STANDARD RATE APPLICATION CHECKLIST

Updated: April 2010

A. General Information Requirements

Please refer to the Standard 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 Exhibit A) and proof of publication. **(Note: Provide proof 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 is required for both 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. 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.

_____ 4. Original certification by the Chairman of the Board and Hospital Administrator. (See Exhibit B)

_____ 5. Copy of the hospital's current license.

_____ 6. Report on the hospital's cost containment efforts ("Section 21" report).

_____ 7. Summary of the hospital's rate increase request. Include with the summary, an explanation for the hospital's need for the requested rate increase.

_____ 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 Donna Crane or Mary Fitzgerald of the Authority's Financial Disclosure Division to determine whether their financial disclosure file is complete and Sheila Chapman of the Data and Public Disclosure 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 Donna Crane or Mary Fitzgerald of the Authority's Analysis Division to determine whether the Related Organization's financial disclosure file is complete.) ***Note: Compliance is required for deeming 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. 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)

_____ 16. 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.

_____ 17. ADDITIONAL INFORMATION REQUIRED – (1) Exhibit G is completed and includes 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) Exhibit C is completed for the budget year (a current listing of all Distinct Part Units (DPUs)).

►►► **NOTE: The Authority no longer sets Distinct Part Unit rates. The data for these units are NOT to be included with acute care data at any time. If the hospital acquires a CON for a new DPU, then that data is to be filed with DPU data. If there is a question about whether it should be a DPU or not, please contact the Authority for determination before filing the rate application.**

For the purposes of the rate application the following are the Authority's definitions:

1. Significant – Of significant importance to warrant disclosure or likely to influence judgments or decisions. (A Dictionary for Accountants, Fourth Addition)

2. Extraordinary Items – Events and transactions that are distinguished by their unusual nature and by the infrequency of their occurrence. **Both** of the following criteria shall be met to classify an event or transaction as an extraordinary item:

a. Unusual nature – the underlying event or transaction possesses a high degree of abnormality and is of the type clearly unrelated to, or only incidentally related to, the ordinary and typical activities or the enterprise.

b. Infrequency of occurrence – the underlying event or transaction is of a type that would not reasonably be expected to recur in the foreseeable future, taking into account the environment in which the enterprise operates. (APB 30, paragraph 20 or FASB Accounting Standards, Current Text 117.401)

3. Outpatient visit – all services provided to an outpatient in the course of a single appearance in an outpatient or inpatient unit. (HFMA – "Fundamentals of Healthcare Financial Management")

4. Distinct Part Unit – See Exhibit C for further instructions as to the Authority's definition of Distinct Part Units.

5. Related Organization – See 65 C.S.R.§13.2.6.(a-h) for the definition of a related organization as defined by the Financial Disclosure Rule.

B. CBM-1 Discharges, Days, Visits and CBM-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 CBM-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 CBM-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. CBM-3 Salary and Wage Summary – Submit one form for Acute care (which includes Home Health and Hospice) and a TOTAL CBM-3 form.

►►► **NOTE: All physicians employed by the hospital should be reported as "supervisory 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 hospital granted discounts to only certain employees, then these discounts must be reported on the CBM-DC forms as discounts. (See Policy Statement 2000-4 for further details)

_____ 3. Compare projected actual salaries and benefits (line 2) to prior year's budgeted salaries and benefits (line 1). Provide an explanation only if the hospital experienced significant variances that are either over or under budget. (i.e. FTEs were replaced by contract labor) **Note: Any variance in projected actual non-supervisory salaries and benefits that are below the prior year's budget (line 1) may result in a reduction of the requested rate.**

_____ 4. Provide an explanation only if the hospital experienced a significant increase or decrease of FTEs from prior year's budget to projected actual to current budget. If the hospital utilized contract labor in lieu of the budgeted FTEs please provide thorough documentations – such as FTE reduction, reductions in benefits, etc.

_____ 5. Do the total supervisory and non-supervisory wages and fringe benefits equal the total wages and benefits on the Board-approved budget? (YES) (NO) If **NO,** provide a narrative reconciliation of any differences.

_____ 6. Have there been any additions or reductions in fringe benefits that have caused the percentage to increase/decrease? (YES) (NO) If **YES**, provide a detailed explanation, including the estimated dollar amounts of the benefits.

D. CBM-4 (Operating Expenses) – Submit a separate form for acute care (which includes Home Health and Hospice), a separate form which includes ALL Distinct Part Unit(s), as well as a TOTAL CBM-4 form.

_____ 1. For total atypical operating expenses (lines 4 through 12), provide an explanation only if the hospital experiences a significant increase or decrease from last year's budget to projected actual.

_____ 2. Do the total expenses on line 3 equal the total operating expenses on the Board-approved budget and line 6 – operating expenses on CBM-5? If **NOT**, provide a reconciliation of any differences (e.g. bad debt expense listed as an operating expense on the Board-approved budget, but not on CBM-4; etc.).

_____ 3. Do CBM-4 line items reported in the hospital's Board-approved budget agree with the CBM form? (YES) (NO) If **NO**, provide a detailed explanation.

_____ 4. Are capital related costs allocated to the Distinct Part Units? (YES) (NO) If **NO**, please provide a brief explanation as to why they are not allocated.

_____ 5. **ADDITIONAL INFORMATION REQUIRED – Exhibit G is to be completed and include the required data (malpractice expense, provider tax, and other taxes) for the most current year for which actual data is available.**

E. CBM-5 (Income Statement) – Submit a separate form for acute care services (which include Home Health and Hospice), a separate form which includes ALL Distinct Part Unit(s) as well as a TOTAL CBM-5 form.

_____ 1. Provide an explanation only if the hospital experienced a significant variance for any line item when comparing the current year's budget to projected actual and projected actual to the new budget.

_____ 2. Indicate on the **TOTAL** CBM-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.

_____ 3. Has there been any change in the method of allocating expenses to Distinct Part Units from prior years? (YES) (NO) If **YES**, provide a detailed explanation of the reason for the change.

_____ 4. Any amount on a CBM-5 line item that is also stated as a separate item on the Hospital's Board-approved budget must agree. If **NOT**, provide a detailed explanation.

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

F. CBM-6 (Balance Sheet)

►►► **NOTE: The reporting time periods must be the same for both prior and current year. Also, please indicate the period ending date on the form.**

_____ 1. Explain significant variances from prior year to current year.

_____ 2. Have there been significant changes in any line items from prior to current year? (YES) (NO) If **YES**, provide a detailed explanation.

G. CBM-DC and CBM-DCL (Discount Contracts) – Both forms must be submitted with the rate application. Submit a TOTAL CBM-DC form and a CBM-DCL form for both projected actual and budget years. All contracts should be listed on the CBM-DCL form 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 CBM-DC and CBM-DCL forms.

_____ 2. The Verification of the CBM-DC Form (Exhibit D) 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 CBM-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 CBM-DCL form. **Note: Any**

contract not listed on the budget CBM-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 CBM-DCL form indicates as a **"Must Separate"** for either the inpatient or outpatient discounts, must be reported on the CBM-DC form in a **separate** column. Conversely, only those contracts in which the CBM-DCL form indicates as a "Combine" for both the inpatient and outpatient discounts can be reported in a combined column on the CBM-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 CBM-DC forms.

_____ 8. All discounts that are considered non-third party contracts by the Authority are listed in the lower section of the CBM-DCL form and are reported **separately** on the CBM-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 CBM-DCL form and are reported **separately** on the CBM-DC form. (See CBM-DCL template form 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 CBM-DCL form and are reported **separately** on the CBM-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 CBM-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 CBM-DC form (e.g.: 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 CBM-5, (line 2, column F).

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

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

H. CBM-RO (Related Organizations)

_____ 1. Complete a column for each related organization. **Note: Each related organization must be in compliance with financial disclosure to be eligible for deeming complete.**

_____ 2. Does the hospital receive management fees? (YES) (NO) If **YES**, provide a detailed summary of the services received for these fees.

_____ **3.** Does the hospital pay management fees? (YES) (NO) If **YES**, please provide a detailed summary of the services covered by the fees**.**

_____ 4. 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 _____

_____ 5. Please provide an explanation of how management fees are calculated.

_____ 6. Has the calculation of management fees changed since the prior fiscal year?

_____ 7. If the hospital receives or pays other monies, provide a detailed summary of the source of the funds received or paid.

I. CBM-9 (Rate Compliance) - COMPLETE ENTIRE FORM, EVEN IF NO OVERAGE (Use only the CBM-9 form entitled: "Application CBM-9")

_____ 1. **Case Mix** – **(Excluding outliers per Policy Statement 2006-1 and nursery discharges with an 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 an 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.**

Also, provide a key or crosswalk from the hospital's financial class codes and insurance plan codes to the class and code full description.

