

CHAPTER 31B
HOSPITAL FINANCING

Authority

N.J.S.A. 26:2H-1 et seq.

Source and Effective Date

R.2000 d.339, effective July 24, 2000.
See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 31B, Hospital Financing, expires on January 20, 2006. See: 37 N.J.R. 2165(a).

Chapter Historical Note

Subchapter 1, Hospital Rate Commission, was adopted as R.1979 d.285, effective July 20, 1979. See: 11 N.J.R. 233(a), 11 N.J.R. 439(c). Pursuant to Executive Order No. 66(1978), Subchapter 1 expired on July 19, 1984.

Subchapter 4, Financial Elements and Reporting, was adopted as R.1979 d.407, effective October 17, 1979. See: 11 N.J.R. 329(a), 11 N.J.R. 550(a).

Subchapter 3, Financial Monitoring and Reporting Regulations, was adopted as R.1979 d.408, effective October 17, 1979. See: 11 N.J.R. 436(a), 11 N.J.R. 550(b).

Subchapter 2, Hospital Reporting of Uniform Bill—Patient Summaries (Inpatient), was adopted as R.1979 d.450, effective November 13, 1979. See: 11 N.J.R. 435(b), 11 N.J.R. 621(a).

Subchapter 5, Diagnosis Related Groups, was adopted as R.1982 d.27, effective February 1, 1982. See: 13 N.J.R. 726(b), 14 N.J.R. 147(b).

Subchapter 6, Mobile Intensive Care Units, was adopted as R.1982 d.38, effective February 16, 1982. See: 13 N.J.R. 647(a), 14 N.J.R. 208(a).

The Executive Order No. 66(1978) expiration date for Subchapter 2, Hospital Reporting of Uniform Bill—Patient Summaries (Inpatient), was extended by gubernatorial directive from November 14, 1984 to February 12, 1985 and the Executive Order No. 66(1978) expiration dates for Subchapter 3, Financial Monitoring and Reporting Regulations, and Subchapter 4, Financial Elements and Reporting, were extended by gubernatorial directive from October 17, 1984 to October 17, 1985. See: 16 N.J.R. 2733(a).

Pursuant to Executive Order No. 66(1978), Subchapter 2, Hospital Reporting of Uniform Bill—Patient Summaries (Inpatient), was readopted as R.1984 d.610, effective December 17, 1984. See: 16 N.J.R. 2728(a), 17 N.J.R. 80(b).

Pursuant to Executive Order 66(1978), Subchapter 3, Financial Monitoring and Reporting Regulations, was readopted as R.1985 d.551, effective October 15, 1985. See: 17 N.J.R. 2000(a), 17 N.J.R. 2633(a).

Pursuant to Executive Order No. 66(1978), Subchapter 4, Financial Elements and Reporting, was readopted as R.1985 d.550, effective October 15, 1985. See: 17 N.J.R. 2004(a), 17 N.J.R. 2637(a).

Subchapter 7, Uncompensated Care Trust Fund, was adopted as R.1987 d.298, effective July 20, 1987. See: 19 N.J.R. 495(a), 19 N.J.R. 1297(a).

Subchapter 6, Mobile Intensive Care Units, was repealed by R.1990 d.462, effective September 17, 1990. See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Subchapter 5, Diagnosis Related Groups, was repealed by R.1993 d.593, effective November 15, 1993. See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Subchapter 7, Uncompensated Care Trust Fund, was repealed by R.1993 d.668, effective December 20, 1993. See: 25 N.J.R. 3125(a), 25 N.J.R. 6016(a).

Pursuant to Executive Order No. 66(1978), Chapter 31B, Hospital Rate Setting, was readopted as R.1990 d.462, effective August 17, 1990. See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Petition for Rulemaking. See: 24 N.J.R. 4131(a), 24 N.J.R. 4290(a).

Pursuant to Executive Order No. 66(1978), Chapter 31B, Hospital Financing, was readopted as R.1995 d.507, effective August 14, 1995. See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

Subchapter 5, Standards for Hospital Notification Regarding Offset of Medicaid Payments and Charity Care Subsidy Payments to Collect Hospital Debts Due to the State, was adopted as new rules by R.1998 d.569, effective December 7, 1998. See: 30 N.J.R. 3179(a), 30 N.J.R. 4221(a).

Pursuant to Executive Order No. 66(1978), Chapter 31B, Hospital Financing, was readopted as R.2000 d.339, effective July 24, 2000. See: Source and Effective Date. See, also, section annotations.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. GENERAL PROVISIONS

- 8:31B-1.1 Purpose and scope
- 8:31B-1.2 Definitions

SUBCHAPTER 2. HOSPITAL REPORTING OF UNIFORM BILL DATA (INPATIENT, SAME-DAY SURGERY AND EMERGENCY DEPARTMENT OUTPATIENT)

- 8:31B-2.1 Purpose
- 8:31B-2.2 Implementation
- 8:31B-2.3 Billing form
- 8:31B-2.4 Guidelines for completion of the patient billing and abstract form
- 8:31B-2.5 Health data submissions to the Department of Health and Senior Services
- 8:31B-2.6 (Reserved)

SUBCHAPTER 3. FINANCIAL MONITORING AND REPORTING REGULATIONS

- 8:31B-3.1 Statement of purpose
- 8:31B-3.2 (Reserved)
- 8:31B-3.3 Uniform reporting: current costs and other financial data
- 8:31B-3.4 through 8:31B-3.10 (Reserved)
- 8:31B-3.11 Same day surgery
- 8:31B-3.12 through 8:31B-3.15 (Reserved)
- 8:31B-3.16 Aggregate Current Cost Data Base
- 8:31B-3.17 Financial elements reporting/audit adjustments
- 8:31B-3.18 through 8:31B-3.23 (Reserved)
- 8:31B-3.24 Off-site primary care
- 8:31B-3.25 Net income from other sources
- 8:31B-3.26 Update factors
- 8:31B-3.27 through 8:31B-3.42 (Reserved)
- 8:31B-3.43 Reporting of charges
- 8:31B-3.44 through 8:31B-3.65 (Reserved)
- 8:31B-3.66 Health planning fees
- 8:31B-3.67 through 8:31B-3.69 (Reserved)
- 8:31B-3.70 (Reserved)
- 8:31B-3.71 through 8:31B-3.75 (Reserved)
- 8:31B-3.76 Necessity and appropriateness of health care services
- 8:31B-3.77 Definitions

- 8:31B-3.78 Criteria for qualification
- 8:31B-3.79 Use of findings
- 8:31B-3.80 Qualification procedure
- 8:31B-3.81 Payment for utilization review services
- 8:31B-3.82 Performance standards for maintenance of qualification
- 8:31B-3.83 through 8:31B-3.90 (Reserved)

SUBCHAPTER 4. FINANCIAL ELEMENTS AND REPORTING

- 8:31B-4.1 Purpose

PART I. REPORTING PRINCIPLES AND CONCEPTS

- 8:31B-4.2 Functional versus responsibility reporting
- 8:31B-4.3 Prescribed reporting principles
- 8:31B-4.4 Accounting entity
- 8:31B-4.5 Continuity of activity
- 8:31B-4.6 Reporting period
- 8:31B-4.7 Objective evidence
- 8:31B-4.8 Conservatism
- 8:31B-4.9 Consistency
- 8:31B-4.10 Full disclosure
- 8:31B-4.11 Materiality
- 8:31B-4.12 Basis of valuation
- 8:31B-4.13 Accrual accounting
- 8:31B-4.14 Matching of revenues and expenses
- 8:31B-4.15 Revenues and deductions from revenue
- 8:31B-4.16 Fund accounting
- 8:31B-4.17 Long-Term Security Investments
- 8:31B-4.18 Pooled investments
- 8:31B-4.19 Inventories
- 8:31B-4.20 Accounting for minor moveable equipment
- 8:31B-4.21 Accounting for capital facilities costs
- 8:31B-4.22 Timing difference
- 8:31B-4.23 Reporting of pledges
- 8:31B-4.24 Self insurance
- 8:31B-4.25 Related organizations
- 8:31B-4.26 through 8:31B-4.30 (Reserved)

PART II. FINANCIAL ELEMENTS

- 8:31B-4.31 Financial elements generally
- 8:31B-4.32 Services related to patient care
- 8:31B-4.33 Direct patient care
- 8:31B-4.34 Paid taxes
- 8:31B-4.35 Educational, research and training program
- 8:31B-4.36 (Reserved)
- 8:31B-4.37 (Reserved)
- 8:31B-4.38 Charity care and reduced charge charity care
- 8:31B-4.39 (Reserved)
- 8:31B-4.40 Demographic information
- 8:31B-4.41 through 8:31B-4.41N (Reserved)
- 8:31B-4.42 Capital facilities
- 8:31B-4.43 (Reserved)
- 8:31B-4.44 Major Moveable Equipment
- 8:31B-4.45 (Reserved)
- 8:31B-4.46 Reasonable Working Capital
- 8:31B-4.47 Return on Investment
- 8:31B-4.48 through 8:31B-4.50 (Reserved)

PART III. NATURAL CLASSIFICATIONS OF EXPENSES

- 8:31B-4.51 Salaries and Wages
- 8:31B-4.52 Physician Compensation—Hospital Component
- 8:31B-4.53 Physician Compensation—Professional Component
- 8:31B-4.54 Employee Fringe Benefits
- 8:31B-4.55 Medical and Surgical Supplies
- 8:31B-4.56 Non-Medical and Non-Surgical Supplies
- 8:31B-4.57 Purchased Services
- 8:31B-4.58 Other Direct Expenses
- 8:31B-4.59 Major Moveable Equipment
- 8:31B-4.60 (Reserved)

PART IV. RECONCILIATION OF COSTS AND REVENUES RELATED TO PATIENT CARE WITH HOSPITAL UNRESTRICTED FUND EXPENSES AND REVENUES

- 8:31B-4.61 Reports of costs and revenues
- 8:31B-4.62 Excluded Health Care Services
- 8:31B-4.63 Education and Research
- 8:31B-4.64 Sales and services not related to patient care
- 8:31B-4.65 Patient convenience items
- 8:31B-4.66 Administrative items
- 8:31B-4.67 Non-operating revenues (net of expenses)
- 8:31B-4.68 through 8:31B-4.70 (Reserved)

PART V. DEFINITION OF COST AND REVENUE CENTERS

- 8:31B-4.71 Reporting of costs and revenues
- 8:31B-4.72 Medical-Surgical Acute Care Units (MSA)
- 8:31B-4.73 Obstetric Acute Care Unit (OBS)
- 8:31B-4.74 Pediatric Acute Care Units (PED)
- 8:31B-4.75 Psychiatric Acute Care Units (PSA)
- 8:31B-4.76 Burn Care Unit (BCU/ICU)
- 8:31B-4.77 Intensive Care Units (ICU/BCU)
- 8:31B-4.78 Coronary Care Units (CCU)
- 8:31B-4.79 Neo-Natal Intensive Care Unit (NNI)
- 8:31B-4.80 Newborn Nursery (NBN)
- 8:31B-4.81 Emergency Services (EMR)
- 8:31B-4.82 Clinics (CLN)
- 8:31B-4.83 Off-Site Health Services (OHS)
- 8:31B-4.84 Skilled Nursing Facility (SNF)
- 8:31B-4.85 Anesthesiology (ANS)
- 8:31B-4.86 Cardiac Catheterization (CCA)
- 8:31B-4.87 Delivery and Labor Rooms (DEL)
- 8:31B-4.88 Dialysis (DIA)
- 8:31B-4.89 Drugs Sold to Patients (DRU)
- 8:31B-4.90 Electrodiagnosis (EDG)
- 8:31B-4.91 Laboratory (LAB)
- 8:31B-4.92 Medical and Surgical Supplies Sold (MSS)
- 8:31B-4.93 (Reserved)
- 8:31B-4.94 Nuclear Medicine (NMD)
- 8:31B-4.95 Other Physical Medicine (OPM)
- 8:31B-4.96 Operating and Recovery Room (ORR)
- 8:31B-4.97 Blood Bank (BBK)
- 8:31B-4.98 Physical Therapy (PHT)
- 8:31B-4.99 (Reserved)
- 8:31B-4.100 Radiology, Diagnostic (RAD)
- 8:31B-4.101 Respiratory Therapy (RSP)
- 8:31B-4.102 (Reserved)
- 8:31B-4.103 Therapeutic Radiology (THR)
- 8:31B-4.104 Central Sterile Supply (CSS)
- 8:31B-4.105 Other General Services (OGS)
- 8:31B-4.106 Dietary (DTY)
- 8:31B-4.107 Housekeeping (HKP)
- 8:31B-4.108 Laundry and Linen (L & L)
- 8:31B-4.109 Medical Records (MRD)
- 8:31B-4.110 Pharmacy (PHM)
- 8:31B-4.111 Patient Care Coordination (PCC)
- 8:31B-4.112 Plant (PLT)
- 8:31B-4.113 Building and fixed equipment (BLD)
- 8:31B-4.114 Physicians (PHY)
- 8:31B-4.115 Education and Research (EDR)
- 8:31B-4.116 (Reserved)
- 8:31B-4.117 Residents (RSD)
- 8:31B-4.118 Administrative and General (A&G)
- 8:31B-4.119 Fiscal (FIS)
- 8:31B-4.120 (Reserved)
- 8:31B-4.121 Malpractice Insurance (MAL)
- 8:31B-4.122 (Reserved)
- 8:31B-4.123 (Reserved)
- 8:31B-4.124 Utilities Cost (UTC)
- 8:31B-4.125 Interest (INT)
- 8:31B-4.126 Legal Fringe Benefits (LFB)
- 8:31B-4.127 Pensions (PEN)
- 8:31B-4.128 Policy Fringe Benefits (PFB)

- 8:31B-4.129 Reconciling Items (RIT)
 8:31B-4.130 (Reserved)
 8:31B-4.131 Financial elements report

SUBCHAPTER 5. STANDARDS FOR HOSPITAL NOTIFICATION REGARDING OFFSET OF MEDICAID PAYMENTS AND CHARITY CARE SUBSIDY PAYMENTS TO COLLECT HOSPITAL DEBTS DUE TO THE STATE

- 8:31B-5.1 Hospital notification regarding offset

SUBCHAPTERS 6 THROUGH 7. (RESERVED)
APPENDIX I THROUGH APPENDIX XI. (RESERVED)

SUBCHAPTER 1. GENERAL PROVISIONS

8:31B-1.1 Purpose and scope

The purpose of this chapter is to satisfy the requirements of the Health Care Facilities Planning Act, P.L. 1971, c.136 as amended by P.L. 1978, c.83; P.L. 1991, c.187; and P.L. 1992, c.160, and support the public policy of the State that hospital and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost, be available to inhabitants of the State.

Amended by R.1993 d.593, effective November 5, 1993.
 See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Case Notes

New Jersey statutes and regulations were not preempted by ERISA because they referred to self-funded union plan. *United Wire, Metal and Mach. Health and Welfare Fund v. Morristown Memorial Hosp.*, C.A.3 (N.J.)1993, 995 F.2d 1179, certiorari denied 114 S.Ct. 382, 126 L.Ed.2d 332, leave to file for rehearing denied 115 S.Ct. 536, 130 L.Ed.2d 438, rehearing denied 114 S.Ct. 651, 126 L.Ed.2d 608, certiorari denied 114 S.Ct. 383, 126 L.Ed.2d 332, rehearing denied 114 S.Ct. 743, 126 L.Ed.2d 706.

Rate setting and review; peer comparison; reimbursement. In re: 1976 Hospital Reimbursement for Kessler Memorial Hospital, 78 N.J. 564, 397 A.2d 656 (1979).

8:31B-1.2 Definitions

The following words and terms, as used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

“Adjusted admissions” means inpatient admissions increased to reflect outpatient activity and is calculated by admissions multiplied by total gross revenue divided by inpatient gross revenue.

“Audited Current Cost Base” means the current cost base of the hospital, as adjusted as a result of audits conducted by the Department and/or acceptance by the Department of adjustments initiated by the hospital, in addition to the adjustments.

“Current Cost Base” means the actual costs and revenues of the hospital as identified in the Financial Elements in the reporting period, as adjusted by the Department for completeness and/or mathematical accuracy.

“Department” means the New Jersey Department of Health and Senior Services.

“Financial Elements” means those items of revenue, expenses and other data defined in N.J.A.C. 8:31B-4 for reporting to the Department of Health and Senior Services.

“Hospital” means a general hospital that is licensed in accordance with N.J.A.C. 8:43G or a special hospital eligible for Medicaid Disproportionate Share subsidies that is licensed in accordance with N.J.A.C. 8:43G.

“Neonate” means a newborn less than 29 days of age.

“Reporting Period” means the most recent calendar or fiscal year prior to the June 30th submission deadline for the hospital’s current cost base reports.

“Reporting Year” means the year in which current financial and statistical data is being reported.

“Uniform Bill–Patient Summary” (also referred to as the UB–82) means a common billing and reporting form used by the hospital for each inpatient (see N.J.A.C. 8:31B–2).

Amended by R.1991 d.158, effective March 18, 1991.
 See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

Definitions for full rate review and prospective operating adjustment added.

Amended by R.1992 d.62, effective February 3, 1992.
 See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Definition for Preliminary Cost Base revised.
 Amended by R.1993 d.593, effective November 15, 1993.
 See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Amended by R.2000 d.339, effective August 21, 2000.
 See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

Inserted “Department”.

Amended by R.2003 d.40, effective January 21, 2003.
 See: 34 N.J.R. 2237(a), 34 N.J.R. 2549(b), 35 N.J.R. 408(a).

Added “Audited Current Cost Base”, “Hospital” and “Reporting Period”; deleted “Base year”, “Equalization Factor”, “Labor Market Area”, “Preliminary Cost Base”, “Utilization Review Committee” and “Utilization Review Organization (URO)”; amended “Current Cost Base”.

SUBCHAPTER 2. HOSPITAL REPORTING OF UNIFORM BILL DATA (INPATIENT, SAME-DAY SURGERY AND EMERGENCY DEPARTMENT OUTPATIENT)

8:31B-2.1 Purpose

(a) The purpose of this subchapter is to provide the basis for a single patient data reporting system to satisfy the health planning requirements of the Health Care Reform Act of 1992 (P.L. 1992, c.160). The subchapter incorporates

herein by reference the National Uniform Bill (UB-92, HCFA-1450) as the common hospital billing format for all payers. The data elements and design of the form have been determined by the National Uniform Billing Committee (NUBC). The NUBC includes representatives of the Federal Government, major payers and hospital associations. The NUBC is a Designated Standard Maintenance Organization (DSMO) in accordance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 as adopted by the United States Congress. The Uniform Bill may be transmitted electronically according to a format for Health Care Claim: Institutional 837, developed and maintained by another DSMO, Accredited Standards Committee X12 (ASC X12) of the American National Standards Institute (ANSI). The UB-92 and Health Care Claim: Institutional 837 and succeeding updates are incorporated herein by reference. The UB-92 can be obtained from the American Hospital Association, National Uniform Billing Committee, 29th Floor, 1 North Franklin, Chicago, IL 60606. The Health Care Claim: Institutional 837 can be obtained from Washington Publishing Company, 5284 Randolph Road, Rockville, MD 20852-2116.

(b) This subchapter will continue to allow hospitals to:

1. Satisfy Department of Health and Senior Services reporting requirements for patient level clinical and financial information;
2. Allow for common and consistent reporting of revenues for services related to patient care; and
3. Promote uniformity and accuracy of patient data reporting. Confidentiality of individual patients and physicians shall be maintained in fulfilling the above purposes.

Amended by R.1984 d.610, effective January 7, 1985.
 See: 16 N.J.R. 2728(a), 17 N.J.R. 80(b).
 Amended by R.1993 d.362, effective July 19, 1993.
 See: 25 N.J.R. 1660(a), 25 N.J.R. 3205(a).
 Amended by R.1994 d.488, effective September 19, 1994.
 See: 26 N.J.R. 10(a), 26 N.J.R. 3839(a).
 Amended by R.2000 d.339, effective August 21, 2000.
 See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).
 Amended by R.2003 d.459, effective December 1, 2003.
 See: 35 N.J.R. 1826(a), 35 N.J.R. 5376(a).
 Rewrote (a).

8:31B-2.2 Implementation

Beginning January 1, 1981, N.J.A.C. 8:31B-2.1, the rule on Hospital reporting of Uniform Bill Patient Summaries (Inpatient), has been used as a common billing and reporting mechanism for each inpatient discharged and ambulatory same day surgery outpatient treated in each acute care general hospital. As of December 1, 2003, this rule will also apply to emergency department outpatients.

Amended by R.1981 d.404, effective November 2, 1981.
 (to become operative January 1, 1982).
 See: 13 N.J.R. 410(a), 13 N.J.R. 756(c).
 Added paragraph (g) 1-3.
 Amended by R.1984 d.610, effective January 7, 1985.

See: 16 N.J.R. 2728(a), 17 N.J.R. 80(b).
 Amended by R.1989 d.154, effective March 20, 1989.
 See: 20 N.J.R. 3057(a), 21 N.J.R. 752(b).
 Newborn inpatient birthweight and Severity of Illness indicators added to DRGs.
 Amended by R.1992 d.62, effective February 3, 1992.
 See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
 (c)2i revised.
 Amended by R.1993 d.362, effective July 19, 1993.
 See: 25 N.J.R. 1660(a), 25 N.J.R. 3205(a).
 Amended by R.2000 d.339, effective August 21, 2000.
 See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).
 Substituted a reference to acute care general hospitals for a reference to hospitals covered under Chapter 83, P.L. 1978.
 Amended by R.2003 d.459, effective December 1, 2003.
 See: 35 N.J.R. 1826(a), 35 N.J.R. 5376(a).
 Added the last sentence.

8:31B-2.3 Billing form

(a) The UB-92 is a multi-part form set. Detailed specifications are included with the UB-92 completion guidelines.

(b) The form is designed to be typed or computer printed. It will be available as unit sets or in a printed version. The number of copies in each form set will be determined by the hospital according to its planned use of the forms.

Amended by R.1984 d.610, effective January 7, 1985.
 See: 16 N.J.R. 2728(a), 17 N.J.R. 80(b).
 Amended by R.1993 d.362, effective July 19, 1993.
 See: 25 N.J.R. 1660(a), 25 N.J.R. 3205(a).
 Amended by R.1994 d.488, effective September 19, 1994.
 See: 26 N.J.R. 10(a), 26 N.J.R. 3839(a).
 Amended by R.2000 d.339, effective August 21, 2000.
 See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).
 In (a), deleted "printed in red ink" at the end.

8:31B-2.4 Guidelines for completion of the patient billing and abstract form

(a) Procedural guidelines for completing the patient billing and abstract form follows:

1. Guidelines for completing the billing form, UB-92 HCFA-1450, have been developed by the NUBC for Medicare, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and Commercial Insurers.

2. Specific instructions for Blue Cross, Medicaid, and other payers will be provided by those payers.

3. Additional data elements required for the Department of Health and Senior Services by this rule are described in detail by an addendum to the National Uniform Bill Manual. Note: The addendum consists of instructions for filling out the new, Federally mandated form; copies of the addendum can be obtained from the Department.

(b) Billing timelines requirements are as follows:

1. A UB-92 must be completed, finalized and submitted to the Data Intermediary for each patient within 30 days of discharge of the patient.

2. Where claims administration and cash flow considerations would dictate a more current billing than the 30 day requirement, a preliminary version of the UB-92 containing only those items required for the particular payer need be utilized at the time of billing. In interim billing cases, it is required that the full patient billing and abstract information be completed and submitted to the data intermediary in compliance with the data intermediary time limits and these rules, specifically N.J.A.C. 8:31B-2.5(g). Data items reported to the data intermediary for transmission to the Department of Health and Senior Services shall not differ from data upon which payment was based.

3. The hospital shall submit discharge data daily to the data intermediary. That daily submission shall include the data on all discharges billed the previous day.

Amended by R.1980 d.361, effective August 7, 1980.

See: 12 N.J.R. 392(d), 12 N.J.R. 517(b).

Amended by R.1981 d.404, effective November 2, 1981 (operative January 1, 1982).

See: 13 N.J.R. 410(a), 13 N.J.R. 756(c).

Item 41: Note substantially amended.

Amended by R.1983 d.598, effective December 19, 1983.

See: 15 N.J.R. 1325(a), 15 N.J.R. 2162(a).

022: New Jersey Blue Cross was "Other" New Jersey Blue Cross; reference to "Host Bank" deleted.

026: New Jersey Blue Cross was "Other" Blue Cross.

Amended by R.1984 d.610, effective January 7, 1985.

See: 16 N.J.R. 2728(a), 17 N.J.R. 80(b).

Amended by R.1989 d.154, effective March 20, 1989.

See: 20 N.J.R. 3057(a), 21 N.J.R. 752(b).

Citation error corrected.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

DRG data items to be same as payment data.

Amended by R.1993 d.362, effective July 19, 1993.

See: 25 N.J.R. 1660(a), 25 N.J.R. 3205(a).

Amended by R.1994 d.488, effective September 19, 1994.

See: 26 N.J.R. 10(a), 26 N.J.R. 3839(a).

Amended by R.2000 d.339, effective August 21, 2000.

See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

In (b), deleted "appropriate" preceding "data" in the second sentence of 2, and added 3.

Amended by R.2003 d.459, effective December 1, 2003.

See: 35 N.J.R. 1826(a), 35 N.J.R. 5376(a).

Rewrote (b)3.

8:31B-2.5 Health data submissions to the Department of Health and Senior Services

(a) A data intermediary shall be selected as follows:

1. A data intermediary is the data processor approved by the Department of Health and Senior Services responsible for collecting, editing, generating selected reports, and submitting the UB-92 data to the Department of Health and Senior Services.

2. A single data intermediary shall be chosen and shall be responsible for all patients regardless of payor class. In the event that it becomes necessary to approve additional data processors, the Department will promulgate an approved list of data processors.

(b) Contractual arrangements between the hospital and the data intermediary shall include the following:

1. The contractual arrangements between a hospital and its data intermediary shall include:

i. Provisions for compliance with the data submission time limits specified in N.J.A.C. 8:31B-2.4(b);

ii. Provisions for permitting delays in such submissions to the intermediary when circumstances require;

iii. Provisions for resolution of any resulting disputes.

2. Provisions must not affect the ability of the intermediary to comply with the timing requirements set forth in (g) below.

(c) The contractual arrangements shall provide for the quality control measures needed to ensure accurate and reliable data submission by the hospital.

(d) To assess the accuracy and reliability of the data provided to the Department of Health and Senior Services, the Department of Health and Senior Services shall periodically audit selected records in the hospital.

(e) Data shall be edited as follows:

1. The data received by the intermediary from the hospital must be edited prior to submission to the Department of Health and Senior Services, in accordance with the current contract between the Department and the data intermediary.

2. Problems detected by these edits shall be corrected by the Intermediary and the hospital.

3. The hospital shall submit information required by the data intermediary for edit correction within two working days of the request.

(f) Reports shall be produced as follows:

1. The data intermediary shall produce, for the Department of Health and Senior Services and each hospital, a set of periodic reports which will accurately represent the data submitted by each hospital, in accordance with the current contract between the Department and the data intermediary.

2. In addition, hospitals may designate an additional organization, known as a data reporter, to assist in the verification of the accuracy and reliability of the data submitted to the intermediary. The Department of Health and Senior Services shall direct the data intermediary, selected under (a) above, to release a hospital's data to the reporter only upon receipt of a current signed agreement between the hospital and the data reporter. This agreement shall be updated annually, and shall:

i. Indicate the hospital's designation of a data reporter;

ii. Provide for the protection of confidential data consistent with Department of Health and Senior Services procedures; and

iii. Allow for subsequent re-release of the data by the reporter only when the procedures, set by the Department of Health and Senior Services, have been followed.

3. These reports are to be used by the hospitals, in conjunction with any other information provided by their data collector or the Department of Health and Senior Services, to verify the accuracy and reliability of the data submitted.

4. The ultimate responsibility for the completeness and accuracy of the UB-92 data submitted to the Department of Health and Senior Services rests with the hospital.

5. Upon request of a payer, the final UB-92 information shall be provided to the payer, for its own cases, by the UB-92 Intermediary.

(g) Data shall be submitted to the Department of Health and Senior Services as follows:

1. Those data elements required to be submitted to the Department of Health and Senior Services by each hospital through the data intermediary are described in detail in the addendum to the UB-92 guidelines. Instructions are available from the Department for formatting the UB-92 data elements into an electronic format for reporting to the Department of Health and Senior Services using the Health Care Claim: Institutional. These instructions are known as the ANSI 837 Addendum Guide, incorporated herein by reference. The ANSI 837 Addendum Guide can be obtained from Program Manager, Health Care Financing Systems, PO Box 360, 225 East State Street, Trenton, NJ 08625-0360.

2. These required data, edited pursuant to (e) above, shall be submitted to the Department of Health and Senior Services by the data intermediary in a computer processable format and medium, specified by the current contract between the Department and the data intermediary, within 5 days of the end of each calendar month.

3. Each submission is to include the data on all discharges billed during the previous calendar month.

4. Records not received by the Department of Health and Senior Services (including corrections of fatal errors and records with missing or incorrect information), within the time frames specified, shall be subject to a penalty of \$1.00 per record per day. The Department shall provide 30 days notice of its intent to close the data base. The data base shall be closed no sooner than 90 days following the end of the calendar year and no additional cases shall be added after that time.

5. All data submitted to the Department of Health and Senior Services will be edited upon receipt by the data intermediary and any problems detected shall be corrected by the data intermediary with any necessary assistance from the hospital.

(h) All protected health information submitted to the data intermediary pursuant to this regulation is subject to Standards for Privacy of Individually Identifiable Health Information, 45 CFR Part 160 and Part 164.

(i) The intermediary(ies) shall charge the hospitals a maximum amount of \$1.45 per discharge to process hospital UB-92 data.

Amended by R.1984 d.610, effective January 7, 1985.

See: 16 N.J.R. 2728(a), 17 N.J.R. 80(b).

Substantially amended.

Amended by R.1991 d.158, effective March 18, 1991.

See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

No cases added to data base after closing.

Amended by R.1993 d.362, effective July 19, 1993.

See: 25 N.J.R. 1660(a), 25 N.J.R. 3205(a).

Amended by R.1994 d.488, effective September 19, 1994.

See: 26 N.J.R. 10(a), 26 N.J.R. 3839(a).

Amended by R.2000 d.339, effective August 21, 2000.

See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

In (a)2, deleted "by each hospital" following "chosen" in the first sentence; in (d), deleted "with no attempt to tie together patient names and patient identification numbers at the Department of Health" at the end; in (e), rewrote 1, and added 4; in (f), rewrote the introductory paragraph, deleted a former 2, and recodified former 3 through 6 as 2 through 5; and rewrote (g).

Amended by R.2003 d.459, effective December 1, 2003.

See: 35 N.J.R. 1826(a), 35 N.J.R. 5376(a).

Rewrote the section.

8:31B-2.6 (Reserved)

SUBCHAPTER 3. FINANCIAL MONITORING AND REPORTING REGULATIONS

8:31B-3.1 Statement of purpose

The following financial monitoring and reporting rules in conjunction with Financial Elements (N.J.A.C. 8:31B-4), the Uniform Cost Reporting (N.J.A.C. 8:31A-5.5) and the Rules on Hospital Reporting of Uniform Bill—Patient Summaries regulations (N.J.A.C. 8:31B-2), constitute the minimum necessary steps for implementing the Health Care Facilities Planning Act, P.L. 1971, c.136 as amended by P.L. 1978, c.83; P.L. 1991, c.187 and P.L. 1992, c.160. These regulations should provide an environment in which to move towards the objectives of an accurate system of monitoring and reporting. This system meets the purpose of the law, to insure the citizens of New Jersey economical provision of necessary and appropriate medical services of the highest quality.

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Case Notes

Hospital Rate Setting Commission required to retroactively correct Health Department error affecting equalization factor. *Alexian Bros. Hosp. v. State, Dept. of Health, Hosp. Rate Setting Com'n*, 242 N.J.Super. 411, 577 A.2d 164 (A.D.1989).

Hospital had statutory right to appeal rate reimbursement issues under Health Care Facilities Act. *In re Amendment of N.J.A.C. 8:31B-3.31 and N.J.A.C. 8:31B-3.51*, 119 N.J. 531, 575 A.2d 481 (1990).

Health Department acted within authority to establish hospital rate setting system. *In re Amendment of N.J.A.C. 8:31B-3.31 and N.J.A.C. 8:31B-3.51*, 119 N.J. 531, 575 A.2d 481 (1990).

In determining how to allocate reduction in Medicare payment, Hospital Rate Setting Commission was required to consider Health Care Facilities Planning Act. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Hospital Rate Setting Commission's reduction in Medicare payments was administrative rule. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Hospital Rate Setting Commission's process to allocate reduction of Medicare payments violated Administrative Procedure Act. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Regulations establish criteria against which Hospital Rate Setting Commission can evaluate arguments; reconciliation process not rule-making by Commission; order modification proper. *In re 1982 Final Reconciliation Adjustment for Jersey Shore Medical Center*, 209 N.J.Super. 79, 506 A.2d 1269 (App.Div.1986).

8:31B-3.2 (Reserved)**8:31B-3.3 Uniform reporting: current costs and other financial data**

(a) The Commissioner shall collect and review the actual costs for the institutions as reported in accordance with the Financial Elements and Reporting rules (N.J.A.C. 8:31B-4). Costs so reported shall be subject to revision due to subsequent audits in accordance with N.J.A.C. 8:31B-3.17. Hospitals shall submit information on these forms electronically in a format compatible with Department specifications.

(b) In addition to (a) above, hospitals shall submit, on a quarterly basis, unaudited financial data to the Department. The data shall be submitted within 60 days from the end of each calendar quarter. The annual cost report forms for the balance sheet and statement of operation (the L-1 and L-3 forms from the New Jersey Acute Care Hospital Cost Report) shall be used for the quarterly submissions. Hospitals shall submit information on these forms electronically in a format compatible with Department specifications. The information shall agree with the hospital's internal unaudited financial statements. Except as otherwise provided in these rules, the information shall be consistent with Generally Accepted Accounting Principles (GAAP).

(c) Late submission of current cost and financial data, as defined in (b) above and N.J.A.C. 8:31B-4.6(c), including Audited Financial Statements, will result in a penalty for each working day past the appropriate submission date. A fine of \$100.00 per working day will be assessed by the Department for late submission of the Acute Care Hospital Cost Reports. A fine of \$50.00 per working day will be

assessed by the Department for late submission of quarterly financial data specified in (b) above. All of the specified forms, containing the required information, are necessary for a submission to be considered complete. A separate fine of \$100.00 per working day will be assessed for late submission of the Acute Care Hospital final audited Financial Statements.

Amended by R.1983 d.597, effective December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

(a): Cross-reference changed from N.J.A.C. 8:31A-5.5 to N.J.A.C. 8:31B-4. (b) added.

Amended by R.1984 d.531, effective November 19, 1984 (operative January 1, 1985).

See: 16 N.J.R. 2321(b), 16 N.J.R. 3197(b).

(b): added "including Audited Financial Statements,".

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Penalty mandatory; to be reflected in next year's rates.

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Amended by R.1995 d.507, effective September 5, 1995.

See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

Amended by R.2000 d.339, effective August 21, 2000.

See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

Rewrote (b) and (c).

Amended by R.2003 d.459, effective December 1, 2003.

See: 35 N.J.R. 1826(a), 35 N.J.R. 5376(a).

In (a), added the last sentence; in (b), added the fourth sentence.

Case Notes

New Jersey statutes and regulations were not preempted by ERISA because they referred to self-funded union plan. *United Wire, Metal and Mach. Health and Welfare Fund v. Morristown Memorial Hosp.*, C.A.3 (N.J.)1993, 995 F.2d 1179, certiorari denied 114 S.Ct. 382, 126 L.Ed.2d 332, leave to file for rehearing denied 115 S.Ct. 536, 130 L.Ed.2d 438, rehearing denied 114 S.Ct. 651, 126 L.Ed.2d 608, certiorari denied 114 S.Ct. 383, 126 L.Ed.2d 332, rehearing denied 114 S.Ct. 743, 126 L.Ed.2d 706.

Exception to Administrative Procedure Act's procedural requirements did not apply to Hospital Rate Setting Commission's rate adjustment cap. *St. Barnabas Medical Center v. New Jersey Hosp. Rate Setting Com'n*, 250 N.J.Super. 132, 593 A.2d 806 (A.D.1991).

Hospital Rate Setting Commission's cap on settlement of hospital rate appeals was rule-making. *St. Barnabas Medical Center v. New Jersey Hosp. Rate Setting Com'n*, 250 N.J.Super. 132, 593 A.2d 806 (A.D.1991).

1976 Rate Review guidelines. *In re: 1976 Hospital Reimbursement for Kessler Memorial Hospital*, 78 N.J. 564, 397 A.2d 656 (1979).

Objectives of 1979 rate review program to require hospitals to establish reasonableness of current costs incurred and increases; burden of reasonableness proof on hospital; measure is additional cost against dollar value or benefit derived; policy fringe benefits, fiscal and plant budget requests disallowed (citing former N.J.A.C. 8:31-17). *In re: Elmer Hospital*, 4 N.J.A.R. 76 (1979).

8:31B-3.4 through 8:31B-3.10 (Reserved)**8:31B-3.11 Same day surgery**

(a) Same Day Surgery is considered an alternative mode of health care delivery which the Department of Health and Senior Services considers to be efficient and worthy of encouragement. Same Day Surgery is intended to lower the cost of health care and provide the appropriate level of care

to patients who are otherwise classified as inpatients. The patient, by definition:

1. Is identified on the Uniform Bill-Patient Summary (UB-PS) as a 131 or 136 bill type in accordance with N.J.A.C. 8:31B-2.1 and discharged before midnight of the day of admission, so admission date and discharge date are the same;

2. Had surgery performed in a fully equipped operating room, for example, one routinely equipped and capable of providing general anesthesia, and identified by an operating room charge on the UB-PS;

3. Had a normal discharge, for example, was not transferred, did not leave AMA, and was not discharged dead.

Amended by R.1982, d.427, eff. December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a), 15 N.J.R. 43(a).

Text changed from "Same day surgical units" to provide for "Same day surgery".

Amended by R.1983 d.597, eff. December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

(a) amended; (a) 1, 2 and 3 added.

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Reference to 2.1 added.

Emergency amendment, R.1991 d.42, effective December 31, 1990, operative January 1, 1991 (expires March 1, 1991.)

See: 23 N.J.R. 227(a).

Provision for petition for adjustment deleted at (b).

Adopted Concurrent Proposal R.1991 d.157, effective February 25, 1991.

See: 23 N.J.R. 227(a), 23 N.J.R. 889(a).

Provisions of emergency amendment R.1991 d.42 readopted without change.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Reporting date in (b) changed to April 30.

Amended by R.2000 d.339, effective August 21, 2000.

See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

8:31B-3.12 through 8:31B-3.15 (Reserved)

8:31B-3.16 Aggregate Current Cost Data Base

(a) Once the Department has reviewed the hospital's submission in accordance with N.J.A.C. 8:31B-4 and determined it is suitable for entry into an aggregate current cost data base including data for all hospitals, the Department shall issue a notice of its intent to close the aggregate current cost data base. The notice to each hospital shall include a list of the completeness and/or mathematical adjustments the Department has made.

(b) A hospital which disagrees with the Department's completeness and/or mathematical adjustments shall submit, in writing, a complete list of its exceptions to the adjustments made by the Department within 30 calendar days of the issuance of the notice of intent to close the aggregate current cost data base. If, upon review, the Commissioner determines that there were errors in the completeness and/or mathematical adjustments, a final list of adjustments will be provided to the hospital before the data is entered into the aggregate current cost data base.

(c) A hospital's current cost base submission cannot be substituted or rearranged after the aggregate current cost data base has been closed. Requests to rearrange or substitute current cost base data must be received in writing within 30 calendar days of the issuance of the notice of intent to close the aggregate current cost data base. If, upon review, the Department determines that the revised submission is acceptable, the data entered into the aggregate current cost data base will be based on the revised submission. The Department will advise the hospital of its final list of adjustments.

(d) If a hospital takes exception to the final list of adjustments provided in accordance with (b) or (c) above, it may appeal the final list of adjustments. A notice by a hospital of an intent to appeal the final list of adjustments entered by the Department into the aggregate current cost data base must be submitted in writing to the Commissioner within 15 calendar days of issuance of the final list. Within 30 calendar days of issuance of the final list of adjustments, the hospital shall submit to the Commissioner two copies of its appeal, describing in detail the basis for its challenge to the final list of adjustments. Appeals shall not include new arrangements or substitutions of current cost submission data that was not previously submitted in accordance with (b) above. The appeal document shall list all factual and legal issues, including citation to applicable provisions of the hospital financing rules, and include all written documentation supporting each appeal issue. If the hospital fails to submit the required documentation within the prescribed time frame, it shall have forfeited its right of appeal and the final list of adjustments to the hospital's current cost base submission shall be deemed to have been accepted by the hospital.

1. The Commissioner shall schedule a detailed review to be conducted by the Department with the hospital not more than 45 calendar days following receipt of the appeal document. If the hospital fails to appear on the established date, it shall have forfeited its right of appeal and the final list of adjustments to the hospital's current cost base submission shall be deemed to have been accepted by the hospital.

2. At the detailed review with the hospital, the Department representative shall indicate whether the appeal is supported by sufficient documentation to permit a resolution, and the hospital shall be permitted 10 calendar days after the date of the review in which to submit additional documentation. The Commissioner shall give consideration only to documentation submitted pursuant to the deadlines set forth above in deciding upon any of the hospital's appeal issues.

3. Within 30 calendar days of the review with the hospital, the Commissioner will render detailed findings on the factual and legal issues concerning whether an adjustment to the final list of adjustments to the hospital's current cost base submission is warranted. The Commissioner's decision shall constitute the final agency adjudication.

Amended by R.1982 d.427, eff. December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).

Added (d).

Amended by R.1989 d.383, effective July 17, 1989.

See: 21 N.J.R. 661(b), 21 N.J.R. 2087(a).

Added (e).

Amended by R.1989 d.387, effective July 17, 1989.

See: 21 N.J.R. 135(a), 21 N.J.R. 2058(a).

Subsection (a) clarified. Base-year cost data base expanded in (b)4, 5 and 6, to include approved reimbursement for waste disposal costs; calculation of economic factor; and calculation of the technology factor. Cost base for 1990 rate year clarified at (b)7.

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Deletion of (b)4 and (e), on 1986 cost base adjustments.

Amended by R.1991 d.158, effective March 18, 1991.

See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

Notice to hospitals of data base closing required; no adjustments after closing.

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Amended by R.2000 d.339, effective August 21, 2000.

See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

Amended by R.2003 d.40, effective January 21, 2003.

See: 34 N.J.R. 2237(a), 34 N.J.R. 2549(b), 35 N.J.R. 408(a).

Rewrote the section.

Case Notes

Hospital's preliminary cost basis accommodates competing policies underlying Health Care Facilities Planning Act. *Slocum v. Hospital Rate Setting Com'n*, N.J. Dept. of Health, 240 N.J.Super. 566, 573 A.2d 971 (A.D.1990).

In determining how to allocate reduction in Medicare payment, Hospital Rate Setting Commission was required to consider Health Care Facilities Planning Act. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Hospital Rate Setting Commission's reduction in Medicare payments was administrative rule. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Hospital Rate Setting Commission's process to allocate reduction of Medicare payments violated Administrative Procedure Act. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Treating final reconciliation adjustments as automatic did not violate Hospital Rate Setting Commission's duty to ensure that adjustments to scheduled rates are necessary and appropriate. In the Matter of 1983 Final Reconciliation Adjustments of Greenville Hospital, 214 N.J.Super. 607, 520 A.2d 809 (App.Div.1987).

Hospital Rate Setting Commission erred in refusing to allow hospital to recalculate number of full-time equivalent residents and residents' salaries based on accepted standard. *St. Barnabas Medical Center v. New Jersey Hospital Rate Setting Commission*, 214 N.J.Super. 599, 520 A.2d 805 (App.Div.1987).

Current cost base is a key component in the derivation of the preliminary cost base and the certified revenue base; current cost base reflects hospital's actual experiences in a given Diagnosis Related Group for the base year; rate setting procedure review; reconciliation process not rulemaking by Commission; order modification proper. In re: 1982 Final Reconciliation Adjustment for Jersey Shore Medical Center, 209 N.J.Super. 79, 506 A.2d 1269 (App.Div.1986).

Commission's denial of inclusion of employee pension and dental plans in reimbursement rate calculation not supported by record; remand to Commission for proper determination. *Riverside General Hospital v. New Jersey Hospital Rate Setting Commission*, 98 N.J. 458, 487 A.2d 714 (1985).

Regulations explain criteria to determine reasonableness of proposed hospital budgets; 1979 minimum base period challenge disallowed; uncompensated services not reimbursable cost but deduction from

revenue; other general services; calculation using economic factor formula (citing former N.J.A.C. 8:31-17). In re: *Millville Hospital*, 6 N.J.A.R. 456 (1980).

8:31B-3.17 Financial elements reporting/audit adjustments

(a) The Audited Aggregate Current Cost Data Base is developed from financial elements reported to New Jersey State Department of Health and Senior Services and includes:

1. Costs related to patient care (as defined in N.J.A.C. 8:31B-4.32);
2. Less net income from specified sources (as defined in N.J.A.C. 8:31B-3.25); and
3. Capital Facilities Costs: Capital cash requirements (as defined in N.J.A.C. 8:31B-4.21).

(b) All reported financial information shall be reconciled by the hospital to the hospital's audited financial statement. In addition, having given adequate notice to the hospital, the Department of Health and Senior Services may perform a cursory or detailed on-site review at the Department's discretion of all financial information and statistics to verify consistent reporting of data and extraordinary variations in data relating to the development of the Current Cost Base (CCB). Any adjustments made subsequent to the financial review (including Medicare and Medicaid audits and New Jersey State Department of Health and Senior Services reviews) shall be brought to the attention of the Commissioner by the hospital, the Department of Health and Senior Services, appropriate fiscal intermediary or payer where appropriate and shall be applied proportionately to the Cost Base.

(c) Hospitals shall submit a complete list of exceptions to the proposed audit adjustments, together with appropriate written documentation, within 60 days of receipt of the Department's written summary of these adjustments, or these adjustments shall be implemented in accordance with (b) above. Consideration shall be given only to documentation submitted in accordance with this schedule.

Amended by R.1982 d.427, eff. December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).

Amended (b) to permit cursory or detailed review.

Amended by R.1984 d.531, eff. November 19, 1984 (operative January 1, 1985).

See: 16 N.J.R. 2321(b), 16 N.J.R. 3197(b).

(b): Added "net"; deleted "for each individual discrepancy".

Amended by R.1988 d.24, effective January 4, 1988.

See: 19 N.J.R. 1145(a), 20 N.J.R. 74(a).

Deleted text in (a)3 "plus a formula allowance".

Amended by R.1991 d.158, effective March 18, 1991.

See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

References to 3.25 and 3.40 added; audit adjustment provisions added at (c) and (d).

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Amended by R.2000 d.339, effective August 21, 2000.

See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

Amended by R.2003 d.40, effective January 21, 2003.

See: 34 N.J.R. 2237(a), 34 N.J.R. 2549(b), 35 N.J.R. 408(a).

In (a), substituted "Audited Aggregate" for "aggregate".

Case Notes

Hospital Rate Setting Commission required to retroactively correct Health Department error affecting equalization factor. *Alexian Bros. Hosp. v. State, Dept. of Health, Hosp. Rate Setting Com'n*, 242 N.J.Super. 411, 577 A.2d 164 (A.D.1989).

8:31B-3.18 through 8:31B-3.23 (Reserved)

8:31B-3.24 Off-site primary care

The Commissioner may establish demonstration projects involving hospital-affiliated off-site outpatient facilities providing primary care under an agreement with the Department of Health and Senior Services. For hospitals selected to participate in such programs, there may be reporting requirements, as defined in rules by the Department of Health and Senior Services, to evaluate these programs.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Text on reasonable indirect patient care costs transferred to 3.23; text on off-site primary care added as new rule.

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Amended by R.2000 d.339, effective August 21, 2000.

See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

8:31B-3.25 Net income from other sources

(a) The new gain (loss) from Other Operating and Non Operating Revenues (as defined in N.J.A.C. 8:31B-4.61 through 4.67), and expenses of the reporting period are items considered as recoveries of or increases to the Costs Related to Patient Care (see N.J.A.C. 8:31B-4.61 through 4.67) as reported to the New Jersey State Department of Health and Senior Services.

(b) Such revenue shall include all Other Operating and Non-Operating Revenues and Expenses reported per SHARE cost center costs and "expense recoveries" as Case B (see N.J.A.C. 8:31B-4.61 through 4.67), and all other items reported per the Uniform Cost Reporting Regulation as to their Case specified in N.J.A.C. 8:31B-4.61 through 4.67.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Certified revenue base added.

Amended by R.1995 d.507, effective September 5, 1995.

See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

Amended by R.2000 d.339, effective August 21, 2000.

See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

8:31B-3.26 Update factors

(a) Economic Factor: An economic factor shall be calculated for each hospital. It shall take into account the level of hospital expenses and replacement cost of major moveable equipment, using the cost components reported to the New Jersey State Department of Health and Senior Services. The economic factor is the measure of the change in the prices of goods and services used by New Jersey hospitals. The economic factor shall be based, as far as possible, on recorded price changes. For that part of the period covered by the economic factor for which recorded prices are unavailable, the economic factor shall be based on the best available forecast of price trends.

1. The economic factor shall be determined by the Commissioner of Health and Senior Services prior to the beginning of each year.

