other EMG personnel providing respiratory care or specimen collection), then the cost associated with the service is part of the EMG determination of Service Level. It is recommended that this distinction be part of the facility's Internal Guidelines.

5. EMG patients will be assigned a Service Level based on total resources consumed, from the EMTALA Medical Screening Examination to final patient disposition.

6. In addition to EMG Service Level charge, the hospital will charge separately for drugs, supplies, and ancillary services (as noted in 4 above). Professional fees are not regulated by the HSCRC and, therefore, are not included in the hospital's charges. Professional fees would be a separate charge.

CPT Services Levels		**RVU**
99281	Level I/ EMTALA (Medical Screening Examination)	1
99282	Level II	1
99283	Level III	2
99284	Level IV	4
99285	Level V	7
99291	Level V	7

Each patient receives an EMTALA Medical Screening Examination and almost all patients receive subsequent treatment. Some payers prefer that the EMTALA screening be billed as a separate line item and post-EMTALA treatment as a separate line item. Other payers prefer that the EMTALA screening be bundled with post-EMTALA treatment as one line item. Therefore, applying the above RVU table, when combining EMTALA screening and post-EMTALA treatment, patients would be billed the following RVUs:

SANDARD UNIT OF MEASURE REFERENCES
EMERGENCY SERVICES

Total RVUs to be billed by CPT Services Levels			**RVU**
99281	Level I	(Includes EMTALA)	1
99282	Level II	(Includes EMTALA)	2
99283	Level III	(Includes EMTALA)	3
99284	Level IV	(Includes EMTALA)	5
99285	Level V	(Includes EMTALA)	8
99291	Level V	(Includes EMTALA)	8

ECS (Extended Care Services) - The RVUs assigned are based on clock time.

1 RVU per 2 hours for a period up to 48 hours (maximum of 24 RVUs).

Extended Care Service (ECS)

- This service is associated with outpatients who have received EMG services and are awaiting transfer/discharge to another facility. Some examples include: tertiary care facility, nursing home, inpatient psychiatric facility, etc. The services being provided to the patient during ECS may or may not be resource intensive.
- This is an add-on RVU to Level V only (e.g., ECS RVUs may be added to the Treatment Level V RVUs) and is for services provided AFTER EMG Treatment.
- If services provided during ECS are resource intensive, the Service Level may be increased.
- Extended Care Services are based on "clock time." For each full two hour period of clock time, one (1) RVU is assigned. Any partial hours are rounded down to the nearest full two hour period. For example, two hours and five minutes is reported as two hours = one RVU. Two hours and fifty-five minutes is reported as a two hour period = one RVU.
- To qualify for ECS reporting, the patient must be an outpatient and must be transferred to another facility. The transfer must be fully documented in the medical record.

- Below are four examples of the proper reporting of Extended Care Service:

1. A patient begins his EMG visit at noon. The resources utilized resulted in a service Level V being assigned. The patient is stabilized and is to be transferred to another facility. The time is now 12:55 pm. Due to conditions beyond the control of the transferring hospital, the transfer is delayed for four and one half (4.5) hours. The reporting of RVUs would be as follows: EMTALA 1 RVU plus Service Level V 7 RVUs, plus ECS for 4 hours = 2 RVUs (rounded down to four hours from the actual of four and one half hours), the total RVUs reported would be 10.
2. A patient begins his EMG visit at noon. The resources utilized resulted in a service Level III being assigned. The patient is stabilized and is to be transferred to another facility. The time is now 12:45 pm. The patient is immediately transferred to another facility. The reporting of RVUs would be as follows: EMTALA 1 RVU, plus Service Level III 2 RVUs. There are no ECS RVUs reported, because the Service Level was not Level V.
3. A patient begins his EMG visit at noon. The patient is stabilized and is to be transferred to another facility. The resources utilized resulted in a Service Level IV being assigned. The time is now 1:00 pm. Due to conditions beyond the control of the transferring hospital, the transfer is delayed for four and one half (4.5) hours. The reporting of RVUs would be as follows: EMTALA 1 RVU plus service Level IV 4 RVUs. There are no ECS RVUs reported, because the Service Level was not Level V.
4. A patient begins his EMG visit at noon. The patient is stabilized and is to be transferred to another facility. The resources utilized resulted in a service Level III being assigned. Due to conditions beyond the control of the transferring hospital, the transfer is delayed for nine (9.0) hours. Significant resources beyond typical ECS services were

utilized during the first three hours of the delay causing the Service Level to be increased from Level III to Level V. The remaining six (6) hours of the delay are now considered ECS. The reporting of RVUs would be a follows, EMTALA 1 RVU plus services Level V 7 RVUs, plus ECS for 6 hours 3 RVUs. The total RVUs reported would be 11 RVUs.