_____ 3. 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 defined as cases, which have a charge exceeding $44,000 and/or stays in excess of 30 days. If the outliers in last year's application were under a different definition (such as benchmarking) then for compliance purposes, the outlier back-up must also be submitted using last year's definition.**

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 may need to be restated using the outlier threshold the hospital was under for the "current year". This threshold was stated in your most current rate order.

_____ 4. 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.**

_____ 5. The revenues and discharges or visits projected for the current year on the CBM-9 should match the projected actual on the CBM-1 and CBM-2 forms.

_____ 6. 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 CBM-9.

_____ 7. 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).

_____ 8. For any new services not included in the prior year's budget and is being used as justification for an overage, Exhibit H must be completed. If applicable, provide information as to when the new service began and the date of CON approval, or notification to the Authority. Further, provide the date of the HCA Rate Review Division order establishing a rate for the new service**.**

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

_____ 9. If more than one rate order was in effect for the current year, complete Exhibit E for the weighted allowed calculation. Utilization used in this calculation must match the CBM-1 form for projected actual.

_____ 10. Provide detailed back-up justification for each overage. Justification for any overage must be: (a) described narratively; (b) quantified; and, (c) verifiable. Use Exhibit F attached to this checklist for outpatient overage 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)**

_____ 11. 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.

J. **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 the application not being deemed complete or completeness may be rescinded at a later date.

1. CBM-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 CBM 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. CBM-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. CBM-4

   All costs are allocated between inpatient and outpatient and allocated proportional to the gross revenues on CBM-2 for each Distinct Part Unit even though separate forms for Distinct Part Units are no longer required.

   NOTE: If all costs are NOT allocated between inpatient and outpatient and allocated proportional to the gross revenues on the CBM-2, what other method of allocation is used? Provide the

documentation for the basis of the allocation and provide detail and verifiable back-up data.

4. CBM-5

Total operating expenses are allocated by payor for each Distinct Part Unit based on the gross revenues by payor on line 1 even though separate forms for Distinct Part Units are no longer required.

5. CBM-DC

a. Exhibit D 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 CBM-5 contractual allowances. The total CBM-DC form is for the entire hospital operation.)**

6. CBM-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 CBM-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 CBM-9 and Outlier Policy for greater detail.)

c. Lines 6, 7, and 8 must provide the prior year's projected actual data if an increase in case mix is being used as justification for an overage, otherwise, these lines may be left blank.

d. The CBM-9 form is completed for both inpatient and outpatient regardless of whether or not there is an overage.

K. <u>MATHEMATICAL CROSS-CHECKS & EDIT</u> – Your signature at the end of this document verifies that all the following math checks and

edits have been completed for both projected actual and current budget. Failure to complete edit checks may result in the application not being deemed complete and/or completeness may be rescinded at a later date.

1. CBM-1-A, B & C

   a. On CBM-1 and CBM-1A, the sum of lines 1 and 2 for each payor equals line 3. The total column equals the sum of all payors.

   b. On CBM-1B, the sum of lines 1 through 6 equals the total acute on line 7. The total of lines 7 and 8 equals the total on line 9 for each payor. The total column equals the sum of all payors.

   c. On CBM-1C, the total licensed and set-up beds for each unit should equal the "total" at the bottom of the form. Compare the licensed beds on this form to the copy of the hospital license submitted with the application and provide an explanation of any differences. **(NOTE: Respite and swing beds are counted in the medical surgical bed complement by Licensure.)**

2. CBM-2 and 2A

   a. CBM-2 – Gross Inpatient Revenue (including any Hospice revenue) – Total acute gross inpatient revenue equals the sum of acute gross inpatient revenue for each payor for both projected actual and budget years.

   b. CBM-2 – Hospital Distinct Part Unit(s) Inpatient Revenue – Total hospital distinct part unit(s) inpatient revenue equals the sum of hospital distinct part unit(s) inpatient revenue for each payor for both projected actual and budget years.

   c. CBM-2 – Total Inpatient Revenue – Total inpatient revenue equals the sum of acute gross inpatient revenue and hospital distinct part unit(s) inpatient revenue for all payor classes and total.

      NOTE: CBM-2 Total Gross Inpatient Revenue must match the Total CBM-5 Inpatient Revenue.

   d. CBM-2A – Acute Gross Outpatient Revenue (including Home Health and Hospice) – Acute gross outpatient revenue equals the sum of acute gross outpatient revenue for each payor for both projected actual and budget years.

e. CBM-2A – Hospital Distinct Part Unit(s) Outpatient Revenue – Total hospital distinct part unit(s) outpatient revenue equals the sum of hospital distinct part unit(s) outpatient revenue for each payor for both projected actual and budget year.

f. CBM-2A – Total Outpatient Revenue – Total outpatient revenue equals the sum of acute gross outpatient revenue and hospital distinct part unit(s) outpatient revenue.