2. The economic factor calculation shall include the most current measure of inflation/deflation and will reflect changes in a fixed market basket of goods as determined by the Commissioner. The economic factor should not take into account changes in technology or disease entities as these are adjusted through the technology factor.

(b) Cost Change Factor: An actual cost change factor shall be calculated for each hospital, in accordance with N.J.A.C. 8:31B-4. It shall take into account the level of hospital expenses and replacement costs of major moveable equipment, using the cost components reported to the New Jersey State Department of Health and Senior Services. The actual cost change factor is the actual measure of the change in the prices of goods and services used by New Jersey hospitals, to be based upon reported expenses.

(c) Technology Factor: The technology factor shall be based on the Scientific and Technological Advancement Allowance recommended annually to the Secretary of the United States Department of Health and Human Services by the Prospective Payment Assessment Commission (ProPAC). The factor shall be composed of the proportion of incremental operating costs associated with ProPAC's identified cost increasing technologies. Allowances for technologies not included in the technology-specific projections, less the proportion of incremental operating costs of cost-decreasing technologies identified by ProPAC will be included, if available.

Amended by R.1983 d.206, effective June 6, 1983.

See: 15 N.J.R. 471(a), 15 N.J.R. 920(a).

In (a), changed how economic factor is calculated. Deleted old (b)1-2 and added new (b). Added (c).

Amended by R.1984 d.531, effective November 19, 1984 (operative January 1, 1985).

See: 16 N.J.R. 2321(b), 16 N.J.R. 3197(b).

Reference to Appendix II (cost components) added.

Amended by R.1989 d.387, effective July 17, 1989.

See: 21 N.J.R. 135(a), 21 N.J.R. 2058(a).

Labor 1 costs capped at 6%. For 1989, labor proxy changed to blend of Bureau of Labor Statistics Index and regional data.

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Text on labor proxy, specific years and (a)3 deleted; reference to 3.72(a)1 added; (a)1ii adjusted.

Emergency amendment, R.1991 d.42, effective December 31, 1990, operative January 1, 1991 (expires March 1, 1991).

See: 23 N.J.R. 227(a).

"Accept" deleted; "implement" added; (c) through (i) (Prospective opening adjustment) added.

Adopted Concurrent Proposal R.1991 d.157, effective February 25, 1991.

See: 23 N.J.R. 227(a), 23 N.J.R. 889(a).

Provisions of emergency amendment R.1991 d.42 readopted with change effective March 18, 1991.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Basis of economic factor deleted, new basis added at (a)5, (e), (i)-(1) added; reference to 1992 added to (f) and (g).

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).
Amended by R.2000 d.339, effective August 21, 2000.
See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

8:31B-3.27 through 8:31B-3.42 (Reserved)**8:31B-3.43 Adjustment of charges**

A hospital shall submit to the Commissioner upon request a copy of its charges in use during the current year for review and monitoring purposes.

Amended by R.1982 d.427, effective December 6, 1982.
See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).

Added plus or minus variances of 20 percent in the third 12 months.
Amended by R.1983 d.597, effective December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

Substantially amended.

Amended by R.1984 d.531, effective November 19, 1984 (operative January 1, 1985).

See: 16 N.J.R. 2321(b), 16 N.J.R. 3197(b).

(b): "15" was "20".

Amended by R.1989 d.79, effective February 6, 1989.

See: 20 N.J.R. 2542(a), 21 N.J.R. 296(a).

Substituted "30" for "45" and "fifteen" for "thirty".

Correction: Text, "subsidization and how . . . Schedule of Rates." in

(d) was inadvertently dropped from the 3-20-89 Update.

Amended by R.1991 d.158, effective March 18, 1991.

See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

Working days changed to calendar days.

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Amended by R.1995 d.507, effective September 5, 1995.

See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-3.44 through 8:31B-3.65 (Reserved)**8:31B-3.66 Health planning fees**

(a) A charge of \$5.00 per adjusted admission, as defined by the American Hospital Association, for each adjusted admission in the most recent complete year shall be assessed each acute care hospital.

(b) An adjusted admission, as defined by the American Hospital Association, means admissions multiplied by total gross revenue divided by inpatient gross revenue.

Amended by R.1982 d.427, effective December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).

Fee increased from \$.50 to \$1.00.

Amended by R.1983 d.597, effective December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

\$2.00 fee was \$1.00.

Amended by R.1989 d.472, effective September 5, 1989.

See: 21 N.J.R. 1606(a), 21 N.J.R. 2787(a).

Fee changed from \$2.00 to \$5.00.

Amended by R.1995 d.507, effective September 5, 1995.

See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-3.67 through 8:31B-3.69 (Reserved)**8:31B-3.70 (Reserved)**

Repealed by R.1995 d.507, effective September 5, 1995.

See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

Section was "Revenue Cap".

8:31B-3.71 through 8:31B-3.75 (Reserved)**8:31B-3.76 Necessity and appropriateness of health care services**

(a) P.L.1978, c.83 provides that reasonable payment may be made only for "appropriate and necessary health care services of high quality required by (each) hospital's mix of patients." In order to discharge this statutory obligation, two systems are required: The reimbursement system, payment by the case, establishes reasonable rates for patients who are correctly assigned to a Diagnosis Related Group (DRG). A utilization review organization system is required to ensure that the hospital services which are provided are appropriate, necessary, and of high quality.

(b) This section sets forth minimum qualification criteria for utilization review organizations, prescribes the qualification procedure, and establishes a method for financing organizations which qualify. The criteria are designed to delineate the respective roles of payment and review so as to capitalize on the strengths of each. In this way, the systems may complement one another to the greatest degree, thereby promoting "effectiveness and efficiency of the health care system as a whole." L.78, c.83, Section 11C.

(c) Once designated by the Department as a qualified Utilization Review Organization, the URO shall have access to only those hospital patient records for which it has direct review responsibility. The URO shall be required to maintain the confidentiality of the hospital and patient records. Access to this data will be allowed for the purpose of fulfilling review responsibility under these regulations.

(d) Nothing in this regulation shall be construed to supersede or conflict with any part of Title XIB of the Social Security Act (42 USC 1320c-1320c-20) or regulations adopted thereunder, nor with prevailing statutes or contracts affecting the business of insurance.

(e) Reporting: Minimum standards for uniform reporting by the Utilization Review Organization utilizing the UB-PS data shall be determined by the Department. Format and reporting timeframe will be reviewed with the Review Organizations.

Amended by R.1983 d.597, effective December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

New (c) added, existing (c) made (d); (e) added.

Amended by R. 1985 d.551, effective November 4, 1985.

See: 17 N.J.R. 2000(a), 17 N.J.R. 2633(a).

(b) substantially amended.

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Utilization review organization system required in (a).

Law Review and Journal Commentaries

Administrative Law—Hospitals. Steven P. Bann, 137 N.J.L.J. No. 3, 70 (1994).

Case Notes

Memorandum represented agency's interpretation of how elimination of reimbursement methodology impacted utilization review organizations; not "rule making". Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

Memorandum assigning "new task" for utilization review organizations was "rule making". Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

Illegal rule-making aspect of Department of Health memorandum, did not taint interpretive aspect of memorandum. Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

Partial repeal of Health Care Facilities Planning Act did not eliminate statutory basis for state-qualified utilization review organizations; access to patient records. Matter of Final Agency Decision by New

Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

Repeal of rate-regulation did not diminish agency's responsibility for medical necessity and efficiency of services. Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

Provisions describing nonreimbursement functions of state-qualified utilization review organizations; not repealed. Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

Hospitals were obligated to collect from payors cost of state-regulated utilization review organization services during transition year. Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

Administrative provision addressing payment for state-regulated utilization review organizations. Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

8:31B-3.77 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the text indicates otherwise.

"Active physicians" means Doctors of Medicine or Osteopathy holding unrestricted licenses and having current admissions privileges at a licensed hospital.

"Admission certification" means a review of the medical necessity and appropriateness of a patient's admission to the hospital.

"Audit Principal Diagnoses and Procedures" means to examine and validate the assignment of principal diagnoses and/or procedures by physician(s) and medical record department.

"Appropriateness of level of care" means compliance with professionally developed criteria that determine whether the patient belongs in an acute hospital, a skilled nursing facility, an intermediate care facility, or none of those.

"Binding determinations" means those decisions of a utilization review organization which direct a type or level of payment, including no payment, by the appropriate payor.

"Carve-out" means a mechanism used to identify medically unnecessary days during a patient's hospitalization which resulted from an avoidable delay. Such delays can be administrative (for example, O.R. scheduling delays) or physician related (for example, delay in responding to a consult request).

"Certification" means the process used by the Review Coordinator (R.C.) to indicate that an admission or continued stay is certified for payment purposes at given levels of care.

“Concurrent review” means a review of medical necessity and/or appropriateness conducted during a patient’s hospitalization, consisting of admission and continued stay certification.

“Continued stay review” means a review and determination of the medical necessity and appropriateness of continuation of the patient’s stay at a given level of care. Continued stay review may also include a detailed assessment of the quality of care being provided.

“Delegated” means authorization granted by a qualified utilization review organization to a hospital to conduct one or more review functions, subject to a finding of the hospital’s capability and willingness to accept such responsibility and submission of an acceptable plan for the review by the hospital.

1. “Full delegation” means complete delegation of both concurrent review and Quality Review Studies (QRS).

2. “Partial delegation” means authorization by the URO to a hospital to conduct a portion of the review. The remainder of review is provided by staff of the URO.

3. “Non-delegation” means the URO retains responsibility to perform all of the review activities in a hospital.

“Denial” means a formal decision by a URO or a delegated hospital committee that all or part of a patient’s stay is medically unnecessary and/or inappropriate, with consultation by physicians licensed to practice medicine in New Jersey (See Physician Advisor—Item Y).

“Denied days” means days which have been determined to be medically unnecessary.

“Diagnosis Related Groups (DRGs)” means a patient classification scheme in which cases are grouped by shared characteristics of principal diagnosis, secondary diagnosis, age, surgical procedure, and other complications. Each DRG exhibits a consistent amount of resource consumption as measured by some unit (e.g., length of stay, dollars, etc.).

“Discharge planning” means advance preparations for placement of a patient at another level of care in the appropriate setting after hospital discharge.

“Focused review” means an application of sampling techniques such as an intensification of or an exemption from detailed review of certain groups of patients or common diagnoses where data indicate it is reasonable to do so.

1. Focus-in describes an intensified review of a specified category of patients, diagnoses, procedures, and/or physicians.

2. Focus-out describes specific categories of patients, diagnoses, procedures, and/or physicians who are exempt from concurrent review, diagnosis, procedures, and/or physicians.

“Grace days” means medically unnecessary or inappropriate days of hospitalization which payor may reimburse in order to facilitate administrative processes or to insure that the implementation of binding determinations does not have a punitive effect on patients or institutions.

“Inliers” means inpatient cases assigned to DRGs, as identified in N.J.A.C. 8:31B-5.3(c) having lengths of stay within the high and low trim points.

“Intensity of service” means the level of service that a patient receives in a hospital setting.

“Intermediate Care Facility (ICF)” means an institution which provides continuous or Intermittent nursing care to in-patients under the general direction of a professional registered nurse.

“Length of Stay” means the number of days that a patient is hospitalized.

1. “Certified length of stay” means the number of days which have been determined to be medically necessary at covered levels of care for payment purposes.

“Medical necessity” means compliance with professionally developed criteria and standards of care for determining that a patient warrants an acute hospital level of care for a given diagnosis and/or problem.

“Outliers” means patients who display atypical characteristics relative to other patients in a DRG (see N.J.A.C. 8:31B-3.38(c)2).

“Peer review organization” means an organization which is composed of or governed by active physicians, and other professionals where appropriate, who are representative of the active physicians in the area in which the review mechanism operates, which is organized in a manner that insures professional competence in the review of services.

“Physician Advisor (P.A.)” means a currently licensed physician who makes determinations and provides consultation on a referral basis to nonphysician reviewers in cooperation with the Attending Physician on the appropriateness, quality and/or necessity of an individual’s admission to or continued stay in a hospital.

“Preadmission certification” means a form of health care review which occurs prior to a patient’s admission to a hospital and consists of a determination of the medical necessity and appropriateness of a patient’s elective admission to a hospital level of care.

“Profile” means a presentation of aggregated data in formats which displays patterns of health care services over a defined period of time.

"Quality assessment" means a retrospective medical record review program by the physician advisor to assess the quality of services rendered.

"Quality review study" means a retrospective, medical record review of the quality and/or utilization of health care services.

"Reconsideration" means a process which allows a patient, patient representative, or physician to request the URO to hold a formal hearing to reconsider an adverse determination.

"Review Coordinator (RC)" means a health care professional, usually a Registered Nurse, who assists physicians in performing chart review to determine if a hospital stay is medically necessary and if the services provided are appropriate.

"Retrospective review" means Medical Record Review performed after a patient has been discharged.

"Severity of illness" means the manifestation of disease or injury that clinically indicates the need for hospitalization.

"Utilization review plan" means a description of utilization review activities to be prepared by the URO and approved by DOH. The plan shall describe methodology for determining hospital delegated status; the criteria and description of the methodology for monitoring admission and discharge review; the criteria and description of the methodology to review the performance of delegated and nondelegated review and focus program.

"Principal diagnosis" means that condition established after study as being responsible for occasioning the admission of the patient to the hospital for care.

"Principal procedure" means that procedure most related to the principal diagnosis and performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication:

1. If only one procedure was performed, it is the principal;
2. If more than one procedure was performed, the principal procedure is one which was performed for definite treatment, rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication;
3. If more than one procedure was performed for definite treatment, the principal procedure is that most related to the principal diagnosis.

"Skilled Nursing Facility (SNF)" means an institution which is primarily engaged in providing skilled nursing care and related services for inpatients who require medical

supervision of their care or rehabilitation services on a daily basis.

"Trim points" means high and low length of stay cutoff points assigned to each DRG (see N.J.A.C. 8:31B-5.3). Cases falling outside trim points are classified as outliers.

"Utilization Review Organization (URO)" means a group of physicians within a designated geographical area who review the health care provided to patients in area hospitals. Physicians may be assisted by other health care professionals.

"Utilization review plan" means a description of utilization review activities to be prepared by the URO and approved by DOH. The plan shall describe methodology for determining hospital delegated status; the criteria and description of the methodology review; the criteria and description of the methodology to review the performance of delegated and nondelegated review and focus program.

As amended, R.1983 d.597, eff. December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

Substantially amended.

Amended by R. 1985 d.551, effective November 4, 1985.

See: 17 N.J.R. 2000(a), 17 N.J.R. 2633(a).

Definitions "focus" and "outliers" substantially amended.

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

References to typical and atypical cases and "Physical Advisor" deleted.

Law Review and Journal Commentaries

Administrative Law—Hospitals. Steven P. Bann, 137 N.J.L.J. No. 3, 70 (1994).

8:31B-3.78 Criteria for qualification

(a) Applicability: Each inpatient in each hospital selected by the Commissioner pursuant to P.L. 1978, c.83, Section 5b, must be subject to review by a qualified utilization review organization concerning the necessity and appropriateness of inpatient admission and continuing stay. The minimum set of activities required to so qualify are set forth below:

1. All cases: With respect to all cases, a qualifying utilization organization:
 - i. Shall certify the medical necessity of each admission;
 - ii. Shall certify the appropriateness of the level of care to be provided;
 - iii. May, with the approval of the Department, discharge the obligations of (a)i and ii above through an appropriate review system;
 - iv. Shall, with the advice and consent of the Department, institute such systems, which may include, but not be limited to, concurrent, retrospective and focused review, medical care evaluation studies and profile analyses, which best promote efficiency and effective-

ness with respect to the health care delivery system, taken as a whole; provided, however, that nothing herein shall be construed as to involve the Department in supervising or regulating the private practice of medicine;

v. Pursuant to N.J.A.C. 8:31B-3.17(b), the Department having given adequate notice to the hospital, may perform a cursory or detailed on site review at the Department's discretion of any hospital procedure deemed necessary to determine the effectiveness of the reimbursement system in effect.

vi. Shall consult with the Department which shall set common upper and lower trim points with respect to all patients; however, any modification of trim points by the Department during a rate period shall not effect the revenues to which any hospitals are entitled under determinations of the Commission. Adjustments to hospital's revenue to compensate for changes in trim points shall be accomplished at final reconciliation, and interim adjustments may be effected through adjustments to hospitals' Indirect Cost percentages, subject to Commission approval, as provided for in N.J.A.C. 8:31B-3.51 through 3.62;

vii. Shall provide for an appropriate mechanism by which to hear and adjudicate appeals by patients, payers, physicians, or the hospital concerning the determinations made pursuant to this subchapter. With respect to such review, the standards to be applied shall be consistent with the prevailing patterns of medical practice in the area or state, as appropriate;

viii. Shall further provide, through the same mechanism, for appeals by individual patients in exceptional cases of DRG assignments which, although technically correct, may produce grossly inequitable or excessive payments. To initiate an appeal, a letter of request from the patient shall be considered as authorization for the Department to review and assess any necessary information pertinent to the hospitalization or charges in question. Upon demonstration, by substantial evidence, that application of the DRG system would result in inequitable consequences for the patient, the qualified utilization review organization may direct that payment be based on an alternative to the DRG rate (for example, charges);

ix. Shall provide a second level of appeal. Party not satisfied with the decision on the first level appeal, may request an appeal to the second level through the appropriate Utilization Review Organization;

x. Shall insure that all binding determinations of medical necessity or appropriateness are made by qualified review personnel of an established peer review mechanism representative of physicians in the appropriate area of the State, as defined in N.J.A.C. 8:31B-3.77;

xi. Shall render a decision in any appeal within 30 working days from the date of receipt of the appeal by the qualified Utilization Review Organization (URO). The appellant, or his or her insurer, shall not be liable for payment to the hospital until a decision on the appeal has been made and communicated to the parties affected. A qualified URO shall not be deemed in receipt of an appeal if the hospital involved is more than one month delinquent in payment of the Commission approved rate to be paid to the URO by the hospital. Any amount not paid to the hospital because of its delinquency in payment to the URO, and the failure to hear an appeal shall not be recoverable by the hospital through bad debt or charity write-offs, but shall become a loss of revenue to the hospital.

(1) DRG Patient Appeal requests shall be submitted to the Department of Health and Senior Services for review within one year after issuance of the bill by the hospital. Any requests submitted thereafter will not be processed for appeal.

xii. Shall certify the necessity and appropriateness of the services, days, and where it is judged reasonable to do so, the items charged to such patients by the hospital;

xiii. Shall institute such system of concurrent review as may be necessary in order to assure the timely discharge, or placement to the most efficient, appropriate level of care, consistent with high quality; and

xiv. Shall, using a reasonable sampling technique, audit principal diagnosis and principal procedure, in order to assure that typical cases have been assigned to appropriate diagnosis related groups.

Amended by R.1983 d.597, effective December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

New (a)1v added, existing text amended and recodified; (a)1ix(1) added.

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

References to typical and atypical cases deleted; process clarified.

Amended by R.2000 d.339, effective August 21, 2000.

See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

Law Review and Journal Commentaries

Administrative Law—Hospitals. Steven P. Bann, 137 N.J.L.J. No. 3, 70 (1994).

Case Notes

New Jersey statutes and regulations were not preempted by ERISA because they referred to self-funded union plan. *United Wire, Metal and Mach. Health and Welfare Fund v. Morristown Memorial Hosp.*, C.A.3 (N.J.)1993, 995 F.2d 1179, certiorari denied 114 S.Ct. 382, 126 L.Ed.2d 332, leave to file for rehearing denied 115 S.Ct. 536, 130 L.Ed.2d 438, rehearing denied 114 S.Ct. 651, 126 L.Ed.2d 608, certiorari denied 114 S.Ct. 383, 126 L.Ed.2d 332, rehearing denied 114 S.Ct. 743, 126 L.Ed.2d 706.

8:31B-3.79 Use of findings

(a) Findings shall be used in all cases as follows:

1. Denial of Payment: Unnecessary admissions: The qualifying utilization review organization shall direct the appropriate payor to deny payment concerning any admission for which medical necessity has not been certified; provided, however, that a payor may agree with any hospital to reimburse charges for a grace period, not to exceed three calendar days, after notification to the patient, hospital, physician, and payor, of denial of payment certification.

2. Adjustment of Payment shall be made as follows:

i. Continuing necessity: The qualifying utilization review organization shall prospectively direct the appropriate payor to deny charges for such items, services or days for which continuing medical necessity has not been certified; provided, however, that a payor may agree to reimburse any hospital for a grace period, not to exceed three calendar days, after notification of the patient, physician, payor and hospital of the denial of medical necessity for continuing stay.

ii. The following shall apply to a finding of an inappropriate level of care: Should the qualifying utilization review organization determine that, for a portion of the patient's length of stay, the level of care is appropriate to a skilled nursing facility and/or intermediate care facility level-of-care, and that a hospital has documented a good faith continuing effort to obtain placement of the patient to the appropriate level-of-care, a Skilled Nursing Facility (SNF) and/or Intermediate Care Facility (ICF) rate, calculated as follows, will become the basis for determination of reasonable Direct Patient Care Costs for that portion of the stay in an atypical case.

(1) Reimbursement for each eligible patient will be based upon a Statewide weighted average SNF or ICF per diem rate of Medicaid participating long-term care facilities, in effect as of January 1 of the rate year. Separate Statewide weighted average per diem rates will be calculated for both the Skilled (SNF) and Intermediate (ICF) levels of care patients as follows:

(2) Multiply the SNF payment rate, of each Medicaid long-term care facility, in effect as of January 1 of the rate year by the total Medicaid SNF patient days as reported on the most recent Medicaid cost report (12-month period). The Statewide Medicaid total SNF dollars are divided by the total Statewide Medicaid SNF days to arrive at a weighted average SNF per diem. The ICF per diem is calculated following the same steps using total Medicaid ICF days and costs. These SNF and ICF rates will be final for billing purposes and final reconciliation.

iii. The following shall apply to a finding of misassigned DRGs: The qualifying utilization review organization shall direct the hospital and the Uniform Bill Intermediary to make an appropriate adjustment to the

price per case where the DRG to which the patient is correctly assigned differs from the DRG on which payment was based. Similarly, the qualifying utilization review organization shall direct the hospital and the Uniform Bill Intermediary to classify cases as outpatients, to be billed as outpatients when there is a finding of medical necessity for items and services rendered, but no medical necessity for inpatient admission.

3. The following shall apply to apportionment of liability: Upon a prospective finding that certain days, services, or items will not be necessary, the qualifying review organization shall so advise the respective patient, attending physician, hospital, and payer. Once all involved parties have had due notice and have exhausted all appeals, under N.J.A.C. 8:31B-3.78(a)lvii, the utilization review organization may direct the hospital to assign financial liability for such unnecessary days, services, or items to the patient. Accordingly, except for any grace days which a payer may agree to reimburse pursuant to this section (N.J.A.C. 8:31B-3.79), liability for the appropriate price per case shall be fixed at the point in time at which the patient was eligible for discharge; and any further days or services shall, subject to prevailing contracts and statutes, be the sole liability of the patient to be reimbursed to the hospital at a rate, determined by the hospital, no greater than its charges for such days or services established in accordance with N.J.A.C. 8:31B-3.53 through 3.57. Revenues received by the hospital in accordance with this provision shall be treated as Expense Recoveries in accordance with N.J.A.C. 8:31B-4.62 through 4.67.

4. Reporting shall be accomplished as follows: The qualifying utilization review organization shall report all denials and adjustments to the hospital, the appropriate physician, and the payer in a timely manner. All denials and adjustments shall be compiled by diagnosis related group and by hospital, and reported to both the Commission and the Department on, at least, an annual basis. However, except for adjustments made in accordance with N.J.A.C. 8:31B-3.71 through 3.86, any adjustment in a hospital's budget, or in a standard for a Diagnosis Related Group or set of Diagnosis Related Groups shall be made only by the Commission, upon recommendation by the Commissioner through a change in the rate period or schedule of Rates, approved by the Health Care Administration Board (see N.J.A.C. 8:31B-3.87).

As amended, R.1982 d.427, eff. December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).

Added per diem rate "in effect as of January 1 and July 1 of each year".

As amended, R.1983 d.597, eff. December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

(b)2ii(2): last sentence added.

Amended by R.1985 d.359, effective July 15, 1985.

See: 17 N.J.R. 873(a), 17 N.J.R. 1761(a).

(b)2ii(2) deleted and new text added.

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

References to typical and atypical cases deleted; provisions added for misassigned DRGs and apportionment of liability.

Law Review and Journal Commentaries

Administrative Law—Hospitals. Steven P. Bann, 137 N.J.L.J. No. 3, 70 (1994).

8:31B-3.80 Qualification procedure

(a) Submission of plans:

1. Any payor, Professional Standards Review Organization, or other qualified entity may submit to the Commissioner, a plan reasonably designed to meet the criteria set forth in N.J.A.C. 8:31B-3.78.

