BENCHMARKING RATE APPLICATION CHECKLIST

Updated: May 2014

A. General Information Requirements

Please refer to the Benchmarking Application Instructions for more detailed information on completing the application.

►►► **NOTE: All application pages MUST be numbered.**

In the space provided by each numbered item, one of the following ***MUST*** be used:

A - Specific page number in the application where the explanation can be found (not just "see Exhibit H");
B - Yes/No and page number in the application if further explanation is required; and,
C - NA if not applicable to the hospital.

►►► **NOTE: checkmarks, "done", etc. will NOT be accepted.**

______ 1. Copy of the published legal advertisement (See Attachment I) and affidavit of publication. **(Note: Provide affidavit of publication within ten (10) days of filing the rate application. Failure to provide the proof of publication timely will result in a delay in the issuance of the hospital's rate decision.)** Requested limits and percent of change over projected actual are required for both nongovernmental acute inpatient and outpatient. **Home Health and Hospice statistics are to be reported with Acute.**

______ 2. Copy of the Hospital's Board approved budget.

______ 3. Original certification by the Chairman of the Board and Hospital Administrator. (See Attachment II)

______ 4. Copy of the hospital's current license.

______ 5. Does the hospital provide services to patients covered by the Small Business Insurance Plan? If so, all utilization, revenue and expenses for these patients are reported under the "Other Governmental" category. (See Policy Statement 2004-2)

______ 6. Verify that any discounts provided to self-pay or uninsured patients that do not qualify under the hospital's charity care policy are reported according to Policy Statement 2000-4.

______ 7. Provide detailed budget assumptions including but not limited to anticipated changes in the following: utilization, revenues, expenses, case mix, service mix, reimbursement, organizational structure, capital assets, supply costs, pharmaceutical costs, new technology, etc.

______ 8. For the projected actual year's data, provide the following information:

a. ______Number of months actual data was used (8 or 9)
b. ______Number of months projected data was used (4 or 3)

NOTE: Application must be filed with either 8 months actual and 4 months projected or 9 months actual and 3 months projected data.

______ 9. Verify that the projected data takes into account any facility changes including but not limited to service mix, utilization, expenses, etc.

______ 10. Provide the year-to-date (based on the number of months reported in 8a above) revenue and utilization by payor **and the calculations used** to determine the projected actual revenue and utilization by payor reported in the application.

______ 11. Is the hospital in compliance with all financial disclosure requirements including Uniform Billing submissions? A rate decision will not be issued if the hospital is not in compliance with financial disclosure. The hospital's current status with regard to financial disclosure requirements can be found in the Health Care Authority's newsletter which is located on the Authority's website at www.hca.wv.gov. (Hospitals should contact Renae Whitlock of the Authority's Financial Analysis Division to determine whether their financial disclosure file is complete and Susan Dolly of the Clinical Analysis Division to determine if the UB data file is complete.)

______ 12. Are the hospital's Related Organizations in compliance with all financial disclosure requirements? (Hospitals should contact Renae Whitlock of the Authority's Financial Analysis Division to determine whether the Related Organization's financial disclosure file is complete.)

______ 13. Has a copy of the complete FY 20___ rate application been provided to the **Consumer Advocate by mailing the application to PO Box 11685 Charleston, WV 25339-1685 or delivering to One Players Club Drive, Third Floor Charleston, WV 25311?**

______ 14. Does the hospital have any CON applications ***pending*** for services that will be starting this fiscal year? (Yes) (No). If **YES**, does the application contain any expenses, utilization or revenues for this CON? (Yes) (No). If **YES**, revise application to remove all expenses, utilization and revenues for the ***pending*** CON.

______ 15. ADDITIONAL INFORMATION REQUIRED – (1) Attachment VI is to be completed and include the required data (malpractice expense, provider tax, and other taxes) for the most current year for which a full year of actual data is available. (2) Attachment VII is to be completed for the budget year (a current listing of all Distinct Part Units (DPUs)).

______ 16. Please provide the following hospital data with respect to management fees paid by the hospital:

Prior year actual management fees _______________
Current year projected actual management fees _______________
Budgeted management fees _______________

______ 17. Please provide an explanation of how management fees are calculated and **provide a detailed summary of the services covered by the fees.**

______ 18. Has the calculation of management fees changed since the prior fiscal year? **If yes, provide a written statement as to the change and why.**

B. B-1 Discharges, Days, Visits and B-2 Gross Inpatient and Outpatient Revenues – Include Home Health and Hospice with Acute statistics.