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STANDARD UNIT OF MEASURE REFERENCES
CT SCANNER

Approach

CT Scanner Relative Value Units were developed with the aid of an industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions of codes in this section of Appendix D were obtained from the 2017 edition of the Current Procedural Terminology (CPT) manual and the 2017 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2017 Medicare Physician Fee schedule (MPFS) released November 2, 2016. RVUs were assigned using the following protocol ("RVU Assignment Protocol").

The RVUs reported in the 2017 MPFS include 2 decimal points. In order to maintain whole numbers in Appendix D, while maintaining appropriate relative value differences reported in the MPFS, the RVU work group agreed to remove the decimals by multiplying the reported RVUs by ten and then rounding the product of the calculation, where values less than X.5 are rounded down and all other values are rounded up.

1. CPT codes with RVUs listed in the MPFS.
    a. For CPT codes with RVUs that include both professional (modifier 26) and technical (modifier TC) components, use only the technical (TC) component RVU.
    b. CPT codes with only a single RVU listed
        a. CPT codes that are considered technical only, the single RVU reported will be used.
        b. CPT codes considered professional only are not listed in Appendix D.

2. CPT codes that do not have RVUs listed in the MPFS (e.g. CMS Status Code "C")
    a. CPT 76497 did not have a published RVU in the MPFS. As this code is for an unlisted procedure, RVUs should be developed "By Report" following the protocol below in the section "CPT Codes without an Assigned RVU Value.".
    b. CPT 77013 did not have a published RVU in the MPFS. As these codes are bundled with a surgical code, these procedures should be reported under Interventional Radiology/Cardiovascular.
    c. HCPCS 0042T did not have a published RVU in the MPS. Due to its similarity to CPT 70496, it was assigned 72 RVUs (58 RVUs plus 14 RVUs for double time post processing).
    d. HCPCS 0351T-0354T did not have published RVU in the MPS. These are new technology codes and RVUs should be developed "By Report".
3. CPT/HCPCS codes for which the published RVU did not make sense,
    a. Even though the resources are higher for lung cancer screening patients due to registry and other documentation requirements, HCPCS G0297 (low dose lung cancer screening) has been synchronized with CPT 71250 (Chest CT wo Contrast) as they often share charge codes within hospitals.

Services with Both a HCPCS Code for Medicare and CPT Code for Non-Medicare

All known HCPCS codes have been addressed in a payer-neutral fashion with this update. In instances of where Medicare implements a new HCPCS code to be utilized in lieu of a CPT code for a service, the RVU developed by the hospital must mirror the established CPT RVUs. The RVU for the service must be the same for all payers.

CPT Codes with Bundled Procedures

CPT codes from 2017 with a surgical component have been assigned a zero (0) RVU value. If a CT CPT becomes bundled with a surgical code or replaced with a surgical code, these procedures should be charged as Interventional Radiology/Cardiovascular (IRC) and the associated costs of the procedure are to be reclassified to the IRC cost center. Note: These IRC procedures may be charged based on actual start/stop times or based on the average case time (based on an annual time study) for the service.

Surgical Component and Non-Invasive Exam on Same Day

If a patient has a service with a surgical component (invasive) and non-invasive exam on same day – for example, an enhanced CT arthrogram and a CT of the joint- the patient will be charged based on IRC rules for the invasive exam and CT RVUs for the non-invasive exam.

Intrathecal Injections

If intrathecal injections are performed, the service should be reported under IRC. If the service does not include intrathecal injections, standard CT RVUs should be reported.

Reporting of Imaging Guidance for Invasive Cases

Standard imaging RVUs are to be used for non-invasive imaging services. For invasive imaging services, the imaging guidance is either separately reportable or bundled into the code for the invasive service. Invasive imaging services occurring in an imaging suite must be charged using IRC minutes based on case time. For separately reportable imaging guidance, hospitals are to report one (1) IRC minute per imaging code. Imaging expenses associated with the guidance are to be allocated from the diagnostic imaging rate center to the IRC rate center.