NOTE: CBM-2A Total Gross Outpatient Revenue must match the Total CBM-5 Outpatient Revenue.

3. CBM-3

Line a + Line b = Line c for Lines 1, 2 and 3, except for the last two columns. For those two columns, Line c is calculated the same as Lines a and b.

4. CBM-4

a. The sum of line 1 + line 2 equals line 3; the sum of lines 5 through 13 equals line 14; line 3 less line 14 equals line 15; line 16 + line 17 equals line 18; line 15 equals line 18.

b. For projected actual and budget, the atypical costs on lines 2a and 3a on the CBM-3 should equal the sum of the respective supervisory and non-supervisory salaries/benefits on line 9 through 11 and line 13 on the CBM-4 for current and budget years respectively.

c. The sum of atypical FTEs listed on the CBM-4 form (lines 9 through 11 and 13) for projected actual and budget years should equal atypical FTEs listed on line 2a and 3a on the CBM-3 form for each unit and in total.

5. CBM-5

a. Line 1 (less) the sum of lines 2 through 4 equals line 5; line 5 less line 6 equals line 7; the sum of lines 7 through 12 equals line 13.

b. Totals on each line in column A equals the sum of columns B through G.

c. The sum of the corresponding figures on each line and column for both acute and hospital distinct part units equals the grand total CBM-5 form.

d. Line 6, column A must equal line 3 of the CBM-4 form for both projected actual and budget years.

e. Line 2, column F must equal line 7 of the total column of the CBM-DC form and line 2, column G must equal line 16 of the total column of the CBM-DC form.

6. CBM-6

a. For assets, the sum of lines 1 though 6 equals line 7; the sum of lines 7 through 9 plus line 12 equals line 13.

b. For liabilities and fund balance, the sum of lines 1 through 5 equals line 6; the sum of lines 6 through 12 equals line 13; the sum of lines 13 through 15 equals line 16.

NOTE: There cannot be numbers in both lines 14 and 15.

7. CBM-DC

a. The total column equals the “Combined Contracts” column and all the individually reported discount contract columns for Lines 4, 5, 7-9, 13, 14, 16-18.

b. For all contract columns, Line 5 less Line 7 equals Line 8 and Line 14 less Line 16 equals Line 17.

c. For the individual contract columns, Line 10 equals Line 5 divided by Line 4; Line 11 equals Line 9 divided by Line 4; Line 19 equals Line 14 divided by Line 13; and, Line 20 equals Line 18 divided by Line 13.

d. Lines 12 and 21 equal the cost-to-charge ratio that matches the CBM-5 form.

NOTE: The total column on page one (1) includes all subsequent pages. There is NOT a total column for each page.

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

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

EXHIBIT A

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 patient stay, from $_____ 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, from $_____ 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.

EXHIBIT B

CERTIFICATION OF STANDARD RATE APPLICATION

I hereby certify that I have examined the accompanying standard rate application for _____ Hospital located at _____, West Virginia, and to the best of my knowledge and belief, it is a true, correct and is a 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**

EXHIBIT C

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):

_____
_____
_____
_____
_____
_____
_____
_____

EXHIBIT D

WEST VIRGINIA
HEALTH CARE AUTHORITY

_____
Hospital Name

VERIFICATION OF CBM-DC AND CBM-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 CBM-DC and CBM-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

EXHIBIT E

Form CBM-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 =**	

Total Allowed Revenue _____ ÷ Total Utilization for the time period_____ = Weighted Allowed per Discharge

*__NOTE__: The **total utilization** must **match** the projected actual total nongovernmental acute discharges reported on the **CBM-1 form**.

Weighted Allowed Calculation per O/P Visit

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 =**	

Total Allowed Revenue _____ ÷ Total Utilization for the time period_____ = Weighted Allowed per Outpatient Visit

****NOTE**: The **total utilization** must **match** the projected actual total nongovernmental acute visits reported on the **CBM-1 form.**

EXHIBIT F

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)		

EXHIBIT G

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.)	$_____

EXHIBIT H

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 Division 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 the Rate Division 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/B9 - Line 4 of the rate application **Must match CBM/B9 – 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/B9 – Line 4 of the rate application **Must match CBM/B9 – 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	