2. A plan may be designed to cover all patients to be admitted by a hospital or group of hospitals, or an appropriate portion thereof, and, where appropriate, on a hospital specific basis, may provide for a form of delegated review in which the hospital performs certain review functions, with monitoring and oversight by the qualifying utilization review organization. Each plan shall be designed to meet the criteria set forth in N.J.A.C. 8:31B-3.78 in the most efficient manner and shall include a payment proposal.

i. Each plan shall contain a review protocol, a description of how review criteria are to be determined and employed, and a plan for focusing reviews;

ii. Each plan which includes provision for delegated reviews shall include a description of how the performance of review at delegated hospitals will be monitored, and of the procedures for awarding and suspending delegation;

iii. The payment proposal shall, at a minimum, itemize proposed cost by category of direct review costs, overhead costs, monitoring costs, physician compensation, and other.

(b) Department review and recommendation:

1. The Department shall review all such plans within 90 days of submission and certify those plans which, consistent with L. 78, c.83:

i. Can be reasonably expected to fully meet the criteria set forth in N.J.A.C. 8:31B-3.78;

ii. Are designed to provide the services required above in the most efficient manner; and

iii. Consistent with high quality medical care, can be expected to best promote effectiveness and efficiency with respect to the health care delivery system, taken as a whole.

2. Special consideration shall be given to organizations which submit joint plans providing for coverage of wide geographical areas. In order to promote effectiveness and efficiency with respect to the health care system, the Department shall seek to avoid the undue proliferation of plans. Where appropriate, the Department may approve more than one plan for a given hospital or region; however, it shall approve more than two plans for a given hospital only under extraordinary circumstances. In considering plans for certification, the Department shall give consideration to the views of hospitals in the areas involved.

3. The Department may approve an effective date for plan activity no later than 90 days after approval of a plan.

Law Review and Journal Commentaries

Administrative Law—Hospitals. Steven P. Bann, 137 N.J.L.J. No. 3, 70 (1994).

Case Notes

Memorandum represented agency's interpretation of how elimination of reimbursement methodology impacted utilization review organizations; not "rule making". Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

Memorandum assigning "new task" for utilization review organizations it was "rule making". Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

Illegal rule-making aspect of Department of Health (DOH) memorandum did not taint interpretive aspect of memorandum. Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

Partial repeal of Health Care Facilities Planning Act did not eliminate statutory basis for state-qualified utilization review organizations; access to patient records. Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

Repeal of rate-regulation did not diminish agency's responsibility for medical necessity and efficiency of services. Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

Provisions describing nonreimbursement functions of state-qualified utilization review organizations; not repealed. Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

Hospitals were obligated to collect from payors cost of state-regulated utilization review organization services during transition year. Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

Administrative provision addressing payment for state-regulated utilization review organizations invalidated. Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

8:31B-3.81 Payment for utilization review services

(a) Proposal: The Commissioner shall propose to the Commission reasonable adjustments to the Schedule of Rates for all hospitals to which this subchapter is applicable, together with such terms and conditions as may promote efficiency and effectiveness with respect to the health care delivery system, taken as a whole. Consistent with the criteria set forth in N.J.A.C. 8:31B-3.78, such proposal, which shall be based on the Department's review, analysis, and findings as to the reasonableness of cost proposals under N.J.A.C. 8:31B-3.71 through 3.86 shall be broken into the components defined in N.J.A.C. 8:31B-3.71 through 3.86.

(b) Commission approval: Following a hearing pursuant to N.J.A.C. 8:31B-3.78, the Commission shall approve or modify, and direct an appropriate adjustment to the Schedule of Rates to which this provision applies. In accordance with N.J.A.C. 8:31B-3.87(a)3, each affected hospital shall implement the approved adjustment consistent with the payor selection procedure set forth in (c) below.

(c) Payor selection procedure:

1. Within 30 days of approval by the Commissioner of any plan in accordance with N.J.A.C. 8:31B-3.80 any payor may:

i. Subject to approval according to N.J.A.C. 8:31B-3.80, apply its own qualified utilization review organization and receive a full discount from the adjustment approved pursuant to N.J.A.C. 8:31B-3.81(b);

ii. Contract directly with a qualified utilization review organization and receive a full discount from the adjustment approved pursuant to N.J.A.C. 8:31B-3.81(b);

iii. Where delegated review has been approved, contract directly with the qualifying utilization review organization to monitor and assist delegated review conducted by hospitals, and receive an appropriate discount from the overhead and monitoring cost components of the adjustment approved pursuant to N.J.A.C. 8:31B-3.81(b); or

iv. Whenever a payor fails to select (c)1i, ii or iii above, it shall be deemed to have elected (c)1ii or iii above, whichever is appropriate, with the qualified utilization review organization responsible for reviewing the greatest proportion of cases in the hospital involved. In the case of (c)1iii above, the payor shall pay the full utilization review adjustment to the hospital, which shall be responsible for remitting the appropriate amount to the qualified utilization review organization on a timely basis.

2. Payors must notify the Department, hospitals, and all qualified utilization review organizations, of their election under (c)1 above in writing. They may change their elections at any time subject to 60 days written notice.

3. Any payor with total utilization among its subscribers or beneficiaries of fewer than 500 days per 1,000 enrollees in the prior calendar year may apply to the Commission for a full discount from the adjustment without exercising (c)1i, ii or iii above, or being subject to (c)1iv above.

Case Notes

Hospitals were obligated to collect from payors cost of state-regulated utilization review organization services during transition year. Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

Administrative provision addressing payment for state-regulated utilization review organizations invalidated. Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

8:31B-3.82 Performance standards for maintenance of qualification

Within one year after certification, and each subsequent year thereafter, each qualified utilization review organization shall submit, in a form and manner to be prescribed by the Commissioner, such information and data as may be required to adequately assess the performance of such organizations in accordance with N.J.A.C. 8:31B-3.78. Qualification may be terminated on a finding of inadequate performance.

8:31B-3.83 through 8:31B-3.86 (Reserved)**8:31B-3.87 (Reserved)**

Repealed by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
Section was "Summary report".

8:31B-3.88 through 8:31B-3.90 (Reserved)**SUBCHAPTER 4. FINANCIAL ELEMENTS AND REPORTING****8:31B-4.1 Purpose**

(a) The purpose of this subchapter is to provide the basis for a standardized system of reporting the financial elements to be used in conjunction with the Hospital Reporting of Uniform Bill-Patient Summaries regulation (N.J.A.C. 8:31B-2), the Financial Reporting and Monitoring regulation (N.J.A.C. 8:31B-3) and the Uniform Cost Reporting rule (N.J.A.C. 8:31A-5.5) for implementing the Health Care Facilities Planning Act, P.L. 1971, c.136 as amended by P.L. 1978, c.83; P.L. 1991, c.187 and P.L. 1992, c.160.

(b) The Commissioner shall require each hospital to report cost, revenue and statistical information in accordance with the uniform system described in this subchapter. Sepa-

rately licensed hospitals that are part of a hospital system shall submit separate Acute Care Hospital Cost Reports as defined in N.J.A.C. 8:31B-4.131. This information is critical and is required to support the Department's public health activities, which include planning, licensing, allocating charity care subsidies, providing information to consumers and other interested parties, and monitoring hospital costs and revenues.

Amended by R.2003 d.40, effective January 21, 2003.
See: 34 N.J.R. 2237(a), 34 N.J.R. 2549(b), 35 N.J.R. 408(a).
Rewrote (b).

PART I. REPORTING PRINCIPLES AND CONCEPTS

8:31B-4.2 Functional versus responsibility reporting

(a) A prerequisite for the informed review of hospital data is good communication, i.e., a common understanding and use of terminology among all parties. Imperfect communication results when terms such as "hours", "dietary", "purchased services", etc. mean different things to different people. The objective in the design of this manual is to achieve uniform reporting of financial elements consistent with uniform definitions of functional cost and revenue centers, statistical data, patient data and the natural classifications of expenses, i.e., salaries, supplies.

(b) Expenses, revenues and other data reported in a manner consistent with the definitions included herein will provide a sound basis for the establishment of a uniform system of reporting. This manual, however, is not requiring that institutions adopt this functional reporting system for their internal management reports, so long as institutions maintain the ability to report data with reasonable accuracy in accordance with the functional definitions and expense and revenue classifications defined herein.

(c) A hospital should structure its accounts for the purpose of managing a sound cost-effective and financially viable organization. In many instances, principally due to various budgetary control objectives, this goal may be better achieved through recording of expenses and revenues on a responsibility basis. However, it is highly unlikely that expenses and revenues recorded on a responsibility basis can be reported "as is" on the prescribed uniformed functional basis. This will necessitate the recast of expenses, revenue and statistics per N.J.A.C. 8:31B-4. Various reporting schedules provide the hospital with the opportunity to insure that the financial data used to develop the financial elements of the current Cost Base, despite the recasts and allocations involved, are equivalent to the hospital's own audited financial statements. A working knowledge of the principles, concepts and definitions included herein, especially with regard to the inclusion of specific functions within reporting centers and of the natural classifications of expense, is necessary for a hospital's accurate compliance with these reporting requirements.

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.3 Prescribed reporting principles

(a) The reporting principles and concepts described in this chapter have been drawn from existing systems wherever possible.

(b) Any reporting principles and concepts not specifically discussed in this manual should be reported according to Generally Accepted Accounting Principles 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).

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.4 Accounting entity

A fundamental reporting concept is that of the accounting entity or unit. For reporting purposes, the hospital is an entity capable of buying, selling and taking other economic action, 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. Many departments of the hospital assume sufficient importance to require separate treatment as subordinate entities or units of accountability for planning and control purposes.

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.5 Continuity of activity

Another basic reporting concept is that of continuity of activity, or the going concern. The assumption is that the hospital will continue to function indefinitely. It then becomes necessary to divide the life of the hospital into reporting 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.

8:31B-4.6 Reporting period

(a) The basic reporting period is 12 consecutive calendar months, which may be either on a calendar or fiscal year basis at the hospital's option. Hospitals shall provide the Department six months notice of an intent to change the reporting period before implementing any revised reporting period or the Department will use the hospital's most recent, previously closed cost report for the purposes listed in N.J.A.C. 8:31B-4.1(b).

(b) New hospitals beginning operations on any day other than January 1 must select an initial reporting period beginning on the first day of operation, through the last month preceding the end of the hospital's fiscal year. For example, a hospital using a calendar year reporting period and beginning operations August 15, 2001 would have an initial reporting period running from August 15, 2001 through December 31, 2001. Its next reporting period would then be January 1 to December 31.

(c) Each hospital's Current Cost Base submission for the most recent reporting period is due on the following June 30. Each hospital's most recent Annual Audited Financial Statement is due on the following June 30th. Failure to meet these time frames will result in penalties as stated in N.J.A.C. 8:31B-3.3.

Amended by R.1983 d.596, effective December 19, 1983.

See: 15 N.J.R. 1334(a), 15 N.J.R. 2166(a).

(c) added.

Amended by R.1984 d.500, effective November 5, 1984.

See: 16 N.J.R. 2326(a), 16 N.J.R. 3019(b).

Financial report forms and Statement due date changed from April 30 and June 30 to May 31.

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Amended by R.2000 d.339, effective August 21, 2000.

See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

In (c), rewrote the first sentence.

Amended by R.2003 d.40, effective January 21, 2003.

See: 34 N.J.R. 2237(a), 34 N.J.R. 2549(b), 35 N.J.R. 408(a).

Rewrote the section.

8:31B-4.7 Objective evidence

(a) 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.

(b) Certain determinations that enter into accounting records are based on estimates. Such estimates should be based on past experience modified by expected future considerations. Examples would include recognition of estimated provisions for bad debts and self-insurance funding and the reporting of other operating expenses separately from Costs Related to Patient Care. Items of Other Operating Expenses, if not directly classified by the hospital, if large in amount, must be identified through a cost study, and if small in amount, costs may be deemed equal to revenue and such costs apportioned among the appropriate natural classifications of expense based on the hospital's estimate or the classifications of the center where originating. Worksheets are provided along with Reporting Schedules to aid the hospital in making all appropriate reclassifications. All such reclassifications should be consistent with the concept of materiality, defined in N.J.A.C. 8:31B-4.11.

(c) 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 the data to be readily verified by qualified auditors.

8:31B-4.8 Conservatism

Conservatism is a quality of judgement 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 justification for excessively high or low estimates.

8:31B-4.9 Consistency

(a) 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. 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 suboptimal method or procedure. Any change of accounting procedure, consistent with the materiality principal, must be brought to the attention of the Department of Health and Senior Services by way of a cover letter which will accompany the hospital's Financial Elements Report to include both a description and analysis of reporting impact of such accounting procedure changes.

(b) As an example, the accounting principal of accrual reporting (see N.J.A.C. 8:31B-4.13) may cause some hospitals who currently account for vacation on a cash basis to incur a one time reporting of expenses related to vacation time earned by employees but not yet taken. Such one time costs must be included in a cover letter and the Financial Elements Report shall identify only those vacations costs accrued in the current reporting period.

(c) Any accounting and reporting changes due to subsequent revisions of this manual or the documents referred to herein will be reported in accordance with the instructions which accompany those revisions.

Amended by R.2000 d.339, effective August 21, 2000.

See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

8:31B-4.10 Full disclosure

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. No fact that would influence the decisions of management, the governing board, or other users of financial statements should be omitted from or concealed in accounting reports.

8:31B-4.11 Materiality

Materiality is an elusive concept with the dividing line between material and immaterial amounts subject to interpretation. 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.

8:31B-4.12 Basis of valuation

(a) 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 donated non-cash goods and services). 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.

(b) Long term investments are to be reported at current market value as noted in N.J.A.C. 8:31B-4.17, with corresponding income or loss reported as realized or unrealized.

(c) Hospitals frequently acquire property, equipment, services and supplies by donation. The property, equipment, service and/or supply is considered donated when acquired without the hospital's making any payment for it in the form of cash, property or service. The property, equipment, service or supply should be valued at acquisition 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). The fair market 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 for valuation. The amounts recorded are not to exceed those paid others for similar work.

(d) The value of donated goods or services of a type not consistent with the definition given are not included as operating expenses (e.g., donated services of individuals such as volunteers, students and trustees).

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.13 Accrual accounting

In order to provide the necessary completeness, accuracy and meaningfulness in reporting data, the 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 in which they apply rather than when cash is received or paid.

8:31B-4.14 Matching of revenues and expenses

(a) Determination of net income for a reporting 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.

(b) 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 matching of revenue and expense, the reported gain or loss of a period is meaningless.

(c) It is important that revenue deductions be given reporting recognition in the same period that the related revenues are recorded, even though certain of these revenue deductions cannot be precisely determined until sometime after the end of the reporting period.

(d) Expenses and revenues are to be matched not only for the hospital as a whole, but also for each cost and revenue center. The cost (revenue) center is an accounting device for accumulating items of cost (revenue) that have common characteristics. A cost center may or may not be a department within the hospital. A cost center such as utilities 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 (see N.J.A.C. 8:31B-4 Part vi) 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 Laboratory are included in the Laboratory cost center and related revenue is to be included in the Laboratory revenue center.

(e) Some hospitals record revenue on an all-inclusive rate basis (a rate based on type of accommodation regardless of the utilization of ancillary services). Utilization of an all-inclusive rate system results only in a modification of the patient billing and revenue accounting system. It does not eliminate the need to report expenses by proper cost center.

(f) Revenues are classified as either operating or non-operating according to the following definitions:

1. Operating revenues and expenses include those transactions which are a part of the normal day-to-day operation of the hospital. They include but are not limited to those operations involved in the performance of all patient care activities (i.e., Services Related to Patient Care, see N.J.A.C. 8:31B-4.32).

2. Non-operating revenues are defined to be all transactions of the hospital which are not part of the normal day-to-day activities. Non-operating revenues (or losses) are to be reported net of expenses incurred in the transaction (e.g., gain or sale of securities should be shown net of brokerage fees, donations net of solicitation expenses, and rental income net of rental expenses.) Included are:

i. Gains or losses from investments and the operation of non-hospital related businesses usually run at a site separate from facilities utilized for Services Related to Patient Care;

ii. Donations and fund raising activities;

iii. Interfund transactions (see N.J.A.C. 8:31B-4.16(c)7).

8:31B-4.15 Revenues and deductions from revenue

(a) If a hospital receives less than its full charges for the services it renders, it shall report to the Department both the gross revenue and revenue "adjustments" resulting from failure to collect full charges for services provided. These revenue adjustments are called Deductions from Gross Revenue. The specific deductions required for reporting Revenue Related to Patient Care, as defined in N.J.A.C. 8:31B-4.32 are defined in (a)1 through 11 below. Any individual allowance must be reported in only one of the 10 deduction categories and three contra categories (although individual transactions may be distributed among several if appropriate):

1. Third party payor allowances: These adjustments represent the differences between full charges for services and the payment anticipated from major third party payors according to contractual agreements or government mandated payor differentials. These adjustments exclude any deductions made by any third party payor for any other allowances which are more appropriately categorized in one of the following classes of deductions from gross revenue.

2. Prompt payment discounts: These adjustments are the difference between charges and payments received due to the prompt payment of a bill.

3. Personnel health allowance: These deductions represent adjustments from charges for services rendered to

employees of the hospital and their families under a formal self-insurance or coinsurance plan of the hospital.

4. Courtesy adjustments: These deductions represent adjustments from charges for services rendered to any individual other than employees of the hospital and not otherwise more appropriately categorized, including any patient accounts written off contrary to the hospital's formal policies relative to credit, bad debts and indigency care.

5. Other Administrative Adjustments: These deductions represent adjustments made by the hospital as a matter of policy because of immateriality. Examples of these types of adjustments would include insignificant balances not billed to the patient or third party payor because of late billing occurring after payment has been received.

6. Medical denials: These deductions represent amounts not due from patients or third party payors because of a ruling by appropriate utilization review or certification processes which determine that the services rendered were not medically appropriate or necessary, but excluding medical denials classified as Nursing Home Placement.

7. Nursing home placement: These deductions represent amounts not due from patients or third party payors because of rulings by appropriate utilization review or certification processes which determine that the services rendered were not medically appropriate to an acute care setting for patients who were unable to be placed in a skilled nursing facility because of a lack of available beds.

8. Charity care: These deductions represent charges for patients determined to be eligible for charity care pursuant to N.J.A.C. 8:31B-4.37.

9. County government grants for the medically indigent; municipal government grants for the medically indigent; other grants for the medically indigent:

i. These three categories represent all amounts received from governmental or other agencies for the care of medically indigent patients.

10. Bad debt provision:

i. These deductions represent the hospital's estimate of the amount of charges for Services Related to Patient Care during the reporting period (not otherwise accounted for as a deduction from Gross Revenue Related to Patient Care) which will not be received, net of recoveries of previously written-off accounts. Collection agency expense should not be included as a deduction from revenue but rather should be reported as operating expense and Cost Related to Patient Care as defined in N.J.A.C. 8:31B-4.32 and 4.118;

ii. The bad debt provision explicitly excludes deductions for contractual allowances, indigent patients, courtesy care, medical denials, finance charges or other non-medical service costs such as late fees and patient convenience items, and nursing home placement medical denial cases. Estimates of the bad debts incurred for the reporting period are to be reconciled to actual bad debts incurred for the reporting period and reconciled in the next reporting period's bad debt provision.

11. Other operating gross revenue: This account represents the amount of billings for services normal to the day-to-day activities of the hospital (net of any items reported as expense recovery) for Services Not Related to Patient Care.

(b) It is important to select the most appropriate classification of each deduction and the hospital is advised to establish procedures which will govern the approval and classification of transactions which will be recorded as deduction from Gross Revenue.

Amended by R.1989 d.491, effective September 18, 1989.

See: 21 N.J.R. 1487(a), 21 N.J.R. 2991(b).

Added (a)4i, concerning Statewide add-on.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Exclusion of non-medical service costs from bad debt provision.

Amended by 1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.16 Fund accounting

(a) Many hospitals receive income, gifts, bequests and grants from donors, governmental or other sources external to the hospital that are restricted as to their use. When funds with externally imposed restrictions are received, they must be recorded in a separate fund. This would not preclude the pooling of assets by the hospital among its funds for investment purposes.

(b) Funds transferred to the Operating Fund from the Restricted Fund for board restricted activities must be recorded in the Unrestricted Fund as nonoperating revenue and as operating expense when expended. For reporting purposes the recording of transactions among and within the Unrestricted Fund and Restricted Funds are to be in accordance with the AICPA Hospital Audit Guide.

(c) Funds fall into four categories: Unrestricted Funds, Donor Restricted Plant and Equipment Fund, Specific Purpose Funds and Endowment Funds. The accounts within each fund are self-balancing, and each fund constitutes a separate subordinate accounting entity. This subsection outlines the conditions and events which require separate accountability within the established funds.

1. Unrestricted Funds are used to account for all monies not restricted by donors or grantors in accordance with the rules set forth in this section. Two funds are to be established for unrestricted funds:

i. Operating Fund is used to account for funds derived from ongoing patient care and related day-to-day activities of the hospital, except for the portions of such funds otherwise classified here.

ii. Board Designated Funds are unrestricted funds which have been designated for specific purposes by the hospitals governing board. The board retains the right to undesignate such funds. The amount of such board designated funds for capital replacement and renovation as well as the sources and applications of all Board Designated Funds shall be reported annually to the Department of Health and Senior Services per N.J.A.C. 8:31B-4.13.

2. Restricted Internally Generated Major Moveable Equipment Replacement Fund ("Equipment Fund") is a fund to be used to account for the portion of all Net Revenues Related to Patient Care for the leasing, depreciation or replacement of major moveable equipment.

i. Income from the investment on the fund's assets shall also be credited to this fund, net of any income taxes attributable to such income. Investments are to be reported at market value, and unrealized gains and losses are to be reported as income or loss each period.

ii. This fund shall only be debited for major moveable equipment leasing and capital expenditures for acquisition or capitalized reporting.

3. Restricted Internally Generated Plant Replacement and Major Renovation Fund ("Plant Fund") is used to account for the portion of all Net Revenues Related to Patient Care (specified as the Capital Facilities Allowance) for the acquisition, preservation, renovation and replacement of the "plant," (as defined in N.J.A.C. 8:31B-4.21), i.e., buildings, building components, fixed equipment, land and capitalized assets other than minor or major moveable equipment. It will also account for all capitalized "plant" expenditures plus all debt service payments on long term debt other than those that may be assigned to the "Equipment Fund." Income earned (losses incurred) on investments (at market value) of the Plant Fund, less any income taxes attributable to such income, is restricted to the same capital purposes as the fund principal.

4. Donor Restricted Plant and Equipment Fund: Resources restricted by donors for the acquisition or construction of plant assets or the reduction of related debt are to be accounted for in the Donor Restricted Plant and Equipment Fund.

i. Income earned on investments and any losses incurred, valuing securities as at market value, must be reflected as an addition/reduction to the Donor Restricted Plant and Equipment Fund Balance if so specified by the donor.

5. **Specific Purpose Funds:** Funds received which are restricted for a specific purpose must be accounted for in a Specific Purpose Fund. Revenue and Expense transactions resulting from these resources, not otherwise restricted by the donor(s), must be recorded as other Operating revenue and operating expenses per the appropriate cost center or classification in the period in which these transactions are incurred. (In some instances the transactions resulting from these resources will be recorded as non-operating revenue and expense.)

6. **Endowment Funds:** Funds classified as Endowment Funds include:

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

Amended by 1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).
Amended by R.2000 d.339, effective August 21, 2000.
See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

Case Notes

Regulation valid including hospital's available philanthropic funds as working capital for initial rate fixing purposes; legislative intent. In re: Barnet Memorial Hospital Rates, 92 N.J. 31, 455 A.2d 469 (1983).

8:31B-4.17 Long-Term Security Investments

Long-Term Security Investments are to be valued at current market value. If acquired by donation, they are to be valued initially at the fair market value at the date of the gift. Changes in the market value of investments, both realized and unrealized, during a reporting period are to be reported as income or losses for that reporting period.

8:31B-4.18 Pooled investments

(a) Investments of various funds may be pooled by the hospital 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 the time of pooling.

(b) Each time an addition is made to the investment pool, a new distribution basis must be calculated. This is also true for any reductions to the pool. All capital gains and losses and investment income from the beginning of the accounting period up to the date of the addition or reduction must be determined and distributed on the basis of account balances prior to the addition. Any capital gains and losses and investment income subsequent to an addition or reduction must be distributed on the new basis until another addition or reduction is made.

8:31B-4.19 Inventories

(a) 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. Cost of inventories based on the last invoice price is not an acceptable method for determining such costs.

(b) Inventory accounting record systems are required, consistent with the method of the inventory valuation employed. Physical valuations must be made at least once a year and the accounting records adjusted to such valuation when appropriate.

(c) Inventory activity records must be maintained for all inventories that are distributed and used by more than one cost center in the hospital. It is recommended that a formal requisition system be used for this purpose. In all cases, the cost of non-billable supplies used during the period must be distributed to the user cost center, preferably on a monthly basis.

8:31B-4.20 Accounting for minor moveable equipment

(a) Minor moveable equipment includes such items as waste baskets, bed pans, silverware, mops, buckets, etc. The general characteristics of this equipment are:

1. In general, no fixed location and subject to use by various departments within a hospital;
2. Comparatively small in size and unit cost;
3. Generally, a useful life of less than three years.