When an operating room or operating room-clinic case involves separately reportable intraoperative/intraprocedural imaging guidance or imaging services, standard imaging RVUs are to be used. These cases are to be charged based on OR or ORC minutes. When imaging guidance is bundled into the underlying procedure, hospitals should not report any additional RVUs for the imaging. If imaging staff is assisting during a case where the imaging is bundled into the underlying procedure, expenses should be allocated from the imaging department to the operating room or operating room clinic rate center.

CPT Codes without an Assigned RVU Value

RVUs for new codes developed and reported by CMS after the 2017 reporting, must be developed “By Report”. When assigning RVUs to these new codes, hospitals should use the RVU Assignment Protocol described above where possible using the most current MPFS. For codes that are not listed in the MPFS, hospitals should assign RVUs based on time and resource intensity of the services provided compared to

like services in the department. Documentation of the assignment of RVUs to codes not listed in Appendix D should always be maintained by the hospital.

For any codes that are in the surgical series of CPT (i.e. 1xxxx-6xxxx) and being performed in the imaging suite, these services are to be reported via IRC.

General Guidelines

The AMA CPT Code will be used as the identifier throughout the system. Assigned RVU's will be strictly tied to the CPT Code.

All RVUs are per CPT unless otherwise stated.

Standard supplies and contrast material are included in the RVU assignment and should not be assigned separately.

No drug is considered a routine part of any CT examination; however, sedation and pain reducing agents may be used to make procedures more easily tolerated. These drugs should NOT be included in the RVU of the exam but would be billed separately through the pharmacy on an "as needed" basis. Drugs should not be assigned an RVU.

CPT Code	Description	RVU
70450	CT Head or Brain w/o contrast	21
70460	CT Head or Brain w contrast	30
70470	CT Head or Brain w & w/o contrast	36
70480	CT Orbit, Sella, Posterior Fossa or outer, middle or inner ear w/o contrast	47
70481	CT Orbit, Sella, Posterior Fossa or outer, middle or inner ear w/ contrast	58
70482	CT Orbit, Sella, Posterior Fossa or outer, middle or inner ear w/ & w/o contrast	64
70486	CT Maxillofacial area w/o contrast	27
70487	CT Maxillofacial area w contrast	31
70488	CT Maxillofacial area w & w/o contrast	40
70490	CT Soft Tissue Neck w/o contrast	36
70491	CT Soft Tissue Neck w/ contrast	47
70492	CT Soft Tissue Neck w/ & w/o contrast	58
70496	CT Angiography, Head w/ contrast, including noncontrast images, if performed and image postprocessing	58
70498	CT Angiography, Neck w/ contrast, including noncontrast images, if performed and image postprocessing	57
71250	CT Thorax w/o contrast	36
71260	CT Thorax w/ contrast	47
71270	CT Thorax w/ & w/o contrast	58
71275	CT Angiography, chest (noncoronary) w/ contrast; including noncontrast images, if performed & image postprocessing	59
72125	CT Cervical Spine w/o contrast - Contrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	37

STANDARD UNIT OF MEASURE REFERENCES
CT SCANNER

CPT Code	Description	RVU
72126	CT Cervical Spine w/ contrast - Contrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	47
72127	CT Cervical Spine w/ & w/o Contrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	
72128	CT Thoracic Spine w/o contrast contrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	36
72129	CT Thoracic Spine w/ contrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	47
72130	CT Thoracic Spine w/ & w/o contrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	58
72131	CT Lumbar Spine w/o contrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	36
72132	CT Lumbar Spine w/ contrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	47
72133	CT Lumbar Spine w/ & w/o contrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	58
72191	CT Angiography; Pelvis w/ contrast, including noncontrast images, if performed, and image postprocessing	60
72192	CT Pelvis w/o contrast	26
72193	CT Pelvis w contrast	47
72194	CT Pelvis w/ & w/o contrast	56
73200	CT Upper Extremity w/o contrast	36
73201	CT Upper Extremity w/ contrast	46
73202	CT Upper Extremity w/ & w/o contrast	61
73206	CT Angiography, Upper Extremity w/ contrast; including noncontrast images, if performed and image postprocessing	67
73700	CT Lower Extremity w/o contrast	36
73701	CT Lower Extremity w contrast	47
73702	CT Lower Extremity w/ & w/o contrast	60
73706	CT Angiography, Lower Extremity w/ contrast, including noncontrast images, if performed, and image postprocessing	73
74150	CT Abdomen w/o contrast	25
74160	CT Abdomen w contrast	47
74170	CT Abdomen w/ & w/o contrast	54

