

FINANCIALS AND OPERATIONS | P&L

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DEFINITIONS

Reference these definitions to guide you in pulling Financials and Operations (formerly Cost & Revenue and Practice Operations), P&L or Income Statement report fields.

Gross fee-for-service charges (does not include capitation charges) [4100-4130]

The full value, at the practice's undiscounted rates, of all services provided to fee-for-service, discounted fee-forservice, and noncapitated patients for all payers.

Included:

- Professional services provided by physicians, advanced practice providers, and other physician extenders such as nurses and medical assistants;
- Both the professional and technical components (TC) of laboratory, radiology, medical diagnostic, and surgical procedures;
- Drug charges, including vaccinations, allergy injections, immunizations, and chemotherapy and anti-nausea drugs;
- Charges for supplies consumed during a patient encounter inside the practice's facilities. Charges for supplies sold to patients for consumption outside the practice's facilities are reported as a subset of "Revenue from the sale of medical goods and services";
- Facility fees. Examples of facility fees include fees for the operation of an ambulatory surgery unit or fees for the operation of a medical practice owned by a hospital where split billing for professional and facility services is utilized;
- Charges for fee-for-service services allowed under the terms of capitation contracts;
- Charges for professional services provided on a case-rate reimbursement basis; and
- Charges for purchased services for fee-for-service patients. Purchased services for fee-for-service patients are defined as services that are purchased by the practice from external providers and facilities on behalf of the practice's fee-for-service patients.

For purchased services, note the following:

- The revenue for such services is included in "Total net fee-for-service collections/revenue";
- The cost for such services is included, as appropriate, in "Clinical laboratory," "Radiology and imaging" or "Other ancillary services"; and
- The count of the number of purchased procedures for fee-for-service patients are included in Total Procedures.

Not included:

- Charges for services provided to capitation patients. Such charges are included in "Gross charges for patients covered by capitation contracts";
- Charges for pharmaceuticals, medical supplies and equipment sold to patients primarily for use outside the practice. Examples include prescription drugs, hearing aids, optical goods, orthopedic supplies, etc. The revenue generated by such charges is included in "Revenue from the sale of medical goods and services"; or
- Charges for any other activities that generate the revenue reported in "Revenue from the sale of medical goods and services."

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Adjustments to fee-for-service charges (value of services performed for which payment is not expected) [4200-4240, 4500-4600]

The difference between "Gross fee-for-service charges" and the amount expected to be paid by or back to patients or third- party payers. This represents the value of services performed for which payment is not expected.

Included:

- Medicare/Medicaid charge restrictions (the difference between the practice's full, undiscounted charge and the Medicare limiting charge);
- Third-party payer contractual adjustments (commercial insurance and/or managed care organization);
- Charitable, professional courtesy or employee adjustments;
- The difference between a gross charge and the Federally Qualified Health Center (FQHC) payment. This could be a positive or negative adjustment; and
- Refunds for overpayments, duplicate payments or for amounts which should not have been collected.

Adjusted Fee-for-service Charges"

The difference between "Gross fee-for-service charges" and "Adjustments to fee-for-services charges."

Bad debts due to fee-for-service activity (accounts assigned to collection agencies) [6900-6920]

The difference between "Adjusted fee-for-service charges" and the amount actually collected.

Included:

- Losses on settlements for less than the billed amount;
- Accounts written off as not collectible;
- Accounts assigned to collection agencies; and
- In the case of accrual accounting, the provision for bad debts.

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Gross charges for patients covered by capitation contracts [4170]

Also known as fee-for-service equivalent gross charges. The full value, at a practice's undiscounted rates, of all covered services provided to patients covered by all capitation contracts, regardless of payer.

Included:

Fee-for-service equivalent gross charges for all services covered under the terms of the practice's capitation contracts, such as:

- Professional services provided by physicians, advanced practice providers, and other physician extenders such as nurses and medical assistants;
- Both the professional and technical components (TC) of laboratory, radiology, medical diagnostic, and surgical procedures;
- Drug charges, including vaccinations, allergy injections, immunizations, and chemotherapy and antinausea drugs;
- Charges for supplies consumed during a patient encounter inside the practice's facilities. Charges for supplies sold to patients for consumption outside the practice's facilities are reported as a subset of "Revenue from the sale of medical goods and services"; and
- Facility fees. Examples of facility fees include fees for the operation of an ambulatory surgery unit or fees for the operation of a medical practice owned by a hospital where split billing for professional and facility services is utilized.

Not included:

- Pharmaceuticals, medical supplies, and equipment sold to patients primarily for use outside the practice. Examples include prescription drugs, hearing aids, optical goods, orthopedic supplies, etc. If such goods are not covered under the capitation contract, the revenue from these charges is included in "Revenue from the sale of medical goods and services";
- The value of purchased services from external providers and facilities on behalf of the practice's capitation patients. The cost of these purchased services is included in "Purchased services for capitation patients";
- Charges for fee-for-service activity allowed under the terms of capitation contracts. Such charges are reported as "Gross fee-for-service charges"; or
- Capitation revenue

Total Gross Charges

The sum of "Gross fee-for-service charges" and "Gross charges for capitation contracts."

Total net fee-for-service collections/revenue [4300-4330, 4350-4420]

The total technical and professional net fee-for-service revenue. If the practice used accrual basis accounting, "Total net fee-for-service collections/revenue" equals "Gross fee-for-service charges" minus "Adjustments to fee-for-service charges," minus "Bad debts due to fee-for-service activity."

Gross capitation revenue (per member per month capitation payments, capitation patient copayments) [4700-4770]

Revenue received in a fixed per member payment, usually on a prospective and monthly basis, to pay for all covered goods and services due to capitation patients.

Included:

- Per member per month capitation payments including those received from an HMO, Medicare AAPCC (average annual per capita cost) payments, state capitation payments for Medicaid beneficiaries, and capitation payments from other medical groups;
- Portions of the capitation withholds returned to a practice as part of a risk-sharing arrangement;
- Bonuses and incentive payments paid to a practice for good capitation contract performance;
- Patient copayments or other direct payments made by capitation patients;
- Payments received due to a coordination of benefits and/or reinsurance recovery situation for capitation patients; and
- Payments made by other payers for care provided to capitation patients.

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Not included:

- Payments paid to a practice by an HMO under the terms of a discounted fee-for-service managed care contract. Such payments are included in "Total net fee-for-service collections/revenue."

Purchased services for capitation patients [7810-7828]

Fees paid to healthcare providers and organizations external to the practice for services provided to capitation patients under the terms of capitation contracts.

Included:

- Payments to providers outside the practice for physician professional, advanced practice professional, clinical laboratory, radiology and imaging, hospital inpatient and emergency, ambulance, out of area emergency and pharmacy services; and
- Accrued expenses for "incurred but not reported" (IBNR) claims for purchased services for capitation patients for which invoices have not been received.

Net Capitation Revenue

The difference between "Gross capitation revenue" and "Purchased services for capitation patients."

Incentive-based revenue [4800-4860]

Payments received from insurance companies and government agencies for incentive-based activities such as pay-for-performance, risk-sharing, shared savings, quality and technology.

Included:

- Pay-for-performance payments for reporting quality, efficiency, or patient satisfaction metrics for patients insured under feed-for-service payment contracts;
- Risk pool insurance;
- Shared savings payments (i.e. Accountable Care Organization (ACO)); and
- Incentive payments for adopting Certified EHR Technology and/or meeting quality standards (i.e. MACRA/MIPS).

Other medical revenue [4900-4950, 4970]

Other sources of medical revenue such as grants, research/clinical studies, educational subsidies, donations, honoraria and more.

Included:

- Payments received for the reproduction of patient records;
- Medical directorship revenue received by the practice and not a specific individual for providing medical administration to hospitals, skilled nursing facilities, long-term care facilities, and other healthcare organizations;
- Grant revenue from federal, state, or local government or private foundation grants for research, provision of patient care to the indigent, or case management of the frail and elderly;
- Research and clinical studies revenue from pharmaceutical studies, medical device studies, and other research activities conducted by the practice;
- Educational subsidies received by the practice for graduate medical education and training of medical, nursing, and medical technician students;
- Any endowment or gift received by the organization;
- Revenue for medical-related activities such as honoraria, educational seminars, expert witness testimonies;
- Payment to the practice for physicians working in a hospital emergency room;
- Contract revenue from a school district for physician services in conducting physical examinations or other service;

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Not included:

- Charges for the delivery of services made possible by subsidies or grants were included in "Gross fee-for-service charges" and/or "Gross charges for patients covered by capitation contracts"; or
- Operating and nonoperating subsidies received from a parent organization such as a hospital, health system, PPMC, or MSO. Such items should be included in, "Financial support from parent organization (subsidies)"; or
- Paycheck Protection Program (PPP) loan forgiveness payment. Such items should be included in, "Extraordinary nonmedical revenue."

Revenue from the sale of medical goods and services [4340-4349]

Income from the sale of medical products and revenue paid to the practice for professional services provided by practice physicians and staff members.

Included:

- Revenue from pharmaceuticals, medical supplies and equipment sold to patients primarily for use outside the practice. This amount should be net of write-offs and discounts. Examples include prescription drugs, hearing aids, optical goods, orthopedic supplies, etc.;
- Compensation paid by a hospital, skilled nursing facility, or insurance company to a practice physician for services as a medical director;
- The hourly wages of physicians working in a hospital emergency room;
- Contract revenue from a hospital for physician services in staffing a hospital indigent care clinic or emergency room;
- Contract revenue from a school district for physician services in conducting physical exams for high school athletes;
- Revenue from the preparation of court depositions, expert testimony, postmortem reports, and other special reports; and
- Fees received from patients for the photocopying of patient medical records.

Not included:

- Capitation revenue used to pay for covered goods and services for capitation patients. Such revenue is included in "Gross capitation revenue."

Gross revenue from other medical activities

The sum of "Incentive-based revenue," "Other medical revenue" and "Revenue from sale of medical goods and services"

Cost of sales and/or cost of other medical activities [7900-7919]

Cost of activities that generate revenue included in "Revenue from the sale of medical goods and services," as long as this cost is not also included in "Total operating cost" or "Nonmedical cost."

Included:

- Cost of pharmaceuticals, medical supplies and equipment sold to patients primarily for use outside the practice. Examples include prescription drugs, hearing aids, optical goods, and orthopedic supplies; and
- Any provider consultant cost(s) within this total.

Not included:

- Cost of drugs used in providing services including vaccinations, allergy injections, immunizations, chemotherapy, and anti-nausea drugs. Such cost is included in "Drug supply"; or
- Cost of medical/surgical supplies and instruments used in providing medical/surgical services. Such cost is included in "Medical and surgical supply."

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Net other medical revenue

The difference between “Cost of sales and/or cost of other medical activities” and “Gross revenue from other medical activities.”

Total Medical Revenue

The sum of fee-for-service collections (revenue collected from patients and third-party payers for services provided to fee-for service, discounted fee-for-service, and non-capitated Medicare/Medicaid patients), capitation payments (gross capitation revenue minus purchased services for capitation payments), and other medical activity revenues.

Nonprocedural gross charges -

The total undiscounted charges billed for services that do not involve procedures, such as consultations or evaluations.

Nonmedical revenue (investment and rental revenue) [9100-9140, 9160-9170, 9190]

Included:

- Interest and investment revenue such as interest, dividends, and/or capital gains earned on savings accounts, certificates of deposit, securities, stocks, bonds, and other short-term or long-term investments;
- Gross rental revenue such as rent, or lease income earned from practice-owned property not used in practice operations;
- Capital gains on the sale of practice real estate or equipment, etc.;
- Interest paid by insurance companies for failure to pay claims on time;
- Bounced check charges paid by patients; and
- Gross revenue from business ventures such as a billing service or parking lot. The direct costs of such ventures should be reported as “Nonmedical cost.”

Not included:

- Cash received from loans.

Extraordinary nonmedical revenue [9150, 9700]

Revenue that is unusual in nature and infrequent in occurrence.

Included:

- Legal settlement receipts;
- Environmental disaster recovery funds; and
- Paycheck Protection Program (PPP) loan forgiveness payment.

Not included:

- Revenues included in “Nonmedical revenue”.

Financial support from parent organization (Subsidies) [4960, 9180]

Medical practices may receive financial support from a parent organization such as a hospital, health system, PPMC or MSO.

Included:

- Operating subsidy income provided to the practice from a parent organization such as a hospital, health system, PPMC or MSO; and
- Nonoperating subsidy income received from parent organization such as a hospital, health system, PPMC or MSO. (i.e. Capitalization projects such as a facility construction).

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Not included:

- Payments received by the practice and not a specified individual for providing medical administration to hospitals, skilled nursing facilities, long-term care facilities, and other healthcare organizations. Such items should be included in "Other Medical Revenue".

Goodwill amortization [9250]

The annual amortization or impairment cost of goodwill. When an IDS, hospital, or PPMC purchases a medical practice, the purchase price can be thought of as having two components — the value of the tangible assets and the value of the goodwill. Goodwill is the premium paid in excess of the value of the tangible and identifiable intangible assets. If financial statements are maintained in accordance with the income tax basis of accounting, goodwill may be amortized over a period of time. If financial statements are reported in accordance with generally accepted accounting principles, goodwill is periodically reviewed for impairment. The tangible and identifiable intangible assets are typically depreciated/amortized over a period of time.

Not included:

- Depreciation of tangible or identifiable intangible assets such as the building or equipment. These depreciation costs are reported as a component of "Information technology" cost, "Building depreciation" cost, "Furniture and equipment depreciation" cost, "Clinical laboratory" cost, "Radiology and imaging" cost, and "Other ancillary services" cost.

Nonmedical cost (income Taxes) [9200-9210, 9230-9240, 9260, 9300-9530]

Included:

- Income taxes based on net profit that is paid to federal, state, or local government. For cash basis accounting, income taxes equal the cash payment or refund for the most recent tax year paid or received in the most recent tax year plus, periodic withholding paid for those taxes. For accrual accounting, the income tax equals the total tax liability for the most recent tax year regardless of when the tax was paid, or refunds were received;
- All costs required to maintain the productivity of income producing rental property and parking lots;
- Losses on the sale of real estate or equipment and losses from the sale of marketable securities;
- Other nonmedical cost;
- All direct costs related to business ventures such as rental property, parking lots, or billing services, for which gross revenue is reported as "Nonmedical revenue"; and
- State taxes on medical revenue.

Extraordinary nonmedical cost [9220, 9600, 9800]

Cost that is unusual in nature and infrequent in occurrence.

Included:

- Legal settlement cost; and
- Environmental disaster recovery cost.

Not included:

- Cost included in "Nonmedical cost."

Net nonmedical income or loss

The sum of "Nonmedical revenue," "Extraordinary nonmedical revenue," and "Financial support from parent organization (subsidies)," minus "Goodwill amortization" minus "Nonmedical cost" minus "Extraordinary nonmedical cost."

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Employed Support Staff Costs

Included:

- Salaries, bonuses, incentive payments, honoraria, and profit distributions;
- Voluntary employee salary deductions used as contributions to 401(k), 403(b), or Section 125 plans;
- Compensation for all support staff employed by all of the legal entities working in support of the medical practice represented on this survey;
- The allocated support staff cost where the practice consists of multiple legal entities. For example, an MSO managing two medical practices and employing one billing clerk who devotes an equal amount of time to each practice would add 50 percent of the one billing clerk's compensation to the total cost of "Patient accounting," for each managed practice; and
- Compensation for both full-time and part-time employed support staff.

Not included:

- Advanced practice provider cost, which is reported in the Provider section;
- Any benefits for employed support staff, which should be reported as "Total employed support staff enefit cost,";
- Expense reimbursements; or
- Any benefits or the cost of contracted support staff who do not work for any of the legal entities that comprise the medical practice. These costs should be reported as "Total contracted support staff,".

Full Time Equivalent (FTE)

A measure based upon the number of actual hours worked regardless of whether it's spent in clinical or nonclinical activities.

- A 1.0 FTE staff member works the number of hours the practice considers to be the minimum for a normal workweek, which could be 37.5, 40, 50 hours, or another standard set by the practice.

General administrative staff cost [5110-5111, 5117, 5210-5211, 5217]

Cost of general administrative and practice management staff, supporting secretaries, and administrative assistants.

Included:

- Cost of executive staff such as administrator, assistant administrator, chief financial officer, medical director, site/branch/office managers, human resources, marketing, credentialing, and purchasing department staff.

Not included:

- Cost of directors of departments listed separately. Examples include information technology director, medical records director, laboratory director, and radiology director. Such cost should be reported in "Information technology," "Medical records," "Clinical laboratory," or "Radiology and imaging," as appropriate; or
- Credentialing staff as they pertain to managed care departments, such cost should be reported in "Managed care administrative."

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Position titles included (but not limited to):

- Associate/Assistant Medical Director
- Chief Medical Officer (CMO)
- Medical Director
- Physician Chief Executive Officer (CEO/President)
- Administrator
- Chief Department Administrator (CDA)
- Associate/Assistant Department Administrator
- Contracts/Grants Department Administrator
- Division/Section Administrator
- Assistant Administrator
- Chief Compliance Officer
- Chief Executive Officer (CEO)/ Executive Director
- Chief Financial Officer (CFO)
- Department Financial Officer
- Chief Information Officer (CIO)
- Chief Nursing/Clinical Officer (CNO)
- Chief Operating Officer (COO)
- Chief Legal Counsel
- Chief Strategy Officer
- Human Resources Executive
- Marketing Executive
- MSO Administrator/Executive Director
- Patient Care Executive
- Ambulatory/Clinical Services Director
- Ancillary Services Director
- Branch/Satellite Clinic Director
- Building and Grounds Director
- Business Services Director
- Clinical Research Director
- Compliance Director
- Contracting Director
- Development Director
- Education and Training Director
- Finance Director
- Health Plan Director
- Human Resources Director
- Information Systems Director
- Laboratory Services Director
- Managed Care Director
- Marketing and Sales Director
- Materials Management Director
- Medical Records Director
- Nursing Services Director
- Operations Director
- Pharmacy Services Director
- Physician Recruitment Director
- Physician Relations Director
- Quality Improvement/Quality Assurance Director
- Radiology Services Director
- Reimbursement Director
- Revenue Cycle Director
- Strategy/Business Planning Director
- Branch/Satellite Clinic Manager
- Business Office Manager
- Call Center Manger
- Clinical Department Manager
- Clinical Practice Manager
- Compliance Manager
- Front Office Manager
- Human Resources Manager
- Marketing Manager
- Materials Management Manager
- Office Manager
- Operations Manager
- Training/Education Manager
- Human Resources Specialist
- Marketing/Communications Specialist
- Recruiter
- Business Office Supervisor
- Clinic Supervisor
- Front Office Supervisor
- Administrative Assistant
- Administrative Secretary
- Business Office Assistant Manager
- Business Office Staff
- Data Analyst
- Executive Assistant
- Human Resources Generalist

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Patient accounting cost [5112, 5212]

Cost of patient accounting (billing and collections) staff, such as department supervisor, billing/accounts receivable manager, financial counselor, coding, charge entry, insurance, billing, collections, payment posting, refund, adjustment, and cashiering staff.

Position titles included (but not limited to):

- Billing Manager
- Coding Manager
- Credit/Collections Manager
- Insurance Manager
- Patient Accounting Manager
- Reimbursement/Collections Manager
- Authorization Specialist
- Billing Specialist
- Coding Specialist
- Billing Staff
- Cashier
- Coder
- Collections Staff
- Insurance Clerk
- Patient Accounts Representative

General accounting cost [5113, 5213]

Cost of general accounting office staff, such as department supervisor, controller, financial accounting manager, accounts payable, payroll, bookkeeping, and financial accounting input staff.

Position titles included (but not limited to):

- Benefits Manager
- General Accounting Manager
- Accountant
- Benefits/Payroll Specialist
- Accounting Staff
- Bookkeeper
- Financial Analyst
- Workers Compensation Liaison

Managed care administrative cost [5114, 5214]

Cost of managed care administrative staff, such as supporting secretaries and administrative assistants.

Included:

- HMO/PPO contract administrators, case management staff, actuaries, managed care medical directors and managed care marketing, quality assurance, referral coordinators, utilization review, credentialing staff, patient care coordinators and case managers.

Position titles include (but not limited to):

- Utilization Review Manager
- Credentialing Specialist
- Care Coordinator
- Care/Case Manager
- Managed Care Coordinator
- QA/QI Coordinator
- QA/UR Nurse
- Referral Coordinator

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Information technology cost [5115, 5215]

Cost of information technology staff, such as data processing, computer programming, telecommunications staff, EHR or initiative compliance specialists, department director or manager.

Position titles include (but not limited to):

- IS Manager/Network Administrator
- Information Systems Manager
- IT Implementation Specialist
- IT Programming Staff
- IT Support Technician

Housekeeping, maintenance, security cost [5116, 5216]

Cost of housekeeping, maintenance, and security staff.

Not included:

- Cost of parking attendants if parking generates revenue, which is reported as "Nonmedical revenue" in the Revenue section. The cost of parking attendants should be included as "Nonmedical cost."

Position titles include (but not limited to):

- Building and Grounds Manager
- Housekeeping Supervisor
- Building Engineer/Maintenance
- Housekeeper

Total business operations support staff FTE

The sum of "General administrative FTE," "Patient accounting FTE," "General accounting FTE," "Managed care administrative FTE," "Information technology FTE," and "Housekeeping, maintenance, security FTE.

Total business operations support staff cost

The sum of "General administrative cost," "Patient accounting cost," "General accounting cost," "Managed care administrative cost," "Information technology cost," and "Housekeeping, maintenance, security cost."

Medical receptionist cost [5121, 5221]

Cost of medical receptionist staff, such as switchboard operators, schedulers, and appointment staff.

Not included:

- Cost of medical receptionists who worked exclusively in the departments of clinical laboratory, radiology and imaging, or other ancillary departments. Such cost is included in "Clinical laboratory," "Radiology and imaging," and "Other medical support services."

Position titles included (but not limited to):

- Appointment Secretary
- Front Desk Staff
- Patient Service Coordinator
- Receptionist
- Scheduling Staff (excluding Surgical Scheduler)
- Surgical Scheduler
- Switchboard Operator

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Medical secretaries, transcribers cost [5122, 5222]

Cost of medical secretaries and transcribers.

Not included:

- Cost of medical secretaries and transcribers who worked exclusively in the departments of clinical laboratory, radiology and imaging, or other ancillary departments. Such cost is included in "Clinical laboratory," "Radiology and imaging," and "Other medical support services."

Position titles include (but not limited to):

- Medical Transcription Manager
- Transcription Manager
- Medical Scribe
- Medical Secretary
- Transcriptionist

Medical records cost [5123, 5223]

Cost of medical records staff such as medical records clerks and department director or manager.

Not included:

- Cost of medical records and coding staff who worked exclusively in the departments of clinical laboratory, radiology and imaging or other ancillary departments. Such cost is included in "Clinical laboratory," "Radiology and imaging," and "Other medical support services."

Position titles include (but not limited to):

- Medical Records Manager
- Clinical Documentation Specialist
- Medical Records Staff

Other administrative support cost [5124, 5224]

Cost of other administrative staff such as shipping and receiving, cafeteria, mailroom, and laundry staff.

Position titles included (but not limited to):

- Courier

Total front office support staff FTE

The sum of "Medical receptionists FTE," "Medical secretaries and transcribers FTE," "Medical records FTE," and "Other administrative support FTE."

Total front office support staff cost

The sum of "Medical receptionists cost," "Medical secretaries and transcribers cost," "Medical records cost," and "Other administrative support cost.

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Registered nurses cost [5131, 5231]

Cost of registered nurse staff and registered nurses working as frontline managers or lead nurses including home health nurses.

Not included:

- Cost of advanced practice providers such as nurse practitioners, certified registered nurse anesthetists (CRNAs), or nurse midwives, who are included in "Advanced practice provider" cost; or
- Cost of registered nurses who worked exclusively in the departments of clinical laboratory, radiology and imaging or other ancillary departments. Such cost is included in "Clinical laboratory," "Radiology and imaging," and "Other medical support services."

Position titles included (but not limited to):

- Infusion Nurse
- Nursing Manager
- Nursing Supervisor*
- Registered Nurse
- Triage Nurse

* categorize based on credentials

Licensed practical nurses cost [5132, 5232]

Cost of licensed practical nurses.

Not included:

- Cost of licensed practical nurses who worked exclusively in the departments of clinical laboratory, radiology and imaging, or other ancillary departments. Such cost is included in "Clinical laboratory," "Radiology and imaging," and "Other medical support services."

Position titles include (but not limited to):

- Nursing Supervisor*
- Licensed Practical Nurse

* categorize based on credentials

Medical assistants, nurse's aides cost [5133, 5134, 5233, 5234]

Cost of medical assistants and nurse's aides.

Not included:

- Cost of medical assistants and nurse aides who worked exclusively in the departments of clinical laboratory, radiology and imaging, or other ancillary departments. Such cost is included in "Clinical laboratory," "Radiology and imaging," and "Other medical support services."

Position titles included (but not limited to):

- Nursing Supervisor*
- Certified Nursing Assistant
- Medical Assistant

* categorize based on credentials

Total Clinical Support Staff FTE

The sum of "Registered nurses FTE," "Licensed practical nurses FTE," and "Medical assistants, nurse's aides FTE."

Total Clinical Support Staff Cost

The sum of "Registered nurses cost," "Licensed practical nurses cost," and "Medical assistants, nurse's aides cost."

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Clinical laboratory cost [5142, 5242]

The clinical laboratory and pathology department conducts procedures for clinical laboratory and pathology CPT codes 80047 89398, 36415, and 36416.

Included:

- Cost of support staff such as nurses, phlebotomists, secretaries and technicians; and
- Cost of department director or manager.

Position titles included (but not limited to):

- Laboratory Services Manager
- Lab Section Supervisor
- Histotechnologist
- Laboratory Assistant
- Medical Lab Technician
- Medical Technologist
- Phlebotomist

Radiology and imaging cost [5141, 5241]

Film library staff and the diagnostic radiology and imaging department conduct procedures for diagnostic radiology CPT codes 70010-76499, diagnostic ultrasound CPT codes 76506-76999, and diagnostic nuclear medicine CPT codes 78012-78999, echocardiography CPT codes 93303-93355, noninvasive vascular diagnostic studies CPT codes 93880-93998, and electrocardiography CPT codes 93000-93042.

Included:

- Cost of support staff such as nurses, secretaries, and technicians; and
- Cost of department director or manager.

Not included:

- Support staff cost for radiation oncology CPT codes 77261-77799 or therapeutic nuclear medicine CPT codes 79005-79999. Such cost is included as “Other medical support services.”

Position titles included (but not limited to):

- Radiology Services Manager
- EEG Lab Supervisor
- EKG Lab Supervisor
- CAT Scan Technician
- Echocardiographer/Echo Tech
- EEG Technician
- EKG Technician
- Mammography Technician
- MRI Tech
- Radiology Technologist
- Ultrasound Technician

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Other medical support services cost [5143-5160, 5243-5260]

Cost of support staff in any ancillary services department other than "Clinical laboratory" and "Radiology and imaging".

Included:

- Cost of support staff who provide assistance to patients, such as patient relations staff or lay counselors;
- Cost of support staff such as nurses, secretaries, technicians, physical therapy aides and assistants in ancillary services departments such as physical therapy, optical, ambulatory surgery, radiation oncology, therapeutic nuclear medicine, clinical research, pharmacists, and pharmacy support staff; and
- Cost of the department directors and managers in these ancillary services departments.

Not included:

- Advanced practice providers such as nurse practitioners, physician's assistants and physical therapists. These providers should be reported in "Advanced practice provider" cost

Position titles included (but not limited to):

- Aesthetician
- Athletic Trainer
- Cardiovascular Technologist
- Clinic Research Manager
- Clinical Research Coordinator
- Dental Assistant
- Dental Hygienist
- DME Technician
- Dosimetrist
- Endoscopy Technician
- Health Coach
- Massage Therapist
- Medical Interpreter
- Nuclear Medicine Technologist
- Occupational Therapy Assistant
- Ophthalmic Assistant
- Ophthalmic Technician
- Optical Shop Supervisor
- Optician
- Orthopedic/Cast Technician
- Paramedic
- Pharmacist
- Pharmacy Technician
- Physical Therapist Aide
- Physical Therapy Assistant
- Physicist
- Polysomnographic/Sleep Technician
- PT Education Coordinator
- Radiation Therapist
- Respiratory Therapist
- Social Worker (non-clinical)
- Speech Therapist
- Surgical Technologist
- Sterile Processing Technician
- Therapist/Counselor

Total Ancillary Support Staff FTE

The sum of "Clinical laboratory FTE," "Radiology and imaging FTE," and "Other medical support services FTE."

Total Ancillary Support Staff Cost

The sum of "Clinical laboratory cost," "Radiology and imaging cost," and "Other medical support services cost."

Total Employed Support Staff FTE

The sum of "Total business operations support staff FTE ," "Total front office support staff FTE," "Total clinical support staff FTE," and "Total ancillary support staff FTE."

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Total Employed Support Staff Cost

The sum of "Total business operations support staff cost," "Total front office support staff cost," "Total clinical support staff cost," and "Total ancillary support staff cost."

Total employed support staff benefit cost [5170, 5180, 5300-5460]

The total benefits for all employed support staff.

Included:

- Employer's share of Federal Insurance Contributions Act (FICA), payroll and unemployment insurance taxes;
- Employer's share of health, disability, life, and workers' compensation insurance;
- Employer payments to defined benefit and contribution, 401(k), 403(b), and nonqualified retirement plans;
- Deferred compensation paid or expensed during the year;
- Dues and memberships in professional organizations, state, and local license fees;
- Allowances for education, professional meetings, travel, and automobile; and
- Entertainment, country/athletic club membership, travel for spouse.

Not included:

- Voluntary employee salary deductions used as contributions to 401(k) and 403(b) plans; or
- Expense reimbursements.

Total contracted support staff cost [5500-5570]

Contracted support staff represents all the staff hired on a contract basis, not employed by any of the legal entities that comprise the medical practice. The utilization of contracted support staff occurs when the medical practice (including all the associated legal entities that comprise the medical practice) decides not to hire support staff as employees to conduct the ongoing support staff activities. Instead, the practice contracts to have these full-time and/or ongoing activities conducted by contracted staff.

One example of this type of cost would be purchased services for billing and collections activities. When a practice decides to hire a billing company to conduct billing activities that the practice employees, it is often not possible to track the hours that the billing company devotes to the given practice. Such cost is reported as "Billing and collections purchased services."

Included:

- Temporary staff working for temporary agencies; and
- Traveling nurses.

Not included:

- The cost of support staff employed directly by the practice or any of the legal entities comprising the medical practice. Such related costs are included in the "Employed Support Staff" section; or
- The cost for legal, accounting, management, and/or other consultants for services performed on a one time or sporadic basis. The costs for these types of consultants are reported as "Legal fees," "Consulting fees," and/or "Outside professional fees."

Total Support Staff FTE

The sum of "Total employed support staff FTE" and "Total contracted support staff FTE."

Total Support Staff Cost

The sum of "Total employed support staff cost," "Total employed support staff benefit cost," and "Total contracted support staff cost."

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Information technology cost [6800-6860]

Cost of practice-wide data processing, computer, telephone, and telecommunications services.

Included:

- Cost of local and long-distance telephone, radio paging, and internet service providers;
- Rental and/or depreciation cost of major data processing, computer and telecommunications furniture, equipment, hardware, and software subject to capitalization;
- Hardware and software repair and maintenance contract cost;
- Cost of data processing services purchased from an outside service bureau;
- Cost of data processing supplies and minor software and equipment not subject to capitalization; and
- Cost of IT purchased services including maintenance of EHRs and patient portals.

Not included:

- Cost of specialized information services equipment dedicated for exclusive use in the departments of clinical laboratory, radiology, and imaging, or other ancillary services departments. Such cost is included in "Clinical laboratory," "Radiology and imaging," and "Other ancillary services"; or
- Cost of contract programmers, which is included in "Total contracted support staff".

Drug supply cost [7210-7213]

Cost of drugs purchased for general practice use.

Included:

- Cost of chemotherapy drugs, allergy drugs, and vaccines used in providing medical/surgical services.

Not included:

- Cost of specialized supplies dedicated for exclusive use in the departments of clinical laboratory, radiology and imaging, or other ancillary services departments. Such cost is included in "Clinical laboratory," "Radiology and imaging," and "Other ancillary services"; or
- Cost of pharmaceuticals, medical supplies and equipment sold to patients primarily for use outside the practice and not used in providing medical/surgical services. Examples include prescription drugs, hearing aids, optical goods, and orthopedic supplies. Such cost is included in "Cost of sales and/or cost of other medical activities".

Medical and surgical supply cost [7200, 7220-7224, 7720]

Cost of supplies purchased for general practice use.

Included:

- Cost of medical/surgical supplies and instruments used in providing medical/surgical services; and
- Cost of laundry and linens.

Not included:

- Cost of specialized supplies dedicated for exclusive use in the departments of clinical laboratