

CHAPTER 31B
HOSPITAL FINANCING

Authority

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

Source and Effective Date

R.1995 d.507, effective August 14, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

Executive Order No. 66(1978) Expiration Date

Chapter 31B, Hospital Financing, expires on August 14, 2000.

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, Hospital Rate Commission, expired on July 19, 1984. 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). Amendments to Subchapter 2 were filed and became effective August 7, 1980 as R.1980 d.361. See: 12 N.J.R. 392(d), 12 N.J.R. 517(b). Note that in order to allow time for implementing the UB-PS system, the original implementation date of September 30, 1980 was changed to January 1, 1981. Subchapter 2 was scheduled to expire November 14, 1984. The Governor granted a waiver of the scheduled expiration date from November 14, 1984 to February 12, 1985. See: 16 N.J.R. 2733(a) (October 15, 1984 New Jersey Register). Subchapter 2 was readopted, filed and became effective on December 17, 1984 as R.1984 d.610 with amendments thereto effective January 7, 1985. See: 16 N.J.R. 2728(a), 16 N.J.R. 2733(a), 17 N.J.R. 80(b). 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 3 was amended by R.1979 d.484, effective December 14, 1979. See: 11 N.J.R. 545(b), 12 N.J.R. 15(b). N.J.A.C. 8:31B-3.48 was completely replaced and recodified as N.J.A.C. 8:31B-5 by R.1980 d.318 effective July 17, 1980. Further amendments were filed as R.1980 d.455, effective October 16, 1980. See: 12 N.J.R. 515(b), 12 N.J.R. 645(a). Subchapter 3 was amended and substantially recodified (including the recodification of N.J.A.C. 8:31B-5 as N.J.A.C. 8:31B-3.78 through 3.82) by R.1981 d.494, effective January 4, 1982. See: 13 N.J.R. 486(b), 14 N.J.R. 45(a). The Executive Order No. 66(1978) expiration date for Subchapter 3 was extended by gubernatorial waiver from October 17, 1984 to October 17, 1985. See: 16 N.J.R. 2733(a). Subchapter 3 was readopted pursuant to Executive Order 66(1978) effective October 15, 1985 with amendments effective November 4, 1985 as R.1985 d.551. See: 17 N.J.R. 2000(a), 17 N.J.R. 2633(a). Subchapter 3 was amended by R.1993 d.593, effective November 15, 1993. See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a). 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). Amendments to Subchapter 4 became effective October 16, 1980 as R.1980 d.453. See: 12 N.J.R. 516(a), 12 N.J.R. 645(a). Further amendments to Subchapter 4 became effective January 9, 1981 as R.1981 d.10. See: 12 N.J.R. 643(d), 13 N.J.R. 92(a). Subchapter 4 was scheduled to expire October 17, 1984. The Governor granted a waiver of the scheduled expiration date from October 17, 1984 to October 17, 1985. See: 16 N.J.R. 2733(a) (October 15, 1984 New Jersey Register). Subchapter 4 was readopted pursuant to Executive Order No. 66(1978) effective October 15, 1985 with amendments effective November 4, 1985 as R.1985 d.550. See: 17 N.J.R. 2004(a), 17 N.J.R. 2637(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 5 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 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). Subchapter 6 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 7, Uncompensated Care Trust Fund, became effective July 20, 1987 as R.1987 d.298. See: 19 N.J.R. 495(a), 19 N.J.R. 1297(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).

Chapter 31B, Hospital Rate Setting, was readopted pursuant to Executive Order No. 66(1978), as R.1990 d.462, effective August 17, 1990. See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a). Notice of Receipt of Petition for Rulemaking. See: 24 N.J.R. 4131(a). Notice of Action on Petition for Rulemaking. See: 24 N.J.R. 4290(a). Chapter 31B, Hospital Financing, was readopted as R.1995 d.507, effective August 14, 1995. See: Source and Effective Date. See section annotations for specific rulemaking activity.

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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.

“Base year” means the year from which historical cost data are utilized.

“Current Cost Base” means the actual costs and revenue of the hospital as identified in the Financial Elements in the base reporting period.

“Equalization Factor” means the factor that is calculated based on defined Labor Market Areas and multiplied by hospital costs to permit comparability between differing regional salary costs.

“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.

“Labor Market Area” means counties and municipalities in the State that are grouped in accordance with similar labor costs.

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

“Preliminary Cost Base” means the estimated revenue a hospital may collect based on an approved schedule of rates which includes DRG rate amounts and indirect costs not included in the all-inclusive rate. Those indirect costs will either be the dollar amount specified or the estimated amount determined by a specific percentage adjustment to the rate.

“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).

“Utilization Review Committee” means a group of physicians in a designated hospital who review the health care provided to patients.

“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.

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).

SUBCHAPTER 2. HOSPITAL REPORTING OF UNIFORM BILL—PATIENT SUMMARIES (INPATIENT)

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.

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

1. Satisfy Department of Health 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).

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 hospital covered under Chapter 83, P.L. 1978.

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).

8:31B-2.3 Billing form

(a) The UB-92 is a multi-part form set printed in red ink. 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).

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 follow:

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 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 appropriate 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, shall not differ from data upon which payment was based.

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).

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

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

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

2. A single data intermediary shall be chosen by each hospital and shall be responsible for all patients regardless of payer 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, the Department of Health shall periodically audit selected records in the hospital with no attempt to tie together patient names and patient identification numbers at the Department of Health.

(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.

i. The edits to be performed shall be agreed upon and confirmed by amendments to the current memorandum of understanding between the Department of Health and the Data Intermediaries and approved by September 30, 1994.

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

3. Information required from the hospital by the Intermediary for edit correction must be provided within five working days of the request unless separate arrangements are made between the hospital and intermediary.

(f) Reports shall be produced as follows:

1. Each data intermediary shall produce, for the Department of Health and each hospital, a set of periodic

reports which will accurately represent the data submitted by each hospital.

2. The reports to be produced will be agreed upon and confirmed by amendment to the current memorandum of understanding between the Department of Health and the data intermediaries.

3. 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 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, beginning September 30, 1994, 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 procedures; and
- iii. Allow for subsequent re-release of the data by the reporter only when the procedures, set by the Department of Health, have been followed.

4. 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, to verify the accuracy and reliability of the data submitted.

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

6. 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(ies).

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

1. Those data elements required to be submitted to the Department of Health by each hospital through their data intermediary are described in detail in the addendum to the UB-92 guidelines.

i. These required data, edited pursuant to (e) above, shall be submitted to the Department of Health in a computer processable format and medium, specified by amendment to the current memorandum of understanding, within 90 days of the end of each calendar quarter.

ii. Each submission is to include the data on all patients discharged during the calendar quarter.

2. Records not received by the Department of Health (including corrections of fatal errors), within the time frames specified, shall be subject to a penalty of \$10.00 per record. For purposes of calculating the penalty, the

total UB-92 records submitted will be compared to the total admissions and/or discharges reported on the Medicare cost report and/or Hospital Cost Forms submitted to the New Jersey Department of Health. A five percent variance will be allowed. The Department shall provide 30 days notice of its intent to close the data base, and no additional cases shall be added after that time.

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

(h) All data collected by the data intermediary pursuant to this regulation are confidential in accordance with Section 1106(a) of the Federal Privacy Act of 1974 as amended by the Congressional Reports Elimination Act of 1982 (p.197-375).

(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).

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.

(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 45 days from the end of each of the first three quarters and audited financial data by May 31 for the year end (December 31) fourth quarter. This data shall consist of:

1. Cumulative (year-to-date) income statements and balance sheets elements in a format to be supplied by the Department. The information shall agree with the hospitals' internally generated unaudited quarterly data and with the audited year end financial statement data. Except as otherwise provided in these rules, the information shall be consistent with Generally Accepted Accounting Principles (GAAP). Elements which shall be reported are as follows:

- i. Net patient service revenue, including subsidy receipts which may include, but are not limited to, funds related to charity care, other uncompensated care, hospital relief fund, and mental health;
- ii. Other operating revenue;
- iii. Total operating revenue;

- iv. Depreciation;
- v. Interest;
- vi. All other operating expenses;
- vii. Total operating expenses;
- viii. Income or loss from operations;
- ix. Non-operating revenue;
- x. Extraordinary gains or losses;
- xi. Net income or loss;
- xii. Cash and equivalents, which shall not include the current portion of assets whose use is limited;
- xiii. Net patient accounts receivable;
- xiv. Total current assets;
- xv. Board designated and Plant Replacement and Equipment funds, excluding bond trustee funds;
- xvi. Total assets;
- xvii. Current portion of long term debt;
- xviii. Total current liabilities;
- xix. Long term debt;
- xx. Fund balances;
- xxi. Principal payments, which are defined as monthly payments made to date on any long term debt, excluding repayment of working capital loans;
- xxii. Total admissions;
- xxiii. Same day medical admissions;
- xxiv. Total patient days;
- xxv. Total same day surgeries;
- xxvi. Total outpatient visits;
- xxvii. Emergency room visits (net of admissions);
- xxviii. Charity care, charges foregone for treating charity patients; and
- xxix. Subsidy receipts, which may include, but are not limited to, funds related to charity care, other uncompensated care, hospital relief fund and mental health.

(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 of \$200.00 per working day past the appropriate submission date.

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).

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 (Reserved)

8:31B-3.5 (Reserved)

8:31B-3.6 (Reserved)

8:31B-3.7 (Reserved)

8:31B-3.8 (Reserved)

8:31B-3.9 (Reserved)

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 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.

8:31B-3.12 through 8:31B-3.14 (Reserved)

8:31B-3.15 (Reserved)

8:31B-3.16 Current Cost Base

(a) A hospital's Current Cost Base is defined as the actual costs and revenue as identified in the Financial Elements in the base reporting period as recognized by the New Jersey Department of Health.

(b) The Current Cost Base is also used as the basis for the health care (hospital) analysis and reporting system.

(c) Hospitals' actual cost reports cannot be substituted or rearranged once the Department has determined that the actual cost submission is suitable for entry into the data base. The Department shall provide 30 days' notice of its intent to close the data base.

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).

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 aggregate Current Cost Base is developed from financial elements reported to New Jersey State Department of Health 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 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 reviews) shall be brought to the attention of the Commissioner by the hospital, the Department of Health, 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).

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 (Reserved)

8:31B-3.19 (Reserved)

8:31B-3.20 (Reserved)

8:31B-3.20A through 8:31B-3.20C (Reserved)

8:31B-3.20D (Reserved)

8:31B-3.21 (Reserved)

8:31B-3.22 (Reserved)

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. For hospitals selected to participate in such programs, there may be reporting requirements, as defined in rules by the Department of Health, 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).

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.

(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).

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. 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 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. 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).

8:31B-3.27 (Reserved)

8:31B-3.28 (Reserved)

8:31B-3.29 (Reserved)

8:31B-3.30 (Reserved)

8:31B-3.31 (Reserved)

8:31B-3.32 (Reserved)

8:31B-3.33 (Reserved)

8:31B-3.34 (Reserved)

8:31B-3.35 (Reserved)

8:31B-3.36 (Reserved)

8:31B-3.37 (Reserved)

8:31B-3.38 (Reserved)

8:31B-3.39 (Reserved)

8:31B-3.40 (Reserved)

8:31B-3.41 (Reserved)

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 (Reserved)

8:31B-3.45 (Reserved)

8:31B-3.46 through 8:31B-3.50 (Reserved)

8:31B-3.51 (Reserved)

8:31B-3.52 (Reserved)

8:31B-3.53 (Reserved)

8:31B-3.54 (Reserved)

8:31B-3.55 (Reserved)

8:31B-3.56 (Reserved)

8:31B-3.57 (Reserved)

8:31B-3.58 (Reserved)

8:31B-3.59 (Reserved)

8:31B-3.60 (Reserved)

8:31B-3.61 through 8:31B-3.62 (Reserved)

8:31B-3.63 (Reserved)

8:31B-3.64 (Reserved)

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 (Reserved)

8:31B-3.72 (Reserved)

8:31B-3.73 (Reserved)

8:31B-3.74 (Reserved)

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 effectiveness 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 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.

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)1vii, 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.

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 the 12 consecutive calendar months utilized for Medicare.

(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 hospital's fiscal year. For example, a hospital beginning operations August 15, 1979 would have an initial reporting period running from August 15, 1979 through December 31, 1979 if it were on a calendar year. Its next reporting period would then be January 1 to December 31.

(c) Each calendar year's Financial Elements Reporting Forms as defined in N.J.A.C. 8:31B-4.131 are due on May 31 of the following year. Each year's Audited Financial Statement is due on May 31 of the following year. 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).

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 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.

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 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).

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 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).

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.

1. These hospitals shall submit quarterly information to the Department of Health 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".

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.

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 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 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.

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, 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.

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 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).

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.

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 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.

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 hospitalization; 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 in-

surance, 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 shall approve Financial Elements Report forms 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.

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).

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

Authority

N.J.S.A. 26:2H-18.62.

Source and Effective Date

R.1998 d.569, effective December 7, 1998.
See: 30 N.J.R. 3179(a), 30 N.J.R. 4221(a).

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. (RESERVED)

SUBCHAPTER 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".