STANDARD UNIT OF MEASURE REFERENCES
CT SCANNER

CPT Code	Description	RVU
74174	CT Angiography, Abdomen & Pelvis w/ contrast material, including noncontrast images, if performed and image postprocessing	78
74175	CT Angiography, Abdomen w/ contrast material,, including noncontrast images, if performed and image postprocessing	61
74176	CT Abdomen & Pelvis w/o contrast material	32
74177	CT Abdomen & Pelvis w contrast	62
74178	CT Abdomen & Pelvis w/ & w/o contrast	71
74261	CT colonography diagnostic, including image postprocessing; w/o contrast	103
74262	CT colonography diagnostic, including image postprocessing; w/ contrast including non-contrast images, if performed	118
74263	CT colonography, screening, including image postprocessing	180
75571	CT Heart w/o contrast; w/ quantitative evaluation of coronary calcium	20
75572	CT Heart w/ contrast material, for evaluation of cardiac structure & morphology (includes 3D imaging postprocessing, assessment of cardiac function and evaluation of venous structures, if performed)	55
75573	CT Heart w/ contrast material, for evaluation of cardiac structure & morphology in the setting of congenital disease (includes 3D imaging postprocessing, assessment of LV cardiac function, RV structure and function & evaluation of venous structures, if performed)	74
75574	CT Angiography, heart, CABG (coronary arteries and bypass graft - when present), with contrast, includes 3D imaging postprocessing (including evaluation of cardiac structure & morphology, assessment of cardiac function & evaluation of venous structures, if performed)	85
75635	CT Angiography, Abdominal aorta and bilateral iliofemoral lower extremity runoff, w/ contrast, including noncontrast images, if performed, and image postprocessing	74
75989	Radiological Guidance (ie. Fluoroscopy, US, or CT), for percutaneous drainage (ie. Abscess, specimen collection), w/ placement of catheter, radiological supervision and interpretation	IRC
76376	3D Rendering w/ interpretation and reporting of CT, MRI, US, or other tomographic modality w/ image post processing under concurrent supervision; not requiring image postprocessing on an independent workstation - use in conjunction w/ code(s) for base imaging procedure	4
76377	3D Rendering w/ interpretation and reporting of CT, MRI, US, or other tomographic modality w/ image post processing under concurrent supervision; requiring image postprocessing on an independent workstation - use in conjunction w/ code(s) for base imaging procedure	9
76380	CT limited or localized follow-up study	27
76497	Unlisted CT Procedure (diagnostic or interventional)	By Report
77011	CT Guidance for stereotactic localization (do not report in conjunction w/ 22586, 0195T, 0196T, 0309T)	IRC

STANDARD UNIT OF MEASURE REFERENCES
CT SCANNER

CPT Code	Description	RVU
77012	CT Guidance for needle placement (eg. Biopsy, aspiration, injection, localization device), radiological supervision and interpretation (do not report in conjunction w/ 10030, 22586, 27906, 32554-32557, 64479-64484,64490-64495, 64633-64636, 0195T, 0196T, 0232T, 0309T)	IRC
77013	CT Guidance for, and monitoring of, parenchymal tissue ablation (do not report in conjunction w/ 20982, 20983, 0340T)	IRC
77014	CT Guidance for placement of radiation therapy fields	21
77078	CT Bone mineral density study, 1 or more sites, axial skeleton (hips, pelvis, spine)	29
G0297	Low dose CT scan (LDCT) for lung cancer screening (Medicare reporting only)	36
0042T	Cerebral perfusion analysis using CT w/ contrast, including post-processing of parametric maps with determination of cerebral blood flow, cerebral blood volume, and mean transit time	72
0351T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real time intraoperative	By Report
0352T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real time or referred	By Report
0353T	Optical coherence tomography of breast, surgical cavity; real time intraoperative	By Report
0354T	Optical coherence tomography of breast, surgical cavity; interpretation and report, real time or referred	By Report

Approach

Magnetic Resonance Imaging Relative Value Units were developed with the aid of an industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions of codes in this section of Appendix D were obtained from the 2017 edition of the Current Procedural Terminology (CPT) manual and the 2017 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2017 Medicare Physician Fee schedule (MPFS) released November 2, 2016. RVUs were assigned using the following protocol ("RVU Assignment Protocol").

The RVUs reported in the 2017 MPFS include 2 decimal points. In order to maintain whole numbers in Appendix D, while maintaining appropriate relative value differences reported in the MPFS, the RVU work group agreed to remove the decimals by multiplying the reported RVUs by ten and then rounding the product of the calculation, where values less than X.5 are rounded down and all other values are rounded up.

1. CPT codes with RVUs listed in the MPFS.
    a. For CPT codes with RVUs that include both professional (modifier 26) and technical (modifier TC) components, use only the technical (TC) component RVU.
    b. CPT codes with only a single RVU listed.
        a. CPT codes that are considered technical only, the single RVU reported will be used.
        b. CPT codes considered professional only are not listed in Appendix D.

2. CPT codes that do not have RVUs listed in the MPFS (e.g. CMS Status Code "C").
    a. CPT 77022 did not have a published RVU in the MPFS. As these codes are bundled with a surgical code, these procedures should be reported under Interventional Radiology/Cardiovascular.
    b. CPT 70557, 70558 and 70559 did not have a published RVU in the MPS. Even though these are performed intraoperatively, they will be charged using standard brain MRI RVUs. They will mirror 70551 (44 RVUs), 70552 (65 RVUs), and 70553 (74 RVUs).
    c. CPT 70555 did not have a published RVU in the MPFS. As this code is similar to 70554, it was set to mirror 70554. See #3 below.
    d. CPT 76498 did not have a published RVU in the MPFS. As this code is for an unlisted procedure, RVUs should be developed "By Report".
    e. CPT 0159T did not have a published RVU in the MPFS. As this procedure is always performed in conjunction with a primary procedure, one RVU will be assigned.

HCPCS 0398T did not have a published RVU in the MPFS. Intracranial procedures are typically performed in the operating room. However, this code is for the MRI piece. Hospital data to establish RVUs is limited as this is a new code and very few hospitals are performing this procedure. Therefore RVUs should be developed "By Report"

a. Following the protocol below in the section "CPT Codes without an Assigned RVU Value."

3. CPT/HCPCS codes for which the published RVU did not make sense
    a. CPT 70554 has a published RVU in the MPFS that is too low for the amount of resources involved. On the professional side, the physician charges this CPT and CPT 96020. Given the significant time and resources involved, the group felt there was a valid reason for deviating from the prescribed methodology. Therefore, an additional 54 RVUs will be added to the MPFS for a total of 150 (96 + 54 = 150).

Services with Both a HCPCS Code for Medicare and CPT Code for Non-Medicare

All known HCPCS codes have been addressed in a payer-neutral fashion with this update. In instances of where Medicare implements a new HCPCS code to be utilized in lieu of a CPT code for a service, the RVU developed by the hospital must mirror the established CPT RVUs. The RVU for the service must be the same for all payers.

CPT Codes with Bundled Procedures

CPT codes from 2017 with a surgical component have been assigned a zero (0) RVU value. If a MRI CPT becomes bundled with a surgical code or replaced with a surgical code, these procedures should be charged as Interventional Radiology/Cardiovascular (IRC) and the associated costs of the procedure are to be reclassified to the IRC cost center. Note: These IRC procedures may be charged based on actual start/stop times or based on the average case time (based on an annual time study) for the service.

Surgical Component and Non-Invasive Exam on Same Day

If a patient has a service with a surgical component (invasive) and non-invasive exam on same day – for example, an enhanced MR arthrogram and a MRI of the joint- the patient will be charged based on IRC rules for the invasive exam and MRI RVUs for the non-invasive exam.

Reporting of Imaging Guidance for Invasive Cases

Standard imaging RVUs are to be used for non-invasive imaging services. For invasive imaging services, the imaging guidance is either separately reportable or bundled into the code for the invasive service. Invasive imaging services occurring in an imaging suite must be charged using IRC minutes based on case time. For separately reportable imaging guidance, hospitals are to report one (1) IRC minute per imaging code. Imaging expenses associated with the guidance are to be allocated from the diagnostic imaging rate center to the IRC rate center.

When an operating room or operating room-clinic case involves separately reportable intraoperative/intraprocedural imaging guidance or imaging services, standard imaging RVUs are to be used. These cases are charged based on OR or ORC minutes. When imaging guidance is bundled into the underlying procedure, hospitals should not report any additional RVUs for the imaging. If imaging staff is assisting during a case where the imaging is bundled into the underlying procedure, expenses should be allocated from the imaging department to the operating room or operating room-clinic rate center.

CPT Codes without an Assigned RVU Value

RVUs for new codes developed and reported by CMS after the 2017 reporting, must be developed "By Report". When assigning RVUs to these new codes, hospitals should use the RVU Assignment Protocol described above where possible using the most current MPFS. For codes that are not listed in the MPFS, hospitals should assign RVUs based on time and resource intensity of the services provided compared to like services in the department. Documentation of the assignment of RVUs to codes not listed in Appendix D should always be maintained by the hospital.

For any codes that are in the surgical series of CPT (i.e. 1xxxx-6xxxx) and being performed in the imaging suite, these services are to be reported via IRC.

General Guidelines

The AMA CPT Code will be used as the identifier throughout the system. Assigned RVU's will be strictly tied to the CPT Code.

All RVUs are per CPT unless otherwise stated.

Standard supplies and contrast material are included in the RVU assignment and should not be assigned separately.

No drug is considered a routine part of any MRI examination; however, sedation and pain reducing agents may be used to make procedures more easily tolerated. These drugs should NOT be included in the RVU of the exam but would be billed separately through the pharmacy on an "as needed" basis. Drugs should not be assigned an RVU.

CPT Code	Description	RVU
70336	MRI Temporomandibular joints	70
70540	MRI Orbit, Face, and/or Neck w/o contrast	66
70542	MRI Orbit, Face, and/or Neck w/ contrast	72
70543	MRI Orbit, Face, and/or Neck w/ & w/o contrast	87
70544	MRA Head w/o contrast	93
70545	MRA Head w contrast	92
70546	MRA Head w/ & w/o contrast	143
70547	MRA Neck w/o contrast	94
70548	MRA Neck w contrast	99
70549	MRA Neck w & w/o contrast	144
70551	MRI Brain (including brain stem), w/o contrast	44
70552	MRI Brain (including brain stem), w/ contrast	65
70553	MRI Brain (including brain stem), w/ & w/o contrast	74
70554	MRI Brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration	150
70555	MRI Brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, requiring physician or psychologist administration of entire neurofunctional testing	150

STANDARD UNIT OF MEASURE REFERENCES
MRI

CPT Code	Description	RVU
70557	MRI Brain (including brain stem & skull) during open intracranial procedure (to access for residual tumor or residual vascular malformation); w/o contrast	44
70558	MRI Brain (including brain stem & skull) during open intracranial procedure (to access for residual tumor or residual vascular malformation); w/ contrast	65
70559	MRI Brain (including brain stem & skull) during open intracranial procedure (to access for residual tumor or residual vascular malformation), w/ & w/o contrast	74
71550	MRI Chest (e.g. for evaluation of hilar and mediastinal lymphadenopathy); w/o contrast	96
71551	MRI Chest (e.g. for evaluation of hilar and mediastinal lymphadenopathy); w/ contrast	105
71552	MRI Chest (e.g. for evaluation of hilar and mediastinal lymphadenopathy); w/ & w/o contrast	131
71555	MRA Chest (excluding myocardium) w or w/o contrast	87
72141	MRI, C-spine, spinal canal and contents; w/o contrast	42
72142	MRI, C-spine, spinal canal and contents; w/ contrast	66
72146	MRI, T-spine, spinal canal and contents; w/o contrast	42
72147	MRI, T-spine, spinal canal and contents; w/ contrast	66
72148	MRI, L-spine, spinal canal and contents; w/o contrast	42
72149	MRI, L-spine, spinal canal and contents; w/ contrast	65
72156	MRI, C-spine, spinal canal and contents; w/ & w/o contrast	74
72157	MRI, T-spine, spinal canal and contents; w/ & w/o contrast	75
72158	MRI, L-spine, spinal canal and contents; w/ & w/o contrast	74
72159	MRA spinal canal and contents w or w/o contrast	92
72195	MRI Pelvis w/o contrast	85
72196	MRI Pelvis w/ contrast	91
72197	MRI Pelvis w/ & w/o contrast	110
72198	MRA Pelvis w/ or w/o contrast	88
73218	MRI Upper Extremity, other than joint; w/o contrast	84
73219	MRI Upper Extremity, other than joint; w/ contrast	90
73220	MRI Upper Extremity, other than joint; w/ & w/o contrast	110
73221	MRI any Joint of Upper Extremity w/o contrast	47
73222	MRI any Joint of Upper Extremity w/ contrast	83
73223	MRI any Joint of Upper Extremity w/ & w/o contrast	102
73225	MRA Upper Extremity w or w/o contrast	91
73718	MRI Lower Extremity, other than joint, w/o contrast	83
73719	MRI Lower Extremity, other than joint, w/ contrast	91
73720	MRI Lower Extremity, other than joint, w/ & w/o contrast	111
73721	MRI any Joint of Lower Extremity w/o contrast	47
73722	MRI any Joint of Lower Extremity w/ contrast	84
73723	MRI any Joint of Lower Extremity w/ & w/o contrast	102
73725	MRA Lower Extremity w/ or w/o contrast	87

MRI

CPT Code	Description	RVU
74181	MRI Abdomen w/o contrast	73
74182	MRI Abdomen w/ contrast	103
74183	MRI Abdomen w & w/o contrast	111
74185	MRA Abdomen, w/ or w/o contrast	88
74712	MRI Fetal; including placental and maternal pelvic imaging when performed; single or first gestation	93
74713	MRI Fetal; including placental and maternal pelvic imaging when performed; each additional gestation	39
75557	Cardiac MRI for morphology and function w/o contrast	57
75559	Cardiac MRI for morphology and function w/o contrast; w/ stress imaging	83
75561	Cardiac MRI for morphology and function w/ & w/o contrast	83
75563	Cardiac MRI for morphology and function w/ & w/o contrast; w/ stress imaging	101
75565	Cardiac MRI for velocity flow mapping (list separately in addition to code for primary procedure)	12
76376	3D Rendering w/ interpretation and reporting of CT, MRI, US, or other tomographic modality w/ image post processing under concurrent supervision; not requiring image postprocessing on an independent workstation - use in conjunction w/ code(s) for base imaging procedure	By Report
76377	3D Rendering w/ interpretation and reporting of CT, MRI, US, or other tomographic modality w/ image post processing under concurrent supervision; requiring image postprocessing on an independent workstation - use in conjunction w/ code(s) for base imaging procedure	By Report
76390	Magnetic Resonance Spectroscopy	106
76498	Unlisted magnetic resonance procedure (e.g. diagnostic, interventional)	By Report
77021	Magnetic Resonance Guidance for needle placement (eg. Biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation (do not report in conjunction w/ 10030,19085, 19287, 32554 ,32555, 32556, 32557 or 0232T)	IRC
77022	Magnetic Resonance Guidance for monitoring of parenchymal tissue ablation	IRC
77058	MRI Breast w/ and/or w/o contrast; unilateral	129
77059	MRI Breast w/ and/or w/o contrast; bilateral	128
77084	MRI Bone Marrow blood supply	87
0159T	Computer-aided detection, including computer algorithm analysis of MRI image data for lesion detection/characterization, pharmacokinetic analysis, w/ further physician review for interpretation, breast MRI (List separately in addition to code for primary procedure)	1
0398T	MRI guided high intensity focused US (MRgFUS), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed	By Report

STANDARD UNIT OF MEASURE REFERENCES
MRI

GLOSSARY

1. Extremities, non joint; Pertains to all extremity imaging where the joint is not the area of interest. However, the nearest joint must be included on at least one series for validation of scan placement. Most commonly used for bone or tissue diseases.
2. MRA; Pertains to all blood vessels imaging. Procedures require multiple images (frequently surpassing 300 source images), requires additional prep and supplies, and requires a minimum of 30 additional minutes of post-processing time.
3. Without contrast; no contrast is injected.
4. With contrast; IV contrast is injected followed by the scanning protocol.
5. Without and With Contrast; the scanning protocol is completed, the patient is brought out from the scanner, the technologist or nurse preps the patient. IV contrast is injected, the patient is returned to the proper scanning position, and the scanning protocol is repeated.