______ 1. Provide an explanation only if the hospital is reporting a significant increase or decrease from the prior year's budget to projected actual **OR** from the projected actual to the new budget for discharges/days/visits and revenues.

______ 2. Verify that nursery discharges are **NOT** included with the discharges and days reported on the B-1. **Nursery discharges to**

be EXCLUDED are MS-DRG 794 and 795 with revenue code 170 and 171.

_____ 3. Verify that nursery revenue is **INCLUDED** with the inpatient revenue reported on the B-2.

_____ 4. Are ***series*** account revenue and observation revenue included as outpatient revenue and consistent with utilization? (YES) (NO). If **NO**, provide a detailed explanation.

C. B-3 Salary and Wage Summary – Submit one form for Acute care (which includes Home Health and Hospice).

►►► **NOTE: All physicians employed by the hospital should be reported as "supervisory atypical". (See B-3 instructions for definition of atypical)**

_____ 1. Lines 1a, 1b, and 1c are the **same** as the **prior year's** rate application **– lines 3a, 3b and 3c.**

_____ 2. Does the hospital give a discount to ***ALL*** of its employees (such as waiving co-pays or discount on the co-pays)? (YES) (NO). If **YES**, these **discounts** are considered additional fringe benefits and should be reported as an **operating expense** (i.e. not bad debts or charity care) and **NOT** a **contractual allowance**. If the discounts are granted to certain employees only, these must be reported on the B-DC forms as discounts. (See Policy Statement 2000-4 for further details)

D. B-5 (Income Statement) – Submit a Total B-5 and B-5a form.

_____ 1. Indicate on the **Total B-5** form for both the projected actual and budget years the amount of Medicaid disproportionate share funds received that have been netted against Medicaid inpatient contractual allowances.

_____ 2. Are unrealized gains and/or losses reflected in the EROE? (YES) (NO). If **YES,** revise the B-5 (projected actual and budget) to exclude unrealized gains and/or losses.

E. B-DC and B-DCL (Discount Contracts) – Both forms must be submitted with the rate application. Submit a TOTAL B-DC form and a B-DCL form for both the projected actual and budget years. All

contracts should be listed on Form B-DCL including separate Distinct Part Unit Contracts. Please read the forms and instructions carefully before completing. See Policy Statement 2002-1 for further explanation.

______ 1. All new contracts or contract amendments have been included in the application and all are complete **(fully executed and dated)** and consistent with the B-DC and B-DCL forms.

______ 2. The Verification of B-DC Form (Attachment III) has been signed by the CEO and notarized.

______ 3. All discount contracts and their respective discounts, and all other discounts (i.e. unallowed administrative write-offs) provided during the projected actual year are listed on the projected actual B-DCL form.

______ 4. All discount contracts and their respective discounts, and all other discounts (i.e. unallowed administrative write-offs) budgeted for the rate year, are listed on the budget B-DCL form. **Note: Any contract not listed on the budget B-DCL form, will not be approved for the upcoming year.**

______ 5. The expiration date of each contract listed on the DCL form is noted beside the contract name. If the contract is an automatic renewal, then enter Auto.

______ 6. All contracts for which the B-DCL form indicates **"Must Separate"** for either the inpatient or outpatient discounts, must be reported on the B-DC form in a **separate** column. Conversely, only those contracts in which the B-DCL form indicates "Combine" for both the inpatient and outpatient discounts can be reported in a combined column on the B-DC form.

______ 7. All new contracts or contracts without a current approval are reported **separately** on both the projected actual (if utilized in the current year) and budget B-DC forms.

______ 8. All discounts that are considered non-third party contracts by the Authority are listed in the lower section of the B-DCL form and are reported **separately** on the B-DC forms.

______ 9. All contracts that have utilization equal to or greater than five (5) percent of the total nongovernmental utilization are listed in the lower section of the B-DCL form and are reported **separately** on

the B-DC form. (See B-DCL form template for calculation of five percent volume threshold.) **NOTE: DO NOT put a contract in both the top and the bottom section of the B-DCL form. Any "Must Separate" contract must be removed from the top section and moved to the bottom section of the B-DCL form.**

_____ 10. All contracts that are for an HMO or include risk-based reimbursements are listed in the lower section of the B-DCL form and are reported **separately** on the B-DC form.