(b) There are three ways in which the cost of minor moveable equipment may be recorded:

1. The original cost of this equipment may be capitalized and not depreciated. Any replacements of or additions to this base stock would be charged to operating expense.
2. 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.
3. All purchases of minor equipment may be capitalized and depreciated over their estimated useful lives.

(c) Once a hospital has elected one of these methods, that method must be used consistently thereafter.

8:31B-4.21 Accounting for capital facilities cost

(a) Capital Facilities include owned or leased land, land improvements, buildings, fixed equipment, leasehold improvements, major moveable equipment and related debt service requirements.

(b) Land improvements include paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc. (if replacement is the responsibility of the hospital).

(c) Buildings include the basic walled structure or shell of a hospital and additions thereto.

(d) Fixed Equipment and Building Components include roofs and attachments to buildings such as wiring, electrical fixtures, plumbing, elevators, heating systems, air conditioning systems, etc. The general characteristics of this equipment are:

1. Affixed to building and not subject to transfer of movement;
2. Used for general purpose rather than for specific department functions.

(e) Leasehold improvements include betterments and additions made by the tenant to the leased property. Such improvements become the property of the lessor after the expiration of the lease.

(f) Major moveable equipment is that equipment which usually has a relatively fixed location in the building, but is capable of being moved, generally has a specific function related to cost center functions, and has a life expectancy of at least three years.

(g) Debt service requirements are principal and interest on buildings, fixed equipment, land, land improvements, leasehold improvements, and capitalized renovations as well as escrow payments in addition to principal and interest required under the terms of a mortgage but not including operating expenses as defined by GAAP and lease payments required for leased assets capitalized in accordance with the GAAP.

1. Classification of Fixed Asset Expenditures: Assets and related liabilities as defined above must be recorded in Unrestricted Funds, since segregation in a separate fund would imply the existence of restrictions on the use of the asset. This includes costs of construction in progress.

2. Basis of Valuation: Property, Plant, and Equipment, whether owned or leased, must be reported on the basis of cost. Cost shall be defined as historical cost or fair market value at the date of bequest in the case of donated property.

i. Interest and capitalization on site preparation costs associated with borrowings for, or purchase of, major moveable equipment are included with the cost of the equipment.

3. Accounting Control: To maintain accounting control over capital assets of the hospital, a plant asset ledger should be maintained as part of a hospital's 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 in a single unit within the ledger so long as such items are depreciated in a manner equivalent in result to individually depreciating each item.

4. Capitalization Policy:

i. If an asset has, at the time of its acquisition, an estimated useful life of greater than three years and a historical cost in excess of \$300.00, its cost must be capitalized.

ii. If an asset does not meet the above criteria, its cost must be recorded as an expense in the year it is acquired. Alterations and renovations which are in excess of \$300.00 and which extend the life of the asset renovated a minimum of three years must be capitalized. Alterations and renovations that do not meet the above criteria are to be reported as operating expense under repair and maintenance costs in the current period.

iii. This shall be the required Capitalization Policy for the reporting assets acquired (and renovations per (g)6 below), subsequent to a hospital's first Commission approved Schedule of Rates. Assets acquired prior to this date are to be reported in accordance with GAAP.

5. Interest Expense During Period of Construction: 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 part of the cost of the construction for reporting purposes. 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.

6. Depreciation Policies:

i. Depreciation allowances generated from assets used in the hospital's operations are to be reported as an operating expense in the Unrestricted Funds. Straight-line depreciation must be reported for all assets, with replacement cost provisions (subject to appropriate planning requirements) and debt service requirements for capital assets utilized for Services Related to Patient Care provided for in N.J.A.C. 8:31B-4.42.

ii. 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 reasonably expected technological advances, climatic or local conditions and the hospital's policy of repair and replacement. In selecting a proper useful life for computing depreciation, hospitals must utilize Asset Depreciation Range or the most recent approved or American Hospital Association useful life guidelines at the time of the cost filing (i.e., 1978 Revisions). Costs of alterations, renovations, etc. over \$300.00 which extend the life of an asset at least three years are to be added to the remaining book value of the altered or renovated asset and depreciated straight-line over the remaining useful life of the asset (as defined in N.J.A.C. 8:31B-4.3).

iii. The preferred depreciation policy for reporting purposes is for hospitals to record one-half year depreciation in the first year an asset is acquired and one-half year depreciation in the last year of the asset's useful life, but that buildings or major renovations be depreciated based on the month first put into use. However, any depreciation policy consistent with GAAP is acceptable.

iv. When an asset is retired, the difference between its book value (historical acquisition cost plus capitalized renovations less accumulated depreciation) and its net salvage value shall be recorded as an adjustment to that year's depreciation expense in the cost center or classification to which the asset was assigned.

v. When Major Moveable Equipment has reached its useful life, but remains in use, its historical cost and accumulated depreciation may be retained in the accounting records by department. However, hospitals must be able to report fully depreciated assets separately from those which are not fully depreciated.

7. Debt Financing for Plant Replacement, Renovation and Expansion purposes:

i. Debt financing for capital facilities 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.

(1) Discounts and Premiums on Bond Issues: Discounts and premiums arising from the issue of bonds are to be amortized over the life of the related issue(s).

(2) Financing Charges: Costs of obtaining debt financing other than discounts (e.g., legal fees, underwriting fees, special accounts costs) are to be reported as deferred costs and amortized over the life of the related debt.

(3) Reporting of Debt Proceeds: 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 are to be reported as other noncurrent assets in the Unrestricted Fund.

8. Sinking and Other Required Funds:

i. 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).

ii. 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.

iii. All internally generating sinking and other required funds will be accounted for in the following manner:

(1) All fund assets, unless the hospital relinquishes control of the fund through a trustee arrangement, must be recorded in the Restricted Internally Generated Plant Replacement Fund as a long-term investment. Payments to a trustee for sinking fund purposes should be recorded as reductions in the associated long-term debt.

(2) All income generated from the investment of such funds, except as excluded in (g.8i-iii) above, must be recorded as non-operating revenue in this fund, except as required under, "Interest Expense during Period of Construction," (see N.J.A.C. 8:31B-4.21). Income generated from funds under covenant agreement may be accounted for as an addition to the appropriate restricted fund balance account.

9. Early Debt Retirement:

i. Many bond contracts provide for the calling of any portion or all of the issue at the option of the issuer at a stated value usually above par, for the purpose of enabling the organization 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.

ii. 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 Principles.

(h) Any changes in debt financing shall be reported to the Commissioner as they occur.

Amended by R.1985 d.550, effective November 4, 1985.

See: 17 N.J.R. 2004(a), 17 N.J.R. 2637(a).

(g) "escrow" substituted for "escrow".

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.22 Timing difference

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 establishing or making payments based upon the reported operations. These differences are to be reported on the hospital's records when they arise in accordance with relevant AICPA policies. For the reporting of deferred income tax refer to—Income Tax Allocation—Accounting Principles Board Opinions Nos. 11, 23, and 34.

8:31B-4.23 Reporting of pledges

All pledges, less a provision for amounts estimated to be uncollectable, are to be included in the hospital's financial reports. If unrestricted they are to be reported as non-operating revenue in the Unrestricted Fund in the period the pledge is made. If part of the pledge is to be applied during some future period, that part is to be reported in the period the pledge is received as deferred revenue. If restricted, they are to be reported as an addition to the appropriate restricted fund balance. See AICPA, Hospital Audit Guide.¹

¹ American Institute of Certified Public Accountants, 1211 Avenue of the Americas, New York, NY 10036.

8:31B-4.24 Self insurance

(a) Self insurance by a hospital for potential losses due to unemployment, and workmen's compensation claims but excluding self insurance for employee health care to be provided by the hospital asserted or otherwise, places all or part of the risk of such losses on the hospital rather than passing all or part of such losses to a third party. Where this method of insuring is used by the hospital, the payments into the fund or pool (if one is maintained) or payments on actual losses incurred are to be considered as insurance expense.

(b) It is required that where self insurance for other than those items listed above is elected to be used by a facility, the method should conform with the following:

1. Self-Insurance Fund: The hospital or pool establishes a fund with a recognized independent fiduciary such as a bank or a trust company. The hospital or pool and fiduciary enter into a written agreement which includes all of the following elements:

i. General Legal Responsibility: The fiduciary agreement must include the appropriate legal responsibilities and obligations required by State laws.

ii. Control of Fund: The fiduciary must have legal title to the fund and be responsible for proper administration and control. The fiduciary cannot be related to the provider either through ownership or control. Thus, the home office of a chain organization or a religious order of which the hospital is an affiliate cannot be the fiduciary. In addition, investments which may be made by the fiduciary from the fund are limited to those approved under State law governing the use of such fund; notwithstanding this, loans by the fiduciary from the fund to the hospital or persons related to the hospital are not permitted.

iii. Payments by Fiduciary: The agreement must provide that withdrawals must be for malpractice and comprehensive general patient liability losses only and those expenses listed in (b)4 below. Any rebates, dividends, etc., to the hospital from the fund will be used to reduce allowable cost.

iv. Reporting: The agreement must require that a financial statement be forwarded to the hospital or pool members by the fiduciary no later than 60 days after the end of each annual insurance reporting period. This statement must show the balance in the fund at the beginning of the period, current period contributions, and amount and nature of final payments, including a separate accounting for claims management, legal expenses, claims paid, etc., and the fund balance. This report and fiduciary's records must be available for review and audit.

v. Income Earned: The agreement must provide that any income earned by the fund less any income taxes attributable to such income, must become part of the Fund and must be used in establishing adequate fund levels.

2. Soundness of the Fund:

i. The hospital receives and retains an annual certified statement from an independent actuary, insurance company, or broker that has actuarial personnel experienced in the field of medical malpractice and general liability insurance. To be independent, there must not be any financial ownership or control, either directly or indirectly in the hospital.

ii. The actuary, insurance company, or broker shall determine the amount necessary to be paid into the fund. The fund should include reserves for losses based on accepted actuarial techniques customarily employed by the casualty insurance industry and expenses related to the self-insurance fund as specified in (b)4 below. The actuary, insurance company, or broker shall also provide for an estimate of the amounts to be in excess of what is reasonably needed to support anticipated disbursements from the fund.

iii. The actuary, insurance company, or broker must state the actuarial basis and the coverage period used in establishing reserve levels. Reserves will not be recognized as allowable costs for losses specifically denied herein. Thus, reserve payments will not be recognized for items such as:

(1) Losses in excess of the greater of 10 percent of a hospital's net worth or \$100,000 where a hospital elects to pay losses directly in lieu of establishing a funded self-insurance fund;

(2) Losses in excess of coverage levels which do not reflect the decisions of prudent management;

(3) Losses in excess of coverage for events that occurred prior to a hospital's participation under the Commission.

iv. The actuary, insurance company, or broker must provide its workpapers upon request.

3. **Claims Management and Risk Management Program:** A hospital or pool has an ongoing claims process and risk management program. The hospital or pool must demonstrate that it has an ongoing claims process to determine whether malpractice and comprehensive general patient liability exists, its cause, and the cost of claims. A hospital or pool may either utilize its qualified personnel or an independent contractor, such as an insurance company, to adjust claims. In addition, a hospital or pool must obtain adequate legal assistance in carrying out its claims process. Each hospital must also have an adequate risk management program to examine the cause of losses and to take action to reduce the frequency and severity of them. Such risk management program has the essential characteristics of programs required by insurers which currently insure providers for these risks. Therefore, a hospital must have an ongoing safety program, professional and employee training programs, etc., to minimize the frequency and severity of malpractice and comprehensive general patient liability incidents.

4. **Expenses Related to Losses Paid Out of Self-Insurance Fund:** The following expenses will be considered costs attributable to a self-insurance fund established by a hospital or pool: expenses of establishing the fund or pool, expenses for administering the claims management program, expenses involved with maintenance of the fund by the fiduciary, legal expenses, actuarial expenses, excess insurance coverage (if purchased by the fiduciary or pool), risk management (if performed by the fiduciary or pool), to the extent that such expenses are related to the hospital's self-insurance program. All other expenses will not be considered costs attributable to the fund, but should be included in provider administrative and general costs in the year incurred.

8:31B-4.25 Related organizations

(a) Auxiliaries, guilds, fund raising groups and other related organizations frequently assist hospitals. Such organizations are independent if they are so characterized by their own charter, by-laws, 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 or combined with reports of the hospitals in accordance with the AICPA's Hospital Audit Guide, as amended and supplemented, available from the AICPA Order Department, P.O. Box 2209, Jersey City, N.J. 07303.

(b) A hospital itself may be a subsidiary to or under the control of a large organization such as a 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. To be included as Costs Related to Patient Care all such charges must be similar to those which would have been charged if the transacting organizations were not related. The direct charges must be recorded in the appropriate cost centers as billed, and the management fee must be distributed to the functional centers where services are provided. The hospital shall maintain documentation of the actual management service for which a management fee is recorded.

(c) Disclosure of information by hospitals dealing with related firm(s):

1. For the purpose of insuring prudent buying, hospitals will report the existence of a related organization and each type of service provided, to the Department, if the total transactions amount to greater than \$10,000 per year.

2. Hospitals may be related to one or more separate organizations if:

i. The hospital controls through contracts or other legal documents the authority to direct the separate organization's management or policies;

ii. The separate organization controls through contracts or other legal documents the authority to direct the hospital's management or policies;

iii. The hospital is for all practical purposes the primary beneficiary of the separate organization.

(d) At the Department's request relevant information reported to the Department may include:

1. The nature of the legal relationship between the hospital and the related firm(s).

2. Frequency of business transactions between the hospital and the firm(s); and

3. Purchase or lease contractual arrangements between the hospital and firms;

4. The amount of money involved; and

5. The financial statements of all related organizations.

Amended by R.1983 d.596, effective December 19, 1983.

See: 15 N.J.R. 1334(a), 15 N.J.R. 2166(a).

(c) and (d) added.

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.26 through 8:31B-4.30 (Reserved)

PART II. FINANCIAL ELEMENTS

8:31B-4.31 Financial elements generally

The financial elements shall include the cost of the following, as defined in regulations proposed by the Commissioner and approved by the board: direct patient care principal and interest payments; paid taxes, excluding income taxes; education, research and training programs, not otherwise paid for by the State; the provision of health care services to individuals unable to pay them for reasons of indigency; bad debts, provided adequate recovery procedures are followed; preservation, replacement and improvement of facility and equipment subject to appropriate planning requirements; reasonable working capital ... and where applicable and appropriate, reasonable return on investment where a hospital is operating efficiently and effectively.

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.32 Services related to patient care

(a) Services related to Patient Care include Direct Patient Care; Paid Taxes excluding Income Taxes; and Educational, Research and Training Programs as further defined in N.J.A.C. 8:31B-4.33-4.35.

(b) Services Related to Patient Care include Routine Services, Ambulatory Services, Ancillary Services, Patient Care General Services, and Institutional Services as defined in N.J.A.C. 8:31B-4, Part V. Costs Related to Patient Care include salaries and wages, physician compensation, employee fringe benefits, medical and surgical supplies, drugs, non-medical and non-surgical supplies, purchased services and other direct expenses (i.e., the Natural Classifications of Expense; see N.J.A.C. 8:31B-4, Part III.) and major moveable equipment costs as determined in accordance with N.J.A.C. 8:31B-4.13 through 4.25 and N.J.A.C. 8:31B-4.42 and reported separately in N.J.A.C. 8:31B-4.131. Revenue Related to Patient Care includes charges and monies received from patients and third party payors for Routine Services, Ambulatory Services, and Ancillary Services. Costs and Revenue Related to Patient Care are to be reported per N.J.A.C. 8:31B-4.131. All cost and revenues of the reporting period not included in the definition Services Related to Patient Care (as above and in N.J.A.C. 8:31B-4, Part V) are to be reported separately as other operating and non-operating costs and revenues per N.J.A.C. 8:31B-4, Part IV and 4.131 for transactions affecting the hospital's unrestricted fund.

(c) All non-physician services and supplies provided to hospital inpatients, whether provided directly by the hospital or by a vendor, will be considered services and costs related to patient care, and are, therefore, financial elements.

(d) The Commissioner shall issue a public report on reimbursement for services purchased from vendors that are in violation of State certificate of need regulation.

Amended by R.1984 d.124, effective March 26, 1984, originally adopted as an emergency rule R.1984 d.26 effective January 24, 1984.

See: 16 N.J.R. 252(a), 16 N.J.R. 893(b).

Added (c) and (c).

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Case Notes

In determining how to allocate reduction in Medicare payments, Hospital Rate Setting Commission was required to consider Health Care Facilities Planning Act. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Hospital Rate Setting Commission's reduction in Medicare payments was administrative rule. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Hospital Rate Setting Commission's process to allocate reduction of Medicare payments violated Administrative Procedure Act. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Hospital Rate Setting Commission erred in refusing to allow hospital to recalculate number of full-time equivalent residents and residents' salaries based on accepted standard. *St. Barnabas Medical Center v. New Jersey Hospital Rate Setting Commission*, 214 N.J.Super. 599, 520 A.2d 805 (App.Div.1987).

Regulation prohibits reimbursement for in-patient services furnished by providers failing to obtain a certificate of need; rebundling of bills for services provides for Commission review of charges. *Radiological Society of New Jersey v. New Jersey State Dept. of Health*, 208 N.J.Super. 548, 506 A.2d 755, (App.Div.1986), certification denied 104 N.J. 444, 517 A.2d 434.

8:31B-4.33 Direct patient care

Direct Patient Care is the provision by a hospital of medically necessary and appropriate health care services.

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.34 Paid taxes

Taxes are monies paid to a governmental unit for conducting business related to direct patient care within its jurisdiction. Taxes related to financing of operations through the issuance of bonds, property transfers, issuance or transfers of stocks, and the like, are not classified as taxes; rather, they are to be amortized or depreciated with the cost of the security or asset. Sales and real estate taxes paid by a hospital in the provision of Services Related to Patient Care are to be included as Paid Taxes. All sales and real estate taxes for Services Related to Patient Care are to be reported in the General Administrative Services cost center and also reported separately from other classification of expense. Employment related taxes, such as FICA, Unemployment Compensation, and Worker's Compensation, are to be classified as employee fringe benefits for all employees, including hospital based physicians. Monies received by a hospital which chooses to self-insure in lieu of payments of Unemployment Compensation taxes and the associated administrative costs of such a self insurance program are included as financial elements and classified as employee fringe benefits, if such monies are reasonably related to the hospital's unemployment compensation experience.

Amended by R.1990 d.462, effective September 17, 1990.
 See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).
 Stylistic changes.
 Amended by R.1993 d.593, effective November 15, 1993.
 See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.35 Educational, research and training program

(a) Educational program costs are the costs incurred by a hospital in the provision of a formally organized, planned program of study in a health service profession approved by an organization which recognizes the professional stature of health services education programs at the national level, net of any grants, tuition, and/or donations received for this purpose. To the extent that approved residencies for primary care physicians require training in ambulatory care facilities associated with a hospital, such reasonable expenses are included. Costs incurred by a hospital for direct patient care services rendered by medical, nursing, or allied health school personnel through an approved program in the hospital are financial elements provided that such costs would be included as financial elements if directly incurred by the hospital rather than under such arrangements. If not salaried or paid a stipend by the hospital, students are not to be considered as functioning in an employee capacity and thus no dollar amount should be imputed and reported for their services.

(b) Research program costs are those costs incurred by a hospital in systematic, intensive study directed toward a better scientific knowledge of the provision of health care services in a program of the National Institutes of Health or other program approved by the Commission. Specific purpose grants or other funds received to offset the costs of such programs from the Federal government, New Jersey State government, New Jersey Heart Association, or other governmental or charitable organizations sponsoring such programs are applied to offset Costs Related to Patient Care per N.J.A.C. 8:31B-4, Part IV of this manual.

(c) Training program costs are the costs of providing to employees orientation or other health care related training, including inservice and on-the-job training, primarily designed to benefit the hospital by helping employees better perform their assigned tasks. The costs of providing such training are classified as administrative expense. Costs of training and/or educational programs which primarily benefit the employee (e.g. tuition reimbursement programs) rather than the hospital are classified as employee fringe benefits and are to be reported as such in the appropriate cost centers.

8:31B-4.36 (Reserved)

8:31B-4.37 (Reserved)

Repealed by R.1995 d.507, effective September 5, 1995.
 See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).
 Section was "Charity care and reduced charge charity care for indigent patients".

8:31B-4.38 Charity care and reduced charge charity care

(a) Charity care includes only the reasonable cost of the following:

1. Charity care for services, provided the patient is qualified as eligible pursuant to N.J.A.C. 10:52-10;
2. Advanced life support (ALS) services provided pursuant to P.L. 1984, c.146 (N.J.S.A. 26:2K-7 et seq.), provided the patient is qualified as eligible for charity care pursuant to N.J.A.C. 10:52-10;
3. Charity care as defined by following N.J.A.C. 10:52-10 for outpatient dialysis services provided after September 1, 1987 to patients ineligible for Medicare coverage. Reasonable costs shall be limited to the lower of the established Medicaid rate or the prospectively determined composite rate as established by Medicare. The amount reported by the hospital as charity care shall not include Medicare co-insurance amounts, since Medicare will reimburse providers for the amount, provided the patient is eligible for charity care pursuant to N.J.A.C. 10:52-10.

(b) Charity care excludes the cost of the following:

1. Medical denials, which are services that are denied for lack of medical necessity by a utilization review organization (URO) or peer review organization, unless the denial is for days within the trim points;
2. Courtesy adjustments as defined in N.J.A.C. 8:31B-4.15(a)4;
3. Discounts provided to health maintenance organizations or other payers;
4. Patient Convenience Items as defined in N.J.A.C. 8:31B-4.65;
5. Excluded Health Services as defined in N.J.A.C. 8:31B-4.62;
6. Cosmetic surgery except where medically necessary;
7. Cost associated with procuring organs sent to foreign countries; and
8. Non-health services provided by a hospital.

Amended by R.1985 d.550, effective November 4, 1985.
 See: 17 N.J.R. 2004(a), 17 N.J.R. 2637(a).

(a)1 substantially amended.

Amended by R.1988 d.276, effective June 20, 1988.
 See: 19 N.J.R. 2092(c), 20 N.J.R. 1430(a).

Added (a)4.

Amended by R.1989 d.620, effective December 18, 1989.

See: 21 N.J.R. 2449(a), 21 N.J.R. 3953(a).

Provisions for advanced life support, exclusions from uncompensated care and specification regarding Chapter 83 service eligibility added.

Amended by R.1993 d.668, effective December 20, 1993.

See: 25 N.J.R. 3125(a), 25 N.J.R. 6016(a).

Amended by R.1995 d.507, effective September 5, 1995.

See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.39 (Reserved)

Amended by R. 1985 d.550, effective November 4, 1985.

See: 17 N.J.R. 2004(a), 17 N.J.R. 2637(a).

Substantially amended.

Amended by R.1988 d.420, effective September 1, 1988.

See: 20 N.J.R. 595(a), 20 N.J.R. 2276(a).

Substantially amended (a)7 and 8; added (a)9 and 10.

Amended by R.1989 d.620, effective December 18, 1989.

See: 21 N.J.R. 2449(a), 21 N.J.R. 3953(a).

Uncompensated care amounts shall be specified, not estimated.

Repealed by R.1993 d.668, effective December 20, 1993.

See: 25 N.J.R. 3125(a), 25 N.J.R. 6016(a).

Section was "Determination of uncompensated care payments".

8:31B-4.40 Demographic information

(a) Hospitals which are licensed to provide acute care services shall submit information about all inpatients and all outpatients to the Department of Health and Senior Services.

1. These hospitals shall submit quarterly information to the Department of Health and Senior Services for all patients who have balances which were written off to bad debt (in that quarter) and for all patients who were screened for charity care (in that quarter). This information shall be provided on media specified by the Department.

i. Quarterly periods shall be: January 1 through March 31; April 1 through June 30; July 1 through September 30; and October 1 through December 31. The first quarter will be from January 1, 1993 through March 31, 1993.

ii. Information will be reported about each patient described in (a)1 above. This information will include: age; sex; marital status; health insurance coverage; health insurance coverage of the parent, spouse or responsible party (when the patient does not have insurance); hospital code number; county in which the hospital is located; employment status code; total charges; amount written off; reason for patient's failure to pay; DRG code (for inpatients); CPT-4 code (for outpatients); family income amount; family size; family assets amount; patient account number; Zip Code; financial screening status; subsidy approval percent; medical record number; treatment date; and treatment location.

Amended by R. 1985 d.550, effective November 4, 1985.

See: 17 N.J.R. 2004(a), 17 N.J.R. 2637(a).

Substantially amended.

Amended by R.1989 d.620, effective December 18, 1989.

See: 21 N.J.R. 2449(a), 21 N.J.R. 3953(a).

Collection process specified in detail, including denial of service to non-emergency patients for failing or refusing to provide information.

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Collection procedure clarified in (d)5.

Repeal and New Rule, R.1993 d.668, effective December 20, 1993.

See: 25 N.J.R. 3125(a), 25 N.J.R. 6016(a).

Section was "Appropriate collection procedures".

Amended by R.2000 d.339, effective August 21, 2000.

See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

8:31B-4.41 through 8:31B-4.41N (Reserved)

Repealed by R.1995 d.507, effective September 5, 1995.

See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

Sections dealt with treatment of charity care claims.

8:31B-4.42 Capital facilities¹

(a) Buildings and Fixed Equipment:

1. The costs of Capital Facilities used for Services Related to Patient Care as defined in N.J.A.C. 8:31B-4.21, except for Major Moveable Equipment as defined in 8:31B-4.21 and 4.44, are included as financial elements for all hospitals through a Capital Facilities Allowance calculated in accordance with N.J.A.C. 8:31B-3.27(a)1i through vii.

2. The amount of Revenue Related to Patient Care prospectively included for Capital Facilities in a hospital's Preliminary Cost Base and Schedule of Rates is to be funded, in the form of cash and/or investments, in the Internally Generated Plant Replacement and Renovation Fund (Plant Fund). Use of the Plant Fund, including any income (net of income taxes) generated by the fund, is restricted to the payment of Capital Cash Requirements and renovations and down payment on replacement of buildings, building components, and fixed equipment where Certificate of Need approval has been granted.¹ For those hospitals which, as part of a debt service agreement relating to Capital Facilities, are or will be required to establish and fund a Restricted Debt Service Reserve Fund, all the revenue included for Capital Facilities in those hospital's Schedule of Rates must be placed in the Reserve Fund as it is received. Once the Reserve Fund is fully funded, it must remain so for the period of time specified in the debt service agreement. Only after the Reserve Fund has been fully funded can the hospital utilize Capital Facilities revenue for other approved purposes.

3. The hospital's governing board, subject to the Certificate of Need process, may use the Plant Fund for appropriate needs of the hospital's service area including the development of multi-institutional programs, the merging of the hospital with other institutions, the provisions of service in alternate modes or settings, or the reduction or elimination of services in an orderly manner including employee relocation, provision for pension rights, and other costs associated with ceasing operation.

Amended by R.1988 d.24, effective January 4, 1988.

See: 19 N.J.R. 1145(a), 20 N.J.R. 77(b).

Deleted old (a)1 and substituted new.

¹ For Profit Hospitals who may be subject to taxes on interest income generated on the Plant Fund or any portion of the Plant Fund tax officials deem to be taxable income, may properly pay such taxes from the Plant Fund. After completion of final reconciliation (see N.J.A.C. 8:31B-3.71-3.87) and upon receipt by the Department of adequate documentation that such payments have been made, they shall be added to the Capital Facilities Formula Allowance indirect portion of the next year's Schedule of Rates. For Profit Hospitals shall not be required to fund depreciation payments for Capital Facilities.

8:31B-4.43 (Reserved)**8:31B-4.44 Major Moveable Equipment¹**

Major Moveable Equipment, as defined in 8:31B-4.21 includes straightline depreciation costs on owned or capitalized leased Major Moveable Equipment plus a Price Level Depreciation Allowance in excess of this historical depreciation (see 8:31B-3.27(a)2 for the explanation of how this allowance is calculated) and operating lease/rent payments relative to Major Moveable Equipment utilized for Services Related to Patient Care. Leased Major Moveable Equipment is to be capitalized or reported as operating lease costs in accordance with Generally Accepted Accounting Principles.² Major Moveable Equipment Costs so determined are reported as a Natural Classification of Expense (see 8:31B-4, Part III, below) of each cost center. Major Moveable Equipment utilized by more than one functional cost center must be assigned to the using cost centers based on an estimate of each center's utilization. Capitalized repair and installation costs should be included with the cost of the equipment. (See also 8:31B-4.32.) Interest associated with capitalized financing purchases or leases is to be excluded and reported as a reconciliation, per 8:31B-4.66(e), since the Internally Generated Major Moveable Equipment Replacement Fund is established to provide sufficient funds to replace purchased equipment or meet installment payments for financed equipment (both principal and interest).

Amended by R.1982 d.449, eff. December 20, 1982.
See: 14 N.J.R. 946(b), 1457(a).
Footnotes amended.

¹ For-profit hospitals shall be reimbursed for major moveable equipment through straightline depreciation, and interest as reported in accordance with Section I.

² See Financial Accounting Standards Board Statement of Financial Accounting Standards Numbers 13, 17, and 23.

8:31B-4.45 (Reserved)**8:31B-4.46 Reasonable Working Capital**

(a) Working Capital, the difference between current assets and current liabilities, is included as a financial element through:

1. Provision for an initial infusion of working capital for those hospitals lacking a reasonable working capital position as of the date of issuance of their initial Commission approval Schedule of Rates; and
2. An ongoing working capital provision for all hospitals, i.e., working cash increases. (For this purpose, the current portion of long term debt payments is not to be included in current liabilities because this financial element is treated separately.)

(b) In the absence of unusual circumstances, if all patients paid for service when rendered, there would be no net working capital requirements to be derived from Revenues Related to Patient Care. Therefore, Working Capital in-

creases are tied to delays in payments after services are rendered.

(c) Accordingly, achieving equity among payors requires that this financial element be included in payments in relation to the duration of time between the rendering of services and the receipt of payment. The cost to the payor should also have a reasonable relationship to the cost of money, i.e., to interest rates that hospitals could reasonably be expected to pay for working capital loans, where the interest income is taxable to the lender.

(d) Subject to change with significant changes in interest rates (that is, so long as interest rates are between six percent and 20 percent per annum), the cost of working capital required is defined as one percentage of patient services billings per month for the approximate period of time between the final billing services and the payment therefore. To encourage prompt timely payments and to minimize potential late payment "penalties," Hospitals' Schedule of Rates shall include a provision for working capital requirements of five percent of Gross Revenue Related to Patient Care in addition to all other approved financial elements subject to the determination by the Commission of quantifiable economic benefits for prompt payment by payers.

Amended by R.1992 d.62, effective February 3, 1992.
See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
Stylistic changes.

Case Notes

Regulations contemplate participating hospitals would have or be provided with adequate initial working capital; two phases of working capital recognized. In re: Barnet Memorial Hospital Rates, 92 N.J. 31, 455 A.2d 469 (1983).

8:31B-4.47 Return on investment

(a) Because of all of the costs for which non-profit hospitals require a return on investment are provided elsewhere under allowable financial elements (e.g., working capital, replacement costs in excess of historical costs, i.e., Major Moveable Equipment Price Level Allowance and Capital Facilities Formula Allowance) it is not included as a distinct Financial Element.

(b) However, because the Major Moveable Equipment Price Level Allowance is not available to for-profit hospitals and because for-profit hospitals have obligations that non-profit hospitals do not, e.g., income taxes and stockholder returns, for-profit hospitals shall receive, as a distinct Financial Element, a return on investment calculated in the manner described in N.J.A.C. 8:31B-3.29(b).

Amended by R.1985 d.550, effective November 4, 1985.
See: 17 N.J.R. 2004(a), 17 N.J.R. 2637(a).

Case Notes

Hospitals lacking adequate initial working capital received one-time rate adjustment so operations could begin with reasonable working

capital under regulation; reasonable working capital standard. In re: Barnet Memorial Hospital Rates, 92 N.J. 31, 455 A.2d 469 (1983).

Former regulation pertained to working capital increases, cost of working capital and relation of working capital to rate schedule. In re: Barnet Memorial Hospital Rates, 92 N.J. 31, 455 A.2d 469 (1983).

8:31B-4.48 through 8:31B-4.50 (Reserved)

PART III. NATURAL CLASSIFICATIONS OF EXPENSE

8:31B-4.51 Salaries and Wages

Salaries and Wages are remuneration, including stipends, payable in cash, for services performed by an employee for a hospital, except a physician, including compensation for time not worked such as on call, vacation, holiday and sickpay; or the monetary value assigned to direct services provided to the hospital by a person performing in an employee relationship. Salaries and wages are reported per N.J.A.C. 8:31B-4.131. Monetary value is not to be assigned to the services of students or other volunteer workers. All labor costs (including deferred income which qualifies as pension costs) shall be included in the accounting period during which the employee accrues the remuneration for their services.

8:31B-4.52 Physician Compensation—Hospital Component

That portion of compensation for a physician's (M.D., D.O., D.D.S./M.D.) activities, provided through agreement with a hospital, representing services which are not directly related to an identifiable part of the medical care of an individual patient is the hospital component of physician compensation, and must be split between salaries and fees per N.J.A.C. 8:31B-4.131. Hospital services include teaching, research conducted in conjunction with and as part of patient care (to the extent that such costs are not met by special research funds), administration, general supervision of technical personnel, laboratory quality control activities, committee work, performance of autopsies, and attending conferences as part of the physicians' hospital service activities. The allocation of physician compensation between hospital and professional components and documentation thereof is to be in accordance with Medicare HIM-15, Section 2108 for provider component.

Amended by R.1995 d.507, effective September 7, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.53 Physician Compensation—Professional Component

That portion of compensation for a physician's services provided through agreement with a hospital pertaining to activities which are directly related to the medical care of an individual patient is the professional component of physician compensation, (i.e., remuneration for the identifiable medical services by the physician which contribute to the diagnosis of the patient's condition or to his treatment) and must be split between salaries and fees per N.J.A.C. 8:31B-4.131. The allocation of physician compensation between hospital and professional components and documentation thereof is to be in accordance with Medicare HIM-15, Section 2108.

Amended by R.1995 d.507, effective September 7, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.54 Employee Fringe Benefits

Employee Fringe Benefits are amounts paid to or on behalf of, an employee, in addition to direct salary or wages, and from which the employee or his beneficiary derives a personal benefit before or after the employee's retirement or death. Fringe Benefits associated with physicians are to be reported with physician's compensation. Pensions, annuities and deferred income arrangement costs for past and current services are to be accounted for and reported in accordance with Employee Retirement Insurance and Security Act (ERISA) and Internal Revenue Service (IRS) requirements. Employee Fringe Benefits include FICA, State and Federal unemployment insurance, disability insurance, life insurance, employee health insurance, retirement (net of actuarial and realized gains on the investment of related funds), worker's compensation insurance, other payroll related employee benefits, tuition reimbursement and other training, moving expenses of new employees of a non-recurring nature, the cost of providing free or subsidized meals or cost to the employee at less than charges to employees, employee parking lot costs net of any revenue received for operation of facility, and other non-payroll employee benefits. The cost of providing health care services to employees is included in classifications of expense in various cost centers providing the funds. Where a hospital elects to self-insure for worker's compensation or unemployment insurance, costs reported should be the amounts set aside for that accounting period plus associated administrative costs, where a separate fund has been established, to the actual amounts of claims paid during the accounting year if a fund is not established. (See N.J.A.C. 8:31B-4.24.) Where a hospital provides free or subsidized health care services to employees or physicians, the hospital's customary charges should be generated and accounted for separately as personnel health allowances. (See N.J.A.C. 8:31B-4.15.) In order to preserve comparability of hospital expenses for provision of direct patient care, purchased employee health insurance expenses are reported as a separate cost center and not distributed to the labor costs of each center. Employee Fringe Benefits are assigned to the cost center in which the employee's compensation is reported on the following bases per N.J.A.C. 8:31B-4.131.

| Benefit | Basis of Assignment |
|---|---------------------|
| FICA—non-physician physician | Direct Cost |
| All other Payroll Related Benefits including Unemployment Insurance, Disability Insurance, Worker's Compensation and Pension and Retirement | Salaries |
| Life Insurance | Salaries or FTEs |
| Employee Education and Training | FTEs |
| Room and Board | FTEs |
| Cafeteria | FTEs |
| Parking Lot | FTEs |

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Case Notes

Provision for allocation of employee fringe benefits, including pension and dental plans; remand to Commission for proper determination regarding inclusion of plans in care cost reimbursement. *Riverside General Hospital v. New Jersey Hospital Rate Setting Commission*, 98 N.J. 458, 487 A.2d 714 (1985).

8:31B-4.55 Medical and Surgical Supplies

(a) Medical and Surgical Supplies are medically necessary supplies, appliances, and minor moveable equipment (as defined in N.J.A.C. 8:31B-4.20) furnished by and used at a hospital for the care and treatment of a patient during a patient's episode of hospital care, and reported per N.J.A.C. 8:31B-4.131. Medically necessary supplies exclude all supplies furnished by a hospital but used by a patient after his episode of care except those items where it would be medically unreasonable to limit the patient's use of the item to his episode of hospital care. (See N.J.A.C. 8:31B-4.20 for the reporting of minor moveable equipment.) Take home supplies for rental Dialysis and Home Health Care should be included to the extent set forth in Medicare HIM-29 and HIM-11 respectively. The fair market value of donated Medical and Surgical Supplies is assigned to this classification if the commodity would otherwise be purchased by the hospital.

(b) Medical and Surgical Supplies include prosthetic devices, surgical supplies, anesthetic materials, oxygen and other medical gases, intravenous solutions, drugs including medically prescribed food supplements, biologicals, admission kits furnished by the hospital to inpatients not possessing such materials, and other medical care materials. The purchase cost of blood and blood components is excluded.

(c) The invoice/inventory cost and related revenue of all Medical and Surgical Supplies for which a separate charge is made to a patient for the use or consumption of the supply must be reported in the Medical and Surgical Supplies or Drugs Sold to Patients cost and revenue centers.

(d) Medical and Surgical Supplies issued by Central Supply services or Pharmacy for which a separate charge is not made to a patient must be accounted for as an interdepartmental transfer at invoice/inventory cost to the cost center using the supplies and materials. The costs of reusable patient non-charged items used by more than one functional center must remain in or be transferred to the Central Supply Services cost center. (See Part V.) The costs of reusable patient non-charged items used by one functional center should be reported in that center. The cost of other Medical and Surgical Supplies not requisitioned from Central Supply Services and for which a separate charge is not made to a patient must be reported in the functional cost center in which the supplies and/or materials are consumed.

(e) The overhead associated with the issuing of Medical and Surgical Supplies are to be reported in the Central Supply Services or Pharmacy cost centers. Except for reusable supplies (in (d) above) and differences between beginning and end of year inventories, no Medical and Surgical Supplies are to be reported in the Central Supply Services or Pharmacy cost centers.

8:31B-4.56 Non-Medical and Non-Surgical Supplies

Non-Medical and Non-Surgical Supplies include the invoice/inventory cost of supplies, instruments, and minor equipment (other than Medical and Surgical Supplies) required for the operation of a hospital for purposes other than the direct provision of care to a patient and reported in the using cost and revenue center per N.J.A.C. 8:31B-4.131. All rebates and quantity purchase discounts are to be offset against these costs as a reconciliation per N.J.A.C. 8:31B-4.66(c) and 8:31B-4.131.

Amended by R.1995 d.507, effective September 7, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.57 Purchased Services

Purchased Services include the cost of all services purchased that could be accomplished by a hospital's own employees but for which the hospital elects to contract (not necessarily with a formal contract) and reported per N.J.A.C. 8:31B-4.131. All physician services are classified as physician compensation.

8:31B-4.58 Other Direct Expenses

Other Direct Expenses include all other direct non-capital operating expenses not classified elsewhere and reported per N.J.A.C. 8:31B-4.131 for Costs Related to Patient Care. Other Direct Expenses include utilities, non-physician professional fees, licensing fees, dues assessments, travel, postage, printing and duplicating costs, outside training sessions, subscriptions, paid taxes as defined in N.J.A.C. 8:31B-4.34 and insurance other than employee fringe benefit insurance programs.

8:31B-4.59 Major Moveable Equipment

Major Moveable Equipment, as defined in N.J.A.C. 8:31B-4.21 are expenses to be included in the costs of each center at historical depreciation costs (or both owned and capitalized leased equipment) and operating lease expenses. Interest expense incurred through purchase or capitalized leases of Major Moveable Equipment is not included with Major Moveable Equipment costs and is reported per N.J.A.C. 8:31B-4.66(e).

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.60 (Reserved)**PART IV. RECONCILIATION OF COSTS AND REVENUES RELATED TO PATIENT CARE WITH HOSPITAL UNRESTRICTED FUND EXPENSES AND REVENUES****8:31B-4.61 Reports of costs and revenues**

(a) Expenses incurred and revenues generated by a hospital for items not included in the definitions of Services Related to Patient Care (i.e., Routine Services, Ambulatory Services, Ancillary Services, Patient Care General Services, and Institutional Services) are classified as either other operating expenses and revenues (determined per N.J.A.C. 8:31B-4.131) or non-operating revenue and are to be accounted for separately to determine if and how they will be applied to Costs Related to Patient Care and the Capital Facilities Allowance to determine the hospital total financial elements or the Current Cost Base. There are three cases into which income is classified:

1. Case A—Expenses and revenues related to activities which the hospital has selected to engage in but which are not an integral part of, or necessary for, the provision of patient care. Such expenses and revenues are netted against each other.

2. Case B—Expenses and revenues related to activities which the hospital has elected to engage in and which are an integral part of, or necessary for, the provision of patient care. Such expenses and revenues are netted against each other.

3. Case C—Expenses and revenues related to activities which are specifically included under N.J.A.C. 8:31B-4.62 through 4.66. Expenses and revenues are not netted against each other.

(b) Items of other operating expense and revenue are excluded from Services Related to Patient Care reporting centers through reporting in N.J.A.C. 8:31B-4.131. Other operating expenses and revenues so determined, in addition to non-operating revenues, are to be classified in N.J.S.A. 8:31B-4.131, to account for all revenue and expense transactions of the hospital's Unrestricted Fund per the hospital's financial statements. Accounting differences between the hospital's financial statements and the Financial Elements Report are to be reconciled per N.J.A.C. 8:31B-4.131.

(c) Other operating expenses and revenues and non-operating revenues are to be categorized below as:

1. Excluded health care services;
2. Education and research;
3. Sales and services not related to patient care;
4. Patient convenience items;
5. Administrative items; and
6. Other income.

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.62 Excluded Health Care Services

(a) Non-Acute Care Services provided by a hospital such as skilled nursing facilities (approved or unapproved); intermediate care facilities, residential care, long term psychiatric care, long term rehabilitation and intermediate care services are not properly acute hospital functions, and hence are excluded and treated as Case C. Sufficient accounting records should be maintained to account for the costs of such operations (i.e., Medicare cost funding SSA-2552 or SSA-2551) and such costs should be excluded from Costs Related to Patient Care by cost center per N.J.A.C. 8:31B-3.19(c) and 3.24.

(b) Organ Donations: Organs acquired by a hospital and donated to a pool or patient at another hospital are not properly service related to care of patients at the donating hospital, and hence costs and revenues are not included in the service definitions. The acquisition costs incurred should be accounted for in accordance with the definition of the Organ Acquisition cost center (see N.J.A.C. 8:31B-4.97) but not reported therein. However, costs of such donated organs are applied as increases to Costs Related to Patient Care and Revenues are applied as offsets (Case B).

(c) Blood: In order to encourage hospital solicitation of blood donations, the purchase cost of whole blood or the equivalent units of blood extender and/or plasma are excluded and treated as Case C.

(d) Provisions of Health Care Services to Another Health Care Facility or Shared Services: Where a hospital care facility utilizes the laboratory, data processing, physical therapy department, or other services of a hospital, such costs are not included in the Costs Related to Patient Care of the hospital providing the services. The associated costs (including overhead) and revenue should be excluded from the definitions of those centers in the providing hospital and are treated as Case B.

(e) Physician Fees Remunerated to a Hospital: Where a physician's compensation arrangement with a hospital requires some or all of the physician's fees received directly from patients to be turned over to the hospital, such fees are not included in Revenue Related to Patient Care and are treated as Case B.

(f) Excluded Ambulatory Services: Outpatient Renal and Home Dialysis. The cost and revenue related to these services are to be treated as Case C. Sufficient accounting records should be maintained to account for the costs of such operations (that is, Medicare cost report HCFA-2552) and such direct and indirect costs shall be excluded from Costs Related to Patient Care.

(g) Excluded Ambulatory Services: HealthStart Maternal Care Health Support Services. The revenues and expenses associated with the provision of these services shall be treated as Case C, netted against each other.

(h) Excluded Ambulatory Services: HealthStart Pediatric Continuity of Care. In Hospitals with salaried pediatricians, revenues and expenses associated with non-institutional Medicaid capitated fee shall be treated as Case C and netted against each other.

(i) Mobile Intensive Care Unit (MICU) Services provided after November 1, 1987: The cost and revenue related to these services are to be treated as Case C, revenues and expenses are netted. Sufficient accounting records should be maintained to account for the costs of such operations (that is, Medicare cost report HCFA-2552) and such direct and indirect cost shall be excluded from Costs Related to Patient Care.

Amended by R.1981 d.10, effective January 9, 1981.
See: 12 N.J.R. 643(d), 13 N.J.R. 92(a).

(a)1 and 2 added.

Amended by R.1987 d.338, effective August 17, 1987.
See: 19 N.J.R. 840(a), 19 N.J.R. 1545(a).

(f) added.

Amended by R.1988 d.213, effective May 16, 1988.
See: 19 N.J.R. 2365(a), 20 N.J.R. 1082(a).

Added (g) and (h).

Amended by R.1989 d.604, effective December 18, 1989.
See: 21 N.J.R. 2453(a), 21 N.J.R. 3970(a).

MICU services provided after November 1, 1987 excluded at (g).
Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.63 Education and Research

(a) Approved Education and Research Income such as grants, or contract payments, tuitions and fees received as direct support for approved educational and research programs (with the exception of those from the Graduate Medical Education Program for primary care residency programs in Family Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology) (see N.J.A.C. 8:31B-4.35) are used to offset such expenses and treated as Case B. (Transfers of Specific Purpose Fund Revenues to the Unrestricted Fund are to be reported as nonoperating revenue, below.)

(b) Non-Approved Education and Research (not approved in accordance with N.J.A.C. 8:31B-4.35) costs and revenues up to the amount of such costs are excluded. Overhead expenses should be included in the costs of such program (Case A).

(c) Salaried House Physicians hired by the hospital to supplement house coverage of attending physicians or patient units such as residents of non-hospital programs, are included (Case B). Coverage of emergency services and other ambulatory and ancillary services by such physicians are included in the cost center definition of these services.

8:31B-4.64 Sales and services not related to patient care

(a) Provision of General Services to an External Organization: The provision of data processing, laundry, house-keeping, managerial or other general services by a hospital to an organization other than another health care facility are excluded and treated as Case A. Costs of such arrange-

ments should include associated overhead and be reported in accordance with the reporting of related organizations (see N.J.A.C. 8:31B-4.25).

(b) Sale of Medical Supplies (other than for an episode of hospital care) to patients such as take-home drugs, excluding those items where it would be medically unreasonable to limit the patient's use to the episode of hospital care, and others are excluded. Take-home supplies for renal dialysis and home health care are included where included in the provisions of Medical HIM-29 and HIM-11 (Case A).

(c) Sale of Scrap revenue is excluded from the revenue center and treated as Case B.

(d) Medical Records Transcription for patients, their legal advocates, or other non-hospital personnel are excluded. Costs (to be reported to the revenue received unless direct costing is available) and revenue are treated as Case A.

(e) Cafeteria operations, including vending machines, are treated as Case C, except for the subsidization of employee meals and meals for students in approved programs. Cafeteria operating losses are to be apportioned among employees, students and others per N.J.A.C. 8:31B-4.131. Subsidization of employee (including resident) meals is included as an employee fringe benefit. Subsidization of student meals is included as other direct expenses in either EDU or GME cost centers (see N.J.A.C. 8:31B-4, Part V).

(f) Gift and Coffee Shops revenue and expense (including sales tax expense) as well as other activities which may be supported by volunteers are excluded from Services Related to Patient Care (Case C).

(g) Services Rendered to Staff Physicians by a hospital which normally would be incurred in a physician's private practice, such as the provision of medical secretarial services, are excluded and treated as Case C so long as the physician's compensation is not provided through agreement with a hospital.

(h) Parking lot or parking garage expenses and revenues at the site of the hospital are to be netted and the remainder apportioned between employees and others per N.J.A.C. 8:31B-4.131. The provision of parking facilities to:

1. Employees are included-Losses incurred from the operation of an employee parking lot are included as an employee fringe;
2. Staff physicians parking is included and treated as Case B.
3. Others are included (Case B) if the hospital's charge for parking is not substantially inconsistent with other parking facilities in the community where the hospital is located.

(i) Non-Patient Room and Board expenses and revenues are to be netted and apportioned among employees, students and others per N.J.A.C. 8:31B-4.131. Sufficient accounting records should be maintained to identify all related expenses as well as number of persons housed. The provision of Room and Board to:

1. Employees and residents (including rotating residents who spend some portion of their residency at the hospital) is included. Losses incurred from housing an employee are included as an employee fringe benefit (Case B., N.J.A.C. 8:31B-4.61(a)2).

2. Students are included if in an approved educational program. Losses incurred from housing a student should be assigned to Nursing and Allied Health Education (EDU) and Graduate Medical Education (GME) Case B, N.J.A.C. 8:31B-4.61(a)2 or Non-Approved Education and Research (Case A).

3. Others not involved with the patient services of the hospital are excluded (Case A).

Amended by R.1983 d.596, effective December 19, 1983.
See: 15 N.J.R. 1334(a), 15 N.J.R. 2166(a).

(h)3 clarified; cross-reference added to (i)1 and 2.
Amended by R. 1985 d.550, effective November 4, 1985.
See: 17 N.J.R. 2004(a), 17 N.J.R. 2637(a).
Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.65 Patient convenience items

(a) Television and Radio provided to patients are excluded and net gains or losses from such services are treated as Case C.

(b) Telephone and Telegraph services provided to patients, including the appropriate portion of the hospital's switchboard costs, are excluded and net gains or losses from such services are treated as Case C.

(c) Luxury Meals and Items provided to patients or guests are excluded and treated as Case A.

(d) Non-Patient Room Rental Income generated from boarders related to or visitors of a patient, are excluded from Revenue Related to Patient Care and Treated as Case B.

(e) Private-Duty Nursing Services where provided through the hospital at the request of the patient and not prescribed by the attending physician are excluded and treated as Case C.

(f) Private Room Differential Income above a hospital's most common charge for a semi-private room for similar routine services, when specifically requested by the patient is excluded and treated as Case C. Where ordered by the attending physician for medical necessity, income is excluded and treated as Case C. Hospitals should maintain separate revenue classifications for medically necessary and patient convenience private room revenue.

Amended by R.1984 d.500, effective November 5, 1984.
See: 16 N.J.R. 2326(a), 16 N.J.R. 3019(b).

(f) substantially amended.
Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.66 Administrative items

(a) Administrative Expense Exclusions as listed in this section are not included in Costs Related to Patient Care and, as such, are not to be included in expenses defined as General Administrative Services (Case C);

1. Life insurance premiums for employees where the hospital is the direct beneficiary;

2. Stockholders servicing costs such as those incurred to schedule and hold annual meetings;

3. Advertising costs, conducted by hospital personnel or agents of the hospital, which are directed at increasing utilization or medical staff membership, except where attempts to increase medical staff membership is for the procurement of a scarce medical service needed in the service area of the hospital;

4. Costs of membership in organizations not related to the development and operation of the hospital and the rendering of patient care services (e.g., social or fraternal organizations) are not included as an employee fringe benefit in N.J.A.C. 8:31B-4.131;

5. Monies paid by a hospital to the home office, corporate or order headquarters for:

i. Non-patient care related enterprises;

ii. Abandoned home office planning costs for construction of a new facility; or

iii. The imputed value of services performed by non-paid workers in the case of religious orders.

(b) Income and Other Taxes including penalties for late payment of taxes (See N.J.A.C. 8:31B-4.34 for full description) are not includable as Costs Related to Patient Care and as such are not to be included in expenses defined as General Administrative Services, N.J.A.C. 8:31B-4.118 (Case C).

(c) Purchase Discounts, revenue from rebates and quantity discounts, are to be reported as expense recoveries.

(d) Gains on pension reversions are included as Services Related to Patient Care and, as such, shall be treated as Case B and offset against Costs Related to Patient Care.

Amended by R.1982 d.449, effective December 20, 1982.
See: 14 N.J.R. 946(b), 14 N.J.R. 1457(a).

Added hospitals "under the conditional accept or not accept options" to (e).

Amended by R.1983 d.596, effective December 19, 1983.
See: 15 N.J.R. 1334(a), 15 N.J.R. 2166(a).

(c): "applied as offsets against ... (Case B)" changed to "reported as expense recoveries".

Amended by R.1986 d.477, effective December 15, 1986 (operative January 1, 1987).

See: 18 N.J.R. 1911(a), 18 N.J.R. 2447(a).

Amended cross reference in (d) to 4.46.

Amended by R.1991 d.158, effective March 18, 1991.

See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

Exception to exclusion at (e); treatment of pension gains added at (f).

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.67 Non-operating revenues (net of expenses)

(a) Income, net of expenses, or Investment in Rental Property to physicians or others is excluded from Revenue Related to Patient Care and treated as Case A.

(b) Income or Investment, net of transaction expense, of Operating Fund are to be applied as offsets against Costs Related to Patient Care and treated as Case B.

(c) Income or Investments, net of transaction expense, of Board Designated Funds are not to be included in Costs Related to Patient Care and are treated as Case C.

(d) Unrestricted Income from Donor Restricted Plant and Endorsement Funds are not to be included in Revenue Related to Patient Care and treated as Case C.

(e) Transfer from Restricted Funds, other than Specified Purpose Funds (i.e., expenditures from principal and interest on gifts which are donor restricted) are not included as Revenue Related to Patient Care and treated as Case C.

(f) Unrestricted Donations, net of Funding Raising Costs, are not to be included as Revenue Related to Patient Care and treated as Case C.

(g) Transfer of Specific Purpose Funds to the Unrestricted Fund and Specific Purpose Grants and other funds received from the Federal Government, New Jersey State Government, New Jersey Heart Association, or other governmental or charitable organizations are offset against Costs Related to Patient Care (with the exception of those from the Graduate Medical Education Program for primary care residency programs in Family Practice, Internal Medicine, Pediatrics or Obstetric/Gynecology). However, grants on behalf of the medically indigent are to be reported as a contra-deducted from Gross Revenue Related to Patient Care (operating). "Seed Money" . . . received with a grant is similarly offset against operating expenses unless this would result in grants being withheld from New Jersey institutions (Case B).

(h) Primary Care Residency Specific Purpose Grants and income from primary care residency specific purpose funds (i.e., grants for the support of LCGME approved residency program in Family Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology) are not to offset the costs of such programs and treated as Case C.

(i) Interest Income on Trustee-held Funds related to borrowing or loans is a Case B, unless a hospital is prohibited from using the funds to offset current debt service obligations. If the hospital is prohibited from using the funds, the interests and income earned is a Case C until these funds are released for the hospital's benefit.

(j) Interest income from financial charges on delinquent accounts receivable shall not be included in Costs Related to Patient Care. Income shall be treated as a Case C item.

Amended by R.1983 d.596, effective December 19, 1983.

See: 15 N.J.R. 1334(a), 15 N.J.R. 2166(a).

(i) added.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Interest on finance charges deleted from (b); (j) added.

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.68 through 8:31B-4.70 (Reserved)

PART V. DEFINITION OF COST AND REVENUE CENTERS

8:31B-4.71 Reporting of cost and revenues

Costs and Revenues Related to Patient Care are to be reported per the following definitions and N.J.A.C. 8:31B-4, Part I, Units of Service are to be reported per N.J.A.C. 8:31B-4.131.

Case Notes

Regulations designed to establish a prospective rate of reimbursement related to measure of hospital resources consumed for each particular illness and identified as a price per case by Diagnosis Related Group; Diagnosis Related Group definition. *Riverside General Hospital v. New Jersey Hospital Rate Setting Commission*, 98 N.J. 458, 487 A.2d 714 (1985).

Diagnosis Related Group regulatory scheme constitutional and not preempted by federal law; preemption discussion; per diem contracts between hospitals and health maintenance organizations (HMO's) not permitted under regulations. *Health Care Plan of New Jersey, Inc. v. Schweiker*, 553 F.Supp. 440 (D.N.J.1982), affirmed 707 F.2d 1391 (3rd Cr.1983), certiorari denied 104 S.Ct. 71, 464 U.S. 815, 78 L.Ed.2d 84 (1983).

Former N.J.A.C. 8:31B-3.12 established Diagnosis Related Group (DRG) method of cost reimbursement. In re: *Barnet Memorial Hospital Rates*, 92 N.J. 31 455 A.2d 469 (1983).

8:31B-4.72 Medical-Surgical Acute Care Units (MSA)

(a) Function:

1. Medical-Surgical Acute Care Units provide care to patients on the basis of physicians' orders and approved nursing care plans. Medical-Surgical Acute should include the cost and revenue associated with services to all patients treated in beds normally designated as Medical-Surgical, regardless of the clinical specialty of attending physicians or age of the patient. Include the cost and revenue of beds designated as definitive observation or intermediate care (i.e., "step down") beds.

2. All revenue generated from charge differentials between private and semi-private rooms (except those assigned for medical necessity) is to be reported here, and also as a reconciliation per instructions in N.J.A.C. 8:31B-4, Part IV. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55.

3. Functions include serving and feeding of patients; collecting sputum, urine; and feces samples; monitoring of vital life sign; 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 beds; observing patients for reaction to drugs; administering specified medication; infusing I.V. fluids, answering to patients' call signals; and keeping patients' room (personal effects) in order.

(b) Units of Service: Patients (Admissions and Transfers In) and Patient Days.

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.73 Obstetric Acute Care Unit (OBS)

(a) Function:

1. The provision of care to the mother before, during and following delivery on the basis of physicians' orders and approved nursing care plans is provided in the Obstetric Acute Care Unit. Obstetrics may include services to clean gynecological patients treated in beds licensed by the Department of Health and Senior Services as obstetrics.

2. All revenue generated from charge differentials between private and semi-private rooms (except those assigned for medical necessity) is to be reported as a reconciliation per instructions in N.J.A.C. 8:31B-4, Part IV. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55.

3. Functions include instructing of mothers in postnatal care and care of the newborn; 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 assistance of physician 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 of drugs; administering specified medication; infusing I.V. fluids; answering of patients' call signals; and keeping patients' room (personal effects) in order.

(b) Units of Service: Patients (Admissions and Transfers In) Patient Days.

Amended by R.2000 d.339, effective August 21, 2000.
See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

8:31B-4.74 Pediatric Acute Care Units (PED)

(a) Function:

1. Pediatric Acute Care Units provide care to Pediatric patients (normally children less than 14 years and including "boarder patients") in Pediatric nursing units on the basis of physicians' orders and approved nursing care plans. Pediatric Acute Care should include the costs and revenues associated with all patients, regardless of age, treated in units normally reserved for the care of patients less than 14 years of age and does not include costs and revenues of treating patients less than 14 years in Medical-Surgical and Pediatric Acute Units. Cost and revenue associated with swing beds (that is, those not designated exclusively for one type of patient) shall be apportioned among the appropriate Routine Service Centers as defined herein based on actual utilization.

2. Special costs shall be allocated as follows: Costs associated with detained newborns should be included in the Pediatric Acute Care Unit (PED). The allocation of detained newborn costs between the Newborn Nursery and the Pediatric Acute Care Unit (PED) should be accomplished by applying a ratio of newborn charges to detained infant charges or the percentage of detained infants to total newborns. Housekeeping costs in Newborn Nursery (NBN) should be reclassified to Housekeeping (HKP). The method chosen for these allocations must be consistent from year to year.

3. All revenue generated from charge differentials between private and semi-private rooms (except those assigned for medical necessity) is to be reported as a reconciliation per N.J.A.C. 8:31B-4. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55.

4. Functions include 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 assistance to physician 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 I.V. fluids; answering of patients' call signals; and keeping patients' room (personal effects) in order.

(b) Units of service: Patients (Admissions and Transfers In) and Patient Days.

Amended by R.1995 d.507, effective September 7, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.75 Psychiatric Acute Care Units (PSA)

(a) Function:

1. Psychiatric Acute Care Units provide care to patients admitted 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. Psychiatric Acute should include only the costs and revenues associated with services to psychiatric patients in a unit solely designated to the care of the acute mentally ill.

2. All revenues generated from charge differentials between private and semi-private rooms (except those assigned for medical necessity) is to be reported as a reconciliation per instructions in N.J.A.C. 8:31B-4, Part IV. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55. Special Service consumed by patients on Psychiatric Acute Care Units are to be reported in the Psychiatric/Psychological Services Center.

3. Functions include 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; 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 I.V. fluids; answering of patients' call signals; and keeping patients' rooms (personal effects) in order.

(b) Units of Service: Patients (Admissions and Transfers In) and Patient Days.

8:31B-4.76 Burn Care Unit (BCU/ICU)

(a) Function:

1. Burn Care units provide care to severely burned patients that are of a more intensive nature than the usual acute nursing care provided in medical 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. Burn Care Units should include only the costs and revenues associated with services to burn patients in a unit solely designated for this purpose. Burn patients not in a unit solely designated for this purpose, should be reported in Intensive Care.

2. Functions include 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 beds; observing patients for reaction to drugs; administering specified medication; infusing I.V. fluids; answering of patients' call signal; and keeping patients' rooms (personal effects) in order.

(b) Units of Service: Patients (Admissions and Transfers In) and Patient Days.

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.77 Intensive Care Units (ICU/BCU)

(a) Function:

1. Intensive Care Units provide nursing care to patients who, because of surgery, shock, trauma, serious injury or life threatening conditions, require intensified comprehensive observation and care. These units are staffed with specially trained nursing personnel and contain specialized equipment for patient monitoring and life support systems. Intensive Care Units include Stroke Care, Pediatric, Intensive Care, Burn Care Unit (BCU), Medical and Surgical Intensive Care and mixed Intensive Care-Coronary Care Units, but exclude units solely designated 25 Coronary Care Units or Neo-Natal Intensive Care Units. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55.

2. Functions include monitoring patients' progress; operating specialized equipment; assisting physicians during examinations and treatments; dispensing prescribed medication, including I.V. solutions, cleansing and dressing incisions and wounds; maintaining patients' charts; and requisitioning and storing medical supplies and drugs kept in these units.

(b) Units of Service: Patients (Admissions and Transfers In) and Patient Days.

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.78 Coronary Care Units (CCU)

(a) Function:

1. Coronary Care Units provide the delivery of care of a more specialized nature than that provided to the usual Medical, Surgical, and Pediatric patient. The unit contains monitoring and specialized support or treatment equipment for patients who, because of heart seizure, open heart surgery or life threatening conditions, require intensified, comprehensive observation and care and is staffed with specially trained nursing personnel. Coronary patients treated in mixed Intensive/Coronary Care Units should be included in the Intensive Care Units (ICU) center. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55.

2. Functions include 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 beds; observing patients for reaction to drugs; administering specified medication; infusing I.V. fluids; answering of patients' call signal; and keeping patients' rooms (personal effects) in order.

(b) Units of Service: Patients (Admissions and Transfers In) and Patient Days.

8:31B-4.79 Neo-Natal Intensive Care Unit (NNI)

(a) Function:

1. A Neo-Natal Intensive Care Unit provides care to newborn infants that is of a more intensive nature than care provided in Pediatric Acute or Newborn Nursing 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. Neo-Natal Intensive Care Units are designated perinatal centers by the Department of Health and Senior Services, Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55.

2. Functions include feeding infants; collecting sputum, urine and feces samples; monitoring of vital life signs; operating specialized equipment needed for this function; preparing equipment and assisting physicians during infant examination and treatment; changing dressings and cleansing wounds and incisions; bathing infants; observing patients for reactions to drugs and administering specified medication; and infusing I.V. fluids.

(b) Units of Service: Patients (Admissions and Transfers In) and Patient Days.

Amended by R.2000 d.339, effective August 21, 2000.
See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

8:31B-4.80 Newborn Nursery (NBN)

(a) Function:

1. Newborn Nursery provides nursing care to newborns on the basis of pediatricians' orders and approved nursing care plans. Newborn Nursery should include all normal care newborns. Bassinets maintained for infants other than newborn (pediatrics) should be included here. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55.

2. Functions include constant observation of newborns; checking on progress of newborns; feeding and diapering newborns; assisting pediatricians during examination and treatment; operating special equipment; dispensing prescribed medication; and educating new mothers on infant care; maintaining newborns' charts; requisitioning and sorting medical supplies; drugs and infants formulae; and scheduling newborns for ancillary services.

3. Costs associated with units designated by the Department of Health and Senior Services as perinatal centers should be reported in this cost center.

(b) Units of Service: Patient and Patient Days (counted comparably with non-newborn patients).

(c) Special costs shall be allocated as follows: Costs associated with detained newborns should be included in the Pediatric Acute Care Unit (PED). The allocation of detained newborn costs between the Newborn Nursery and the Pediatric Acute Care Unit (PED) should be accomplished by applying a ratio of newborn charges to detained infant charges or the percentage of detained infants to total newborns. Housekeeping costs in NBN should be reclassified to Housekeeping (HKP). The method chosen for these allocations must be consistent from year to year.

Amended by R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).
Amended by R.2000 d.339, effective August 21, 2000.
See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

8:31B-4.81 Emergency Services (EMR)

(a) Function:

1. Emergency Services provide emergency treatment to sick and injured patients requiring medical care on an immediate, unscheduled basis. Also included are non-emergency type patients who request outpatient treatment on an unscheduled basis in the Emergency Room.

2. Functions include assisting critical patients to and from vehicles; expediting treatment for critical patients for ancillary services; coordinating emergency admissions; operation of an ambulance; operation of cast room; assisting physicians in emergency treatment; cleaning and dressing wounds; applying casts; maintaining aseptic conditions; monitoring of vital life signs.

(b) Units of Service: Visits.

8:31B-4.82 Clinics (CLN)

(a) Function:

1. Clinics provide organized non-emergency diagnostic, preventive, curative, rehabilitative and educational services on a primarily scheduled basis to ambulatory patients, including those referred by private physicians.

2. This center should include the costs and revenues associated with operating organized clinics for all purposes. Examples of organized clinics include Alcoholism, Dental, Diagnostic, Diabetes, Drug Abuse, Employee Health, ENT, Health Centers, General Clinic, Guidance Counseling, Obstetrics/Gynecology, Ophthalmology, Pediatrics, Physical Medicine, Psychiatric Day Care and

Speech. The costs and revenues associated with an organized Ambulatory Renal Dialysis Unit should be reported in the Dialysis (DIA) center. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55. The cost and revenue of operating clinics that are a branch of the institution are included in Clinics.

3. Functions include assisting physicians in treatments and examinations; health guidance and counseling; scheduling and arranging for other hospital services for patient; referring ambulatory patients requiring prolonged or specialized care to appropriate services; and participating in community activities designed to promote health education.

(b) Units of Service: Visits.

8:31B-4.83 Off-Site Health Services (OHS)

(a) Function:

Offsite Health Services encompass health care services rendered to patients outside the facility and branches of the facility. This cost center includes the direct costs (supplies, leased equipment, etc.) of all services to patients which are not defined as emergency room, clinic or private ambulatory patients. Services include home health care, community nursing, and offsite psychiatric services. Examples of functions included are travel, operating specialized equipment, nursing care, counseling, educating, rendering treatments and advising patients about the availability of specific health services.

(b) A home health agency provides care to patients normally at their place of residence in accordance with the definition of services contained in Medicare HIM-11. Expenses and revenues of ancillary services performed at homes of patients serviced under a home health program should be reported in the appropriate ancillary service center.

Amended by R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.84 Skilled Nursing Facility (SNF)

(a) For reporting purposes, the definition of a Skilled Nursing Facility contained in the Health Insurance for the Aged Program, Title XVIII of the Social Security Act and N.J.A.C. 8:39 shall be incorporated herein by reference.

New Rule, R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.85 Anesthesiology (ANS)

(a) Function:

1. Anesthesiology is a hospital based service conducted under the direction of either a qualified physician trained in anesthesiology (i.e., an anesthesiologist) or the operating surgeon.

2. Anesthesia gases and other anesthesia supplies and minor moveable equipment if not individually charged to the patient are to be reported in Anesthesiology. The costs of anesthesiologists' compensation and any other costs associated with anesthesiologists' practice (i.e., employees of the physician, supplies the physician purchases through their private practice, etc.), as well as the revenue generated by the anesthesiologist and anyone under the physician's employment, are to be reported to the extent that the anesthesiologists' compensation is provided through agreement with the hospital. Cost associated

with nurse anesthetists employed by the hospital are also to be reported here.

3. Functions include obtaining laboratory findings and patient's anesthetic history prior to administration of anesthetics; administering anesthetics; recording kind and amount of anesthetic administered; observing patient's condition until all effects of anesthesia have passed; accompanying patient to recovery room or intensive care unit; administering treatment to patients having symptoms of post anesthetic complication; prescribing pre-and post-anesthesia medications; and carrying out safeguards for administration of anesthetics.

(b) Units of Services: Anesthesia Minutes.

8:31B-4.86 Cardiac Catheterization (CCA)

(a) Function:

1. Cardiac Catheterization includes all invasive cardiac diagnostic procedures performed in dedicated or non-dedicated cardiac catheterization or coronary angiographic laboratories. Cardiac catheterization procedures are performed in a limited number of hospitals that are designated as cardiac diagnostic facilities or regional cardiac surgical centers. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55.

2. Functions include preparation of patients for testing; explaining test procedures to patients; inspecting, testing and maintaining special equipment; and achieving optimal quality physiological and coronary angiographic studies.

(b) Units of Services: Procedures.

8:31B-4.87 Delivery and Labor Rooms (DEL)

(a) Function:

1. Delivery and Labor Rooms provide nursing care by specially trained personnel to obstetrical patients and patients having gynecological procedures performed in the Delivery Suite. Cesarean sections are to be included if they are performed in a delivery room. Costs of routine housekeeping functions (i.e., those conducted throughout the hospital) performed by delivery and labor personnel are to be included in the Housekeeping center—only specialized clean-up procedures unique to Delivery and Labor Rooms functions are to be included in Delivery and Labor. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55.

2. Functions include maintaining aseptic conditions; enforcing of safety rules and standards; arranging sterile setup for deliveries; monitoring patient and caring for patient's needs while in labor and in recovery; transporting patients within the labor and delivery suite; preparing for delivery; comforting the patient during delivery; assisting the physician during delivery; fetal heart monitoring; amniocentesis (if performed in the delivery suite); circumcision of male newborns; and cleaning up after delivery to the extent of preparation for pickup and disposal of used linen, instruments, utensils and waste.

(b) Units of Services:

1. Deliveries;
2. Gynecological Procedures.

(c) Special costs shall be allocated as follows: House-keeping costs in Delivery and Labor Rooms (DEL) should be reclassified to housekeeping (HKP).

Amended by R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.88 Dialysis (DIA)

(a) Function: Dialysis is a hospital based service employing the use of an artificial kidney machine for cleansing the blood. Dialysis includes both hemodialysis and peritoneal dialysis procedures. The inclusion of Dialysis take-home supplies, if not individually charged, and other costs and revenues is in accordance with Medicare HIM 29 instructions. Dialysis take-home and other supplies individually charged for are to be reported in Medical and Surgical Supplies Sold, whether sold or rented, if such supplies are included per Medicare HIM 29.

(b) Units of Service: Treatments.

8:31B-4.89 Drugs Sold to Patients (DRU)

(a) Function:

1. The Drugs Sold to Patients center is used for the accumulation of the invoice cost and corresponding revenue of all pharmaceuticals and intravenous solutions individually charged to patients including chemotherapy drugs. The invoice/inventory cost of non-charged (pharmaceuticals) or I.V. solutions issued by the Pharmacy to other centers shall be transferred to the using centers, preferably on a monthly basis. If such items are sold in other centers, the cost of those items must be transferred to this center. The overhead cost of preparing and issuing drugs and I.V. solutions sold directly to patients must be accumulated in the Pharmacy center.

2. Medically prescribed food supplements, if charged directly to patients are included in Drugs Sold to Patients. Cost and revenue associated with blood (i.e., whole blood and packed red cells) and blood components (i.e., fibrinogen, gamma globulin) are to be excluded from the Laboratory center and reported as a reconciliation per N.J.A.C. 8:31B-4, Part IV and N.J.A.C. 8:31B-4.91. Excluded from this center are the cost and revenue associated with drugs furnished to a patient for use after his episode of hospital care (except for those items where it would be medically unreasonable to limit the patient's use to the episode of hospital care). Included in the center are the cost and revenue associated with drugs and I.V. solutions sold under renal dialysis and home health agency programs as specified in Medicare HIM 29 and HIM 11.

Amended by R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.90 Electrodiagnosis (EDG)

(a) Function:

1. Electrocardiology is a hospital service that utilizes specialized electrical equipment to record electromotive variations in actions of the heart muscle on an electrocardiograph for diagnosis of heart ailments under the direction of a qualified physician. The cost incurred and revenue generated by personnel or equipment for electrocardiology procedures continuously available as part of the functions of other centers (i.e., Intensive or Coronary Care Units, Operating and Recovery Rooms, Diagnostic Radiology, and Cardiac Catheterization) should be included in those centers.

2. The cost of cardiologists' compensation as well as the revenue generated by cardiologists are to be reported to the extent that the cardiologists' compensation is provided through agreement with the hospital.

3. Functions include wheeling portable equipment to patient's bedside; conducting stress tests; explaining test procedures to patient; operating electrocardiograph equipment; inspecting, testing and maintaining special equipment; and attaching and removing electrodes from patients.

4. This center provides diagnostic neurology services such as electroencephalography and electromyography under the direction of a qualified physician. Specialized equipment is used to record electromotive variations in brain waves and to record electrical potential variation for diagnosis of muscular and nervous disorders.

5. The costs of compensation of physicians involved in diagnostic neurology as well as the revenue generated by these physicians for their activities are to be reported to the extent that their compensation is provided through an agreement with the hospital.

(b) Special Cost Considerations are as follows: Costs of angiograms performed by cardiologists should be reported in Diagnostic Radiology, except that such procedures which are coronary invasive should be reported in Cardiac Catheterization.

Amended by R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.91 Laboratory (LAB)

(a) Function:

8:31B-4.99 (Reserved)

Repealed by R.1995 d.507, effective September 5, 1995.

See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

Section was "Psychiatric/Psychological Services (PSY)".

8:31B-4.100 Radiology, Diagnostic (RAD)**(a) Function:**

1. Diagnostic Radiology is normally a hospital based service conducted under the direction of a qualified radiologist, and includes procedures such as angiograms (except coronary angiograms), arteriograms, computerized axial tomography scans, and echograms (ultrasonography).

2. Cost shared with Therapeutic Radiology and Nuclear Medicine such as radiologists, radiology office expense and maintenance costs should be apportioned among the benefiting cost centers. The salaries of personnel such as bioengineers, assigned substantially full-time for the purpose of maintaining, testing and inspecting Diagnostic Radiology equipment are to be reported here.

3. The cost of compensation of radiologists as well as the revenue they generate are to be reported in this center to the extent that their compensation is provided through agreement with the hospital.

4. Functions include taking, processing, examining and interpretation of radiographs and fluorographs; consultation with patient and attending physicians; storage of radioactive materials; and radioactive waste disposal.

Amended by R.1995 d.507, effective September 5, 1995.

See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.101 Respiratory Therapy (RSP)**(a) Function:**

1. Respiratory Therapy is a hospital based service for diagnosis and treatment of pulmonary diseases. This includes pulmonary function testing, the administration of oxygen and certain potent drugs through inhalation or positive pressure, and other forms of rehabilitative therapy, under the direction of a qualified physician. Pulmonary function testing is the testing and thorough measurement of inhaled and exhaled gases and analysis of blood, and evaluation of the patient's ability to exchange oxygen and other gases.

2. The cost of compensation of pulmonary physicians involved in rendering respiratory diagnostic and therapeutic services as well as the revenue generated by these physicians for such activities, are to be reported to the extent that these physicians' compensation is provided through agreement with the hospital.

3. Included in this center are the costs of and revenue generated from all gases administered to patients, excluding the costs and revenue associated with gases administered as part of the anesthetizing process which are included in the Anesthesiology Center.

4. Functions include transporting therapy equipment to patient's bedside; setting up and operating various types of oxygen and other therapeutic gas and mist inhalation equipment; blood gas testing; observing and instructing patients during therapy; visiting all assigned respiratory cases to insure that physicians' orders are being carried out; inspecting and testing equipment; and enforcing safety rules.

(b) Units of Service: Treatments.

8:31B-4.102 (Reserved)

Repealed by R.1995 d.507, effective September 5, 1995.

See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

Section was "Speech Pathology and Audiology (SPA)".

8:31B-4.103 Therapeutic Radiology (THR)**(a) Function:**

1. Therapeutic Radiology is a hospital based service providing therapy by radium and other radioactive substances, including cobalt therapy and linear accelerator treatment, under the direction of a qualified radiologist.

2. Costs shared with Diagnostic Radiology and Nuclear Medicine, such as radiologists, radiology office expense and maintenance costs including salaries of bioengineering personnel, should be apportioned among the benefiting centers.

3. The cost of compensation of radiologists involved in therapeutic radiology as well as the revenue they generate are to be reported to the extent that their compensation is provided through agreement with the hospital.

4. Functions include consultation with patient and attending physician; operation of specialized equipment; storage of radioactive material; disposal of radioactive waste; and inspecting, testing and maintaining specialized equipment.

(b) Units of Service: Procedures.

8:31B-4.104 Central Sterile Supply (CSS)**(a) Function:**

1. Central Supply Services prepares and issues medical and surgical supplies and equipment, except pharmaceuticals and I.V. solutions, to patients and to other cost centers.

2. The invoice cost of non-charged supplies and equipment issued to other centers shall be transferred to the using centers, preferably on a monthly basis. The invoice cost of charged medical supplies shall be transferred to the Medical and Surgical Supplies Sold center, preferably on a monthly basis.

3. The cost of non-charged reusable medical supplies and equipment requisitioned from CSS by different cen-

ters (e.g., respirators) are to be reported in the Central Supply Service center. Costs associated with non-charged reusable medical supplies and equipment requisitioned from only one center are to be reported in that center.

4. Functions include requisitioning and issuing of appropriate supply items required for patient care; preparing sterile irrigating solutions; collecting, assembling, sterilizing, and redistributing reusable items; and cleaning, assembling, maintaining, and issuing portable apparatuses.

(b) Statistics: Costed Requisitions of All Medical and Surgical Supplies.

Amended by R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.105 Other General Services (OGS)

The Other General Services cost center should include general service activities which may vary between hospitals such as: elevator operation; grounds maintenance; maintenance of personnel (excluding dormitories for students and residents); medical library; medical photography; motor pool; plant security and property taxes.

New Rule, R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.106 Dietary (DTY)

(a) Function:

1. Dietary is responsible for the procurement, storage, processing of food, delivery and collection of trays and nourishment to nursing units or outpatient centers. Costs of delivery of trays to the patient once trays have been prepared or have arrived at the nursing unit should be reported in the appropriate Routine Service center. The cost of preparing meals for cafeterias, residents, students, visitors, or house physicians should be reported as per N.J.A.C. 8:31B-4.62 through 4.66 and N.J.A.C. 8:31B-4.131 for luxury and guest meals per N.J.A.C. 8:31B-4.62 through 4.66 and N.J.A.C. 8:31B-4.131. Cost and Revenue of food supplements where charged to patients should be reported in the Drugs Sold to Patients center.

2. Functions include preparing diet manuals; recommending diets; preparing selective menus for various diet requirements; recording diet history; nutrition counseling; determining patient food preferences as to type and method of preparation; food storage and preparations; transportation of food trays to and from nursing units; stocking formula room; cashiering; dishwashing; and maintaining sanitary standards in all facilities.

(b) Statistics: Meals.

8:31B-4.107 Housekeeping (HKP)

(a) Functions:

1. Housekeeping is responsible for the maintenance of a clean and sanitary environment in the institution. The cost of routine cleansing of all areas, excluding Dietary (DTY) and Boiler Room (RPM) should be included in Housekeeping. The cost of housekeeping to non-acute care areas N.J.A.C. 8:31B-4.62 through 4.66 gift and coffee shops, N.J.A.C. 8:31B-4.62 through 4.66 offices rented or maintained for fund raising, N.J.A.C. 8:31B-4.67 or non-approved education N.J.A.C. 8:31B-4.62 through 4.66, and research programs N.J.A.C. 8:31B-4.64(b), and for the room and board of employees, students, or others N.J.A.C. 8:31B-4.62 through 4.66, as well as the expense and revenue of providing housekeeping to entities outside of the hospital N.J.A.C. 8:31B-4.62 through 4.66 should not be reported here, but should be reported per N.J.A.C. 8:31B-4.131. Specialized clean-up activities associated with direct care of patients in nursing units and outpatient and ancillary centers should be reported in those centers.

2. Functions include maid service; janitorial service; transporting trash to plant staging areas; mopping, stripping and waxing floors; washing of walls, ceilings, partitions and windows (inside and outside); stripping, disinfecting and making beds; and moving furniture and fixtures.

(b) Statistics: Hours of Services.

8:31B-4.108 Laundry and Linen (L & L)

(a) Function: Laundry and Linen is responsible for the requisitioning, laundering, distribution, control and mending of linen, bedding, wearing apparel, and disposable linen substitutes used by the institution. The purchased cost and maintenance of all wearing apparel, as well as all linen, bedding, etc. are included. The cost of providing laundry and linen services to non-acute care units (see N.J.A.C. 8:31B-4.62 through 4.66) and for the room and board of employees, students, and others (N.J.A.C. 8:31B-4.62 through 4.66) should not be included in this center but reported N.J.A.C. 8:31B-4.131.

(b) Statistics: Pounds of Laundry

8:31B-4.109 Medical Records (MRD)

(a) Function:

1. Medical Records is responsible for creating and maintaining a medical record for all patients and for maintaining a tumor registry in accordance with Department of Health and Senior Services requirements. The revenue and cost associated with medical records transcriptions for persons outside of the hospital should be reported as reconciliations per N.J.A.C. 8:31B-4.62 through 4.66.

2. Functions include coding; typing; abstracting; filing; indexing; accessing; preparation of birth and death certificates; processing of court and other types of inquiries; maintenance and reporting of data such as patient days, visits, ancillary services and statistics by patient, disease, physician and operation; and coordinating the flow of statistics with certain hospital stations.

(b) Statistics: Percentage of Time Spent.

Amended by R.2000 d.339, effective August 21, 2000.
See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

8:31B-4.110 Pharmacy (PHM)

(a) Function:

1. 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.

2. The invoice cost of non-charged pharmaceuticals issued to other cost centers shall be transferred to the using cost centers, preferably on a monthly basis. The invoice cost of charged pharmaceuticals and I.V. solutions shall be transferred to the Drugs Sold to Patients center, preferably on a monthly basis.

3. Functions include development and maintenance of formulary(ies) established by the medical staff and consultation and advice to medical staff and nursing staff on drug therapy; adding drugs to I.V. solutions; determining incompatibility of drug combinations; and stocking of floor drugs and dispensing machines.

(b) Statistics: Costed Requisition of All Drugs.

8:31B-4.111 Patient Care Coordination (PCC)

(a) Function:

1. Patient Care Coordination encompasses utilization review, coordination of pre-admission testing, patient representatives, admission reviews, patient care evaluation and social services. Social Services obtains, analyzes, interprets social and economic information to assist in diagnosis, treatment and rehabilitation of patients. These services include counseling of staff and patients in case units and group units; participation in development of community social and health programs and community education. Revenues received by hospitals should not be reported here, but should be reported with the routine or ambulatory revenue centers where social services were provided and billed for.

2. Functions include interviewing of patients and relatives to obtain a social history relevant to medical problems and planning; interpreting problems of social situations as they relate to medical condition and/or hos-

pitalization; arranging for post discharge care of chronically ill; collecting and revising information on community health and welfare resources.

Amended by R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.112 Plant (PLT)

(a) The Plant center is responsible for maintenance and operation of an institution's buildings and equipment in a state of readiness required to perform hospital operations. Repairs and maintenance of physical plant not used for services related to patient care (for example, rental of apartments) should be reported as reconciliations per N.J.A.C. 8:31B-4 and N.J.A.C. 8:31B-4.131. Renovation of capital assets shall be distinguished from Repairs and Maintenance and capitalized with the asset according to the criteria described in N.J.A.C. 8:31B-4.20.

(b) The maintenance and repair of specialized equipment in areas such as Diagnostic Radiology, Therapeutic Radiology, or Laboratory should be reported as costs in those cost centers. Bio-medical engineers should be treated in this manner.

(c) Functions include all maintenance of buildings and plant equipment including painting, maintenance of movable equipment to the extent done by institutional employees, and minor improvements and renovation of building and plant equipment.

New Rule, R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.113 Building and fixed equipment (BLD)

Building and fixed equipment depreciation shall be reported in this cost center. This cost center also includes the costs of leasing and depreciation of building and building equipment; improvements to land, buildings and leaseholds; plant major and minor movable equipment not reported in other cost centers.

New Rule, R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.114 Physicians (PHY)

(a) The Physicians cost center includes services directly or indirectly related to patient care such as: identifiable medical services by the physician which contribute to the diagnosis of the patient's condition or treatment, teaching, research conducted in conjunction with and as part of patient care (to the extent that such costs are not met by special research funds), administration, general supervision of technical personnel, laboratory quality control activities, committee work, performance of autopsies, and attending conferences as a part of the physicians' hospital service activities.

(b) The Physicians cost center includes the cost of hospital staff physicians, including the chief of staff, director of

medical education, department chiefs and attending physicians and the cost of maintaining their offices. The cost of physician coverage in the outpatient cost centers and physicians who administer and/or conduct the functions of other ancillary cost centers described in this chapter should not be included in the physicians cost center.

New Rule, R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.115 Education and Research (EDR)

(a) Function:

1. This center administers, manages, and carries on research projects of the National Institutes of Health or other projects approved by the NIH. Approved research should be reported per N.J.A.C. 8:31B-4.62 through 4.66. Separate accounting should be maintained for each research activity in accordance with relevant contracts, grant agreements, or because of restrictions made on donations. Revenue received for research activities such as specific purpose grants should be recorded as reconciliations per N.J.A.C. 8:31B-4.62 through 4.66. This center includes expenses related to fellowships.

2. Education includes the costs of formal educational programs for nursing and allied health, inservice education programs in the hospital or for extensive periods outside the hospital. Nursing and allied health education provides organized programs, approved by an organization which recognizes the professional status of health services educational programs at the national level, of nursing and medical related clinical education other than for physicians. Hospitals may either operate a school or provide the clinical training activities leading to the issuance of a degree by a college or university.

3. Included here are expenses related to the upkeep of student rooms and dormitories, except for the salaries of housekeeping, plant operations and laundry personnel, which should be charged to their respective cost centers. Related revenues such as tuition, grants and non-approved education costs and revenue should be reported per N.J.A.C. 8:31B-4.62 through 4.66.

4. Functions include 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 or nursing care to selected patients; and administering aptitude and other tests for counseling and selection purposes.

Amended by R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.116 (Reserved)

Repealed by R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

Section was "Nursing and Allied Health Education (EDU)".

8:31B-4.117 Residents (RSD)

(a) Function:

1. The residents cost center includes graduate medical education which provides an organized program of graduate medical clinical education to interns and residents. To be approved, a medical residency training program must be approved by the Liaison Committee on Graduate Medical Education or, in the case of Osteopathic residencies, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association. Residency programs in the field of dentistry in a hospital must have the approval of the Council on Dental Education of the American Dental Association. Included here are expenses related to the office of the Director of Medical Education and the housing and board of residents. Non-approved education costs and revenue should be reported per N.J.A.C. 8:31B-4.62 through 4.66. Expenses associated with fellowships are to be included in the Education and Research (EDR) center.

2. Functions include selecting qualified students, providing education in theory and practice conforming to approved standards; maintaining student personnel records; counseling of students regarding professional, personal and education problems; and assigning and supervising students.

Amended by R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

Case Notes

Hospital Rate Setting Commission erred in refusing to allow hospital to recalculate number of full-time equivalent residents and residents' salaries based on accepted standard. *St. Barnabas Medical Center v. New Jersey Hospital Rate Setting Commission*, 214 N.J.Super. 599, 520 A.2d 805 (App.Div.1987).

8:31B-4.118 Administrative and General (A&G)

(a) Function:

1. Administrative and General services are those services associated with the overall direction and administration of the institution at all levels. Expenses and revenues directly associable with services not related to patient care (for example, data processing services sold to outside organizations, administrative personnel responsible for the operation of skilled nursing facilities, and other exclusions) should be reported as reconciliations per N.J.A.C. 8:31B-4.62 through 4.66. Detailed reporting of certain administrative services should be provided per N.J.A.C. 8:31B-4.131.

2. Administrative and General Services include:

i. Governing Board;

ii. Office of Hospital Administrator Medical Administration;

- iii. Medical Administration;
- iv. Nursing Administration (persons responsible for more than one functional center);
- v. Personnel;
- vi. Public Relations;
- vii. Communications;
- viii. Management Engineering;
- ix. Health Sciences Library;
- x. Auxiliary Groups;
- xi. Travel;
- xii. Purchasing and Stores;
- xiii. Motor Pool;
- xiv. Postage;
- xv. Medical Library;
- xvi. Medical Photography and Illustration;
- xvii. Licenses and Taxes (other than income taxes and payroll taxes);
- xviii. Insurance (other than Malpractice and Employees Fringe Benefits);
- xix. Security;
- xx. Planning;
- xxi. Professional Association Memberships;
- xxii. Legal and Audit Fees;
- xxiii. Duplicating and Printing;

Amended by R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.119 Fiscal (FIS)

Fiscal includes Admitting and Outpatient registration, cashiering (excluding cafeteria), patient billing and receivables (including outpatients), financial administration and controllership, data processing (as it relates to these functions), payroll, accounts payable, general ledger, budgets and reimbursement, fund accounting and internal audit.

Repeal and New Rule, R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).
Section was "Inpatient Administrative Services (IAM)".

8:31B-4.120 (Reserved)

Repealed by R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).
Section was "Outpatient Administrative Services (OAM)".

8:31B-4.121 Malpractice Insurance (MAL)

Function: Malpractice Insurance should include the institution's total premium or self-insurance cost for hospital and

professional liability coverage. No other type of insurance coverage is to be included here.

8:31B-4.122 (Reserved)

Repealed by R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).
Section was "Employee Health Insurance (EHI)".

8:31B-4.123 (Reserved)

Repealed by R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).
Section was "Repairs and Maintenance (RPM)".

8:31B-4.124 Utilities Cost (UTC)

(a) Function:

1. The center should be used to account for all utility costs such as electricity, gas, oil, disposal services and water. A breakdown of the cost and source of these utilities should be provided per N.J.A.C. 8:31B-4.131.

2. Telephones are not considered utilities and thus such costs and revenues are not to be reported in this center. Costs associated with utilities provided to buildings and areas not involved in patient care are to be excluded and reported as reconciliations per instructions in N.J.A.C. 8:31B-4.62 through 4.66 and N.J.A.C. 8:31B-4, Part VI.

8:31B-4.125 Interest (INT)

The interest cost center includes the total cost of interest incurred by the institution. All interest costs related to the acquisition of institutional facilities should be reported as facilities interest. Working capital interest is reported as other expense in this cost center. Interest not applicable to services related to patient care (for example, rental of apartments) should be reported as reconciliations per N.J.A.C. 8:31B-4, Part IV and N.J.A.C. 8:31B-4.131.

New Rule, R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.126 Legal Fringe Benefits (LFB)

The Legal Fringe Benefits cost center should include the cost of all employee benefits required by law such as: FICA-OASDI, FICA-Medicare, worker's compensation, unemployment compensation and disability insurance.

New Rule, R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.127 Pensions (PEN)

The Pensions cost center should include the cost of all pensions and annuity plans for hospital employees.

New Rule, R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.128 Policy Fringe Benefits (PFB)

(a) The Policy and Fringe Benefits cost center should include the cost of all employee benefits granted by institution policy, excluding pension costs, such as: medical insurance, life insurance, other employee related insurance (excluding malpractice), deferred compensation, tuition reimbursement and other employee recognition programs.

(b) Employee Health Insurance includes all premium payments and associated costs with union or group health insurance for employees. Hospitals which self-insure for employees, health insurance should report no insurance costs in this cost center; however, deductions from operating revenue for personnel health programs are to be reported by cost center.

New Rule, R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.129 Reconciling Items (RIT)

The Reconciling Items cost center should include the difference between total institutional costs from the hospitals' certified financial statements and the cost of services related to hospital patient care. The costs of services not related to patient care should also be reported as reconciliations per N.J.A.C. 8:31B-4 and N.J.A.C. 8:31B-4.131.

New Rule, R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-4.130 (Reserved)

8:31B-4.131 Financial elements report

The Commissioner of Health and Senior Services shall approve Financial Elements report forms, also known as Acute Care Hospital Cost Reports, and reporting instructions consistent with the five Parts of the Financial Elements and Reporting Regulations for completion by all New Jersey hospitals. The Commissioner may refine these report forms for research purposes by adding, modifying, or changing cost centers. Hospitals shall submit information on these forms electronically in a format compatible with Department specifications.

Amended by R.1983 d.596, effective December 19, 1983.
See: 15 N.J.R. 1334(a), 15 N.J.R. 2166(a).

(b) deleted.

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Amended by R.2000 d.339, effective August 21, 2000.

See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

Inserted a reference to Acute Care Hospital Cost Reports.

Amended by R.2003 d.459, effective December 1, 2003.

See: 35 N.J.R. 1826(a), 35 N.J.R. 5376(a).

Added the last sentence.

SUBCHAPTER 5. STANDARDS FOR HOSPITAL NOTIFICATION REGARDING OFFSET OF MEDICAID PAYMENTS AND CHARITY CARE SUBSIDY PAYMENTS TO COLLECT HOSPITAL DEBTS DUE TO THE STATE

8:31B-5.1 Hospital notification regarding offset

(a) The Department of Human Services' Division of Medical Assistance and Health Services will, upon receipt of documentation from the Department of Health and Senior Services, apply an offset to a hospital's Medicaid payments to collect delinquent statutory and/or regulatory debts owed by the hospital to the State.

(b) On the 10th day after the due date, the Department of Health and Senior Services shall send each hospital that is delinquent in paying its statutory and/or regulatory debt a notice of intent to initiate an offset to its Medicaid payments.

(c) If the Department of Health and Senior Services receives a payment from a hospital for the delinquent amount after an offset has been initiated, the amount of offset shall be applied to any statutory debts owed by the hospital to the State within the next 30 days.

(d) The Department of Health and Senior Services shall request the Division of Medical Assistance and Health Services to initiate maximum offsets until individual hospital debts are satisfied. Offset payment schedules may be negotiated with individual hospitals based on financial stability.

SUBCHAPTER 6 THROUGH 7. (RESERVED)

APPENDIX I

(RESERVED)

Repealed by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

APPENDIX II

(RESERVED)

Amended by R.1985 d.189, effective April 15, 1985.

See: 17 N.J.R. 153(a), 17 N.J.R. 914(a).

Section substantially amended.

Amended by R. 1985 d.551, effective November 4, 1985.

See: 17 N.J.R. 2000(a), 17 N.J.R. 2633(a).

Labor 1. Proxies completely amended.

Amended by R.1989 d.78, effective February 6, 1989.

See: 20 N.J.R. 2543(a), 21 N.J.R. 297(a).

Changed household linens 40% to Textile home furnishings 40% and household linens 20% to Textile home furnishings 20%.

Amended by R.1989 d.387, effective July 17, 1989.

See: 21 N.J.R. 135(a), 21 N.J.R. 2058(a).

Labor proxy adjustment factor added.

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Clarification of derivation of economic factor.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Text deleted.

APPENDIX III

(RESERVED)

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Text at E.-G. deleted; H recodified.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Was "Preliminary Cost Base Report".

APPENDIX IV**(RESERVED)**

Repealed by R.1993 d.593, effective November 15, 1993.
 See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
 Was "Preliminary Cost Base Gross Revenue Requirements".

APPENDIX V**(RESERVED)**

Amended by R.1992 d.62, effective February 3, 1992.
 See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
 References to 1980 deleted.
 Repealed by R.1993 d.593, effective November 15, 1993.
 See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
 Was "Revenue Budget Worksheet/Submitted Budget Supplied by NJDOH-Completed by Hospital".

APPENDIX VI**(RESERVED)**

Administrative Correction to delete "DRG 383" and "Outpatient Dialysis".
 See: 22 N.J.R. 3229(b).
 Repealed by R.1993 d.593, effective November 15, 1993.
 See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
 Was "Computation of reasonable direct patient care costs".

APPENDIX VII**(RESERVED)**

Amended by R.1992 d.62, effective February 3, 1992.
 See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
 Financial elements changed.
 Repealed by R.1993 d.593, effective November 15, 1993.
 See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
 Was "Preliminary Cost Base Reconciliation to Net Revenue Related to Patient Care".

APPENDIX VIII**(RESERVED)**

Amended by R.1990 d.462, effective September 17, 1990.
 See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).
 Dialysis deleted.
 Amended by R.1992 d.62, effective February 3, 1992.
 See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
 Direct and indirect cost items revised; payer classes introduced.
 Repealed by R.1993 d.593, effective November 15, 1993.
 See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
 Was "Schedule of Rates as Adjusted for Compliance".

APPENDIX IX**(RESERVED)**

Amended by R.1989 d.387, effective July 17, 1989.
 See: 21 N.J.R. 135(a), 21 N.J.R. 2058(c).
 Specification for Rate Years through 1988 added.
 Repealed by R.1990 d.462, effective September 17, 1990.
 See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).
 Appendix IX, Volume Variability Adjustment, deleted.

APPENDIX X**(RESERVED)**

Repealed by R.1990 d.462, effective September 17, 1990.
 See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).
 Appendix X, Nursing Cost Allocation Methodology, deleted.

APPENDIX XI**(RESERVED)**

Amended by R.1989 d.388, effective July 17, 1989.
 See: 21 N.J.R. 1059(a), 21 N.J.R. 2082(a).
 Amended by R.1990 d.266, effective May 21, 1990.
 See: 22 N.J.R. 735(a), 22 N.J.R. 1591(a).
 Medicine—Pediatrics added at I(a)10; Rehabilitation added at 14; DRGs conformed to New York Grouper 7.
 Amended by R.1992 d.62, effective February 3, 1992.
 See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
 GME reimbursement methodology revised.
 Repealed by R.1993 d.593, effective November 15, 1993.
 See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
 Was "Reimbursement Methodology for Graduate Medical Education".