_____ 11. Costs on line 9 and line 18 for all columns must be allocated on the ***total*** cost to charge ratio that is used on the B-5 form and entered on line 12 and line 21.

_____ 12. **Contracts with separate discount percentages contained within one contract are to be listed as one contract in one column on the B-DC form (for example: Basic, PPO/HMO rates are to be converted to a combined percentage for the over-all contract).**

_____ 13. The total inpatient contractual allowance amount (line 7) must equal the total nongovernmental contractual allowance on B-5, (line 2, column F).

_____ 14. The total outpatient contractual allowance amount (line 16) must equal the total nongovernmental contractual allowance on B-5, (line 2, column G).

_____ 15. Confirm that items not considered a contractual allowance per Policy Statement 2000-4 are **NOT** listed on the B-DC form as a contractual allowance.

_____ 16. Separate columns are required for any contract that was used prior to obtaining approval by the Authority. (i.e. contract was used Jan., Feb., and March without obtaining the Authority's approval. Approval was given April 2, then, there should be a column for the discounts granted Jan., Feb., and March and a column for the discounts granted from April 2 to the fiscal year end.) **Note: If otherwise qualified to be combined, the approved portion of the provided discounts may be included in the combined column.**

F. B-9 (Rate Compliance) COMPLETE ENTIRE FORM, EVEN IF NO OVERAGE

_____ 1. **Case Mix** – **(Excluding outliers per Policy Statement 2006-1 and nursery discharges with MS-DRG of 794 or 795 with revenue codes of 170 or 171)** Provide details and back-up for the projected actual year (regardless of whether or not the hospital has an overage). The reporting time periods are the same for both projected actual year and the prior year data. Also, please indicate the reporting time periods (e.g. July 1 through March 31). The reporting time period should be the same as the reporting period indicated in Section A number 8a of this checklist.

_____ 2. The case mix backup data (**excluding** outliers and nursery discharges with MS-DRG of 794 or 795 with revenue codes of 170 or 171) includes the following required information for each discharge:

Account Number, Date of Discharge, DRG, Weight, Length of Stay,

Total Charges, Financial Class Code, and Insurance Plan Code

►►► **NOTE: Case mix backup should include NONGOVERNMENTAL PAYORS ONLY.**

_____ 3. Provide a key or crosswalk from the hospital's financial class codes and insurance plan codes to the class and code full description.

_____ 4. Outliers - Provide details and back-up for the projected actual year (regardless of whether or not the hospital has an overage). The reporting time periods are the same for both projected actual year and the prior year data. Also, please indicate the reporting time periods (e.g. July 1 through March 31). The reporting time period should be the same as the reporting period indicated in Section A number 8a of this checklist.

►►► **NOTE: If no outliers occurred, please indicate.**

►►► **NOTE: Outliers are now defined by peer groups and are updated annually. Your next year's outlier threshold will always be listed in your order for the budget year.**

The "prior year" and "current year" outliers reported on the B-9 must be stated using the same outlier threshold. Therefore, the "prior year" outliers must be restated using the outlier threshold the hospital was under for the "current year". This threshold was stated in your most current rate order.

_____ 5. The outlier backup data includes the following required information for each outlier:

Account Number, Date of Discharge, DRG, Weight, Length of Stay, Total Charges, Financial Class Code, and Insurance Plan Code.

NOTE: Outlier backup should include NONGOVERNMENTAL PAYORS ONLY.

_____ 6. The revenues and discharges or visits projected for the current year on the B-9 should match the projected actual on the B-1 and B-2 forms.

_____ 7. Amounts on Lines 6, 7, and 8 have been revised to reflect the projected actual data reported in the prior year's rate application on Lines 1, 2, and 3 of the prior year's B-9.

_____ 8. The amount on Line 9 should equal the prior year's unjustified overage per discharge (either **assessed** or placed **in abeyance)** from the most recent order. (**NOT** the amount of the penalty levied)

_____ 9. For any new services not included in the prior year's budget complete Attachment VIII to determine the amount of justification provided by the new service. If applicable, provide information as to when the new service began and the date of CON approval, or notification to the Authority.

NOTE: In order to utilize new service(s) as justification for an overage it must first have been approved by the Rate Review Department. Approval or non-reviewability by CON does NOT constitute approval by the Rate Review Department.

_____ 10. If more than one rate order was in effect for the current year, complete Attachment V for the weighted allowed calculation. Utilization used in this calculation must match the B-1 form for projected actual.

_____ 11. Provide detailed back-up justification for each overage. Justification for any overage must be: (a) described narratively; (b) quantified; and, (c) verifiable. Use Attachment IV for outpatient justification. **Note: See Policy Statement 2009-2, which revised the method for calculating the outpatient overage justification.**

NOTE: All high cost/low cost procedures provided in the budget will be utilized (those with increased utilization as well as decreased utilization) when calculating outpatient overage justification in the next rate application. (See Policy Statement 2009-2)

_____ 12. Provide revenues and visits included in the budget for any high cost/low cost outpatient procedures that the hospital may wish the Authority to consider as potential justification for any potential overages in the next year. (e.g.: Ambulatory Surgeries, MRI, etc.)

REMEMBER: If this data is NOT provided, the hospital cannot use these items as justification for an overage in the next rate application.

G. MISCELLANEOUS – Your signature at the end of this document verifies the application has been completed according to the following guidelines unless a detailed explanation regarding any variances from required guidelines is provided. Failure to follow the guidelines and/or supply a detailed explanation may result in a delay in processing the application.

1. B-1

a. Excluded from the patient days and patient discharges are the days and discharges the hospital recorded as normal newborn nursery days and discharges. These are newborns billed on the UB forms that are indicated with MS-DRG 794 and 795 with Revenue Codes of 170 or 171.

b. Outpatient visits must include outpatient series visits with a brief explanation of how the visits are counted. Series visits represent recurring visits on separate days, over the course of a treatment period. (e.g. outpatient physical therapy) A visit should be recorded for each day treatment is provided.

c. Nongovernmental payors observation statistics must be included as outpatient statistics with lengths of stay less than 24 hours. **NOTE: Observation stays included in outpatient statistics and outpatient**

revenue are not to exceed a 24-hour length of stay. (e.g.: 23 hours 59 minutes)

d. All application forms are completed for both the projected actual year and budget year.

e. Home Health visits – only count a visit where a charge (billable visit) is made.

2. B-2

Ancillary revenues are included with Distinct Part Units even though each Distinct Part Unit is not reported separately in the application.

NOTE: If ancillary revenues are NOT included with Distinct Part Units, please provide an explanation as to why they are not and where they are accounted for in the application.

3. B-DC

a. Attachment III has been signed by the hospital CEO and notarized.

b. The application only includes a total form. No separate forms are required for acute and Distinct Part Units. **(NOTE: The Total form must include all contracts, including contracts negotiated specifically for Distinct Part Units. Further, the total form contractuals must match the total form B-5 contractual allowances. The total B-DC form is for the entire hospital operation.)**

4. B-9

a. The prior year case mix used on the form matches what was accepted in the prior year order. If this is not quoted in the rate order, then the case mix index must match what was submitted on the prior year's B-9 Line 12. However, this must now be **re-stated** removing the outliers at the threshold stated in the order that set the revenue limits on Line 4. (See Policy Statement 2006-1 for additional information)

b. Outlier information should be projected actual for both prior and current years and for revenue and utilization data. (See instructions for B-9 and Outlier Policy for greater detail)

c. Lines 6, 7, and 8 must provide the prior year's projected actual data.

d. The B-9 form is completed for both inpatient and outpatient.

I hereby verify that the application has been completed in accordance with the checklist directives and guidelines unless specifically noted. I further acknowledge that failure to follow these directives and guidelines may result in this application not being deemed complete or that completeness may be rescinded at a later date.

____

Preparer of Rate Application

____

Contact Person***

____

Contact Person's fax number

____

Contact Person's telephone number

____

Contact Person's email address

____

CFO

____

CEO

*****<u>NOTE</u>: Please indicate a contact person either from the hospital or within the consultant's firm to which questions are to be directed.**

Attachment I

LEGAL NOTICE

In accordance with the Procedural Rules of the West Virginia Health Care Authority (Authority), ___________________________ Hospital, on ___________ applied for a change to its current schedule of rates. The application and proposed budget for Fiscal Year ____________ includes an increase of _____% from the hospital's nongovernmental acute **projected actual** average charge per inpatient discharge of $_______ to $_________. The application and proposed budget for Fiscal Year ___________ includes an increase of ______% from the hospital's nongovernmental acute **projected actual** average charge per outpatient visit of $____________ to $___________.

The application and proposed budget are available for public inspection at the hospital or the offices of the West Virginia Health Care Authority at 100 Dee Drive, Charleston, WV 25311 during regular business hours. Any person who claims to be an interested person in the proceedings for the setting of the hospital's rate schedule must file with the Authority, a written notice setting forth the interested person's name, address and facts relied upon to establish his or her interest. This notice must be filed within thirty days from the date of the hospital's filing of its application with the Authority.

Attachment II

CERTIFICATION OF BENCHMARKING RATE APPLICATION

I hereby certify that I have examined the accompanying benchmarking rate application for ____________ Hospital located at ____________, West Virginia, and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the Hospital in accordance with the applicable instructions.

Further, I hereby certify that I have examined the accompanying proposed 20___ budget for _____________________ Hospital and that said budget was approved by the Board of Directors of _________________ Hospital on ___________.

____ __________________
Administrator **Date**

____ __________________
Chairman of the Board of Trustees **Date**

Attachment III

WEST VIRGINIA
HEALTH CARE AUTHORITY

____
Hospital Name

VERIFICATION OF B-DC AND B-DCL

I certify that the information pertaining to discount contracts for the projected actual year of 20____, and budget year of 20____ contained in the B-DC and B-DCL forms are accurate and true to the best of my knowledge and belief.

____
Hospital Administrator (CEO)

Taken, sworn and subscribed to me by ___________________
this _________ day or ________________, 20____.

____ (SEAL)
Notary Public

Attachment IV

Outpatient Overage Justification

TABLE A

FY 20___ Projected Actual

1	Nongovernmental Acute Outpatient Revenue			
2	Divide by: Nongovernmental Acute Visits			
3	Average Projected Actual Rate per Visit			
4	Less: FY 20__ Allowed or Wtd. Allowed*			
5	FY 20__ Overage**			

*Must match CBM/B-9 – Line 4 of the rate application **Must match CBM/B-9 – Line 5 of the rate application

TABLE B

High Cost/Low Cost Procedure Calculation

NOTE: The hospital must include ALL (those with increased utilization as well as decreased utilization) high cost and/or low cost procedures included with the budget when calculating the outpatient overage justification.

			FY 20__ - Current Year Budget (1)	FY 20__ - Current Year Projected Actual (2)	Difference (FY 20__ current projected actual less FY 20__ budget) Column 3 minus Column 2 (3)
1	CT Scans*	Revenues^^			
2		Visits			
3		Avg/Visit^			
4	MRI*	Revenues^^			
5		Visits			
6		Avg/Visit^			
7	Amb. Surgery*	Revenues^^			
8		Visits			
9		Avg/Visit^			
10	Totals	Revenue			
11		Visits			

***High cost/Low cost categories may be changed as needed to include those high cost/low cost categories provided with the budget.**
^The current year projected actual average charge per visit (column 2) must equal the current year budgeted average charge per visit (column 1).
^^The current year projected actual revenue is calculated by multiplying the current year projected actual utilization by the average charge per visit.

TABLE C

"Calculated" Per Visit Table

		FY 20__ Projected Actual Average (From Table A)	Less: Sums of FY 20__ Current Projected Actual less FY 20__ Budget (From Table B Column #3 – Totals)	"Calculated" Revenue per Visit
1	Revenue			
2	Visits			
3	Avg. per visit			

TABLE D

Dollar Value of High Cost/Low Cost Procedures

1	Projected Actual Revenue per visit (from Table A, line 3)		
2	Less: "Calculated" Revenue per Visit (from Table C, line 3)		
3	Increase Due to Change in High/Low Cost Procedures		

TABLE E

Calculation for remaining overages

1	FY 20__ Overage (from Table A, line 5)		
2	Less: Justification due to change in high/low cost procedures (from Table D, line 3)		
3	Remaining Outpatient Overage – (unjustified overage)		

Attachment V

Form B-9

Weighted Allowed Calculation per Discharge

(Complete only if more than one rate was in effect during the projected actual year)

Time Period Rate was in Effect	Utilization for the Time Period	X	Revenue Limit in Effect	=	Allowed Revenue
		X			
		X			
		X			

Total Utilization* =

Total Revenue =

Attachment VI

Additional Information Required

Please provide the following data for the most current year for which actual data would be available.

FY 20__	**Malpractice Expense**	**$_____________**
FY 20__	**Provider Tax**	**$_____________**
FY 20__	**Other taxes (sales tax, personal property tax, etc.)**	**$_____________**

Attachment VII

Additional Information Required

Although separate forms are not required, the hospital is to provide the Authority a listing of all Distinct Part Units (DPUs) for the budget year only. However, if there is a change from current year to budget year please note any change. Remember DPU data is ***NOT*** to be included with acute care data **EXCEPT** for home health and hospice which **IS** included with acute care.

For rate review purposes the following are considered rate review approved DPUs:

Skilled Nursing Facility, Long Term Care Unit, Rehabilitation Unit, Respite Care, Physicians' Office Practice (owned by the hospital), Clinics (could include Ambulatory Care, Rural Health, Primary Care and others), Swing beds and Psychiatric/Behavioral Medicine/Substance Abuse.

For budget year FY 20___, the hospital has the following rate review approved DPUs (Note: if more than 1 clinic please list each separately):

____
____
____
____
____
____
____
____

ATTACHMENT VIII

New Service Justification

In order to use a New Service as justification for an overage it must have been submitted previously to the Rate Review Department and received approval (§ 65-5-13).

If the New Service is for both inpatient and outpatient, complete the entire form. However, if the New Service is only inpatient or outpatient then only complete the applicable portion of the form.

TABLE A

FY 20___ Projected Actual

Date of Order from Rate Review that approved the new service: __________

INPATIENT

1	Nongovernmental Acute Inpatient Revenue			
2	Divided by: Nongovernmental Acute Discharges			
3	Average Projected Actual Charge per Discharge			
4	Less: FY 20____ Allowed or Wtd. Allowed*			
5	FY 20___ Inpatient Overage**			

*Must match CBM/B-9 – Line 4 of the rate application **Must match CBM/B-9 – Line 5 of the rate application

OUTPATIENT

1	Nongovernmental Acute Outpatient Revenue			
2	Divided by: Nongovernmental Acute Visits			
3	Average Projected Actual Charge per Visit			
4	Less: FY 20____ Allowed or Wtd. Allowed*			
5	FY 20___ Outpatient Overage**			

*Must match CBM/B-9 – Line 4 of the rate application **Must match CBM/B-9 – Line 5 of the rate application

TABLE B

New Service Calculation

INPATIENT

			FY 20__ Current Year Projected Actual
1	New Service*	Nongov't Revenues	
2		Nongov't Discharges	
3		Nongov't Avg/Disch.	
4	New Service*	Nongov't Revenues	
5		Nongov't Discharges	
6		Nongov't Avg/Disch.	
7	Totals	Nongov't Revenues	
8		Nongov't Discharges	
9		Nongov't Avg/Disch.	

OUTPATIENT

			FY 20__ Current Year Projected Actual
1	New Service*	Nongov't Revenues	
2		Nongov't Visits	
3		Nongov't Avg/Visit	
4	New Service*	Nongov't Revenues	
5		Nongov't Visits	
6		Nongov't Avg/Visit	
7	Totals	Nongov't Revenues	
8		Nongov't Visits	
9		Nongov't Avg/Visit	

*The actual name of the new service should be submitted in place of “New Service”.

TABLE C

“Calculated” Per Discharge and/or Visit Tables

INPATIENT

		FY 20__ Nongov't Projected Actual (From Table A)	Less: Total FY 20___ Prj. Actual New Services (From Table B – lines 7 and 8)	“Calculated” Revenue per Discharge
1	Revenue			
2	Discharges			
3	Avg. per Disch.			

OUTPATIENT

		FY 20__ Nongov't Projected Actual (From Table A)	Less: Total FY 20___ Prj. Actual New Services (From Table B – lines 7 and 8)	"Calculated" Revenue per Visit
1	Revenue			
2	Visits			
3	Avg. per Visit			

TABLE D

Dollar Value of New Services

INPATIENT

1	Projected Actual Revenue per Discharge (from Table A - Inpatient, line3)	
2	Less: "Calculated" Revenue per Discharge (from Table C - Inpatient, line3)	
3	Increase in Average Charge per Discharge due to New Service	

OUTPATIENT

1	Projected Actual Revenue per Visit (from Table A - Outpatient, line3)	
2	Less: "Calculated" Revenue per Visit (from Table C - Outpatient, line3)	
3	Increase in Average Charge per Visit due to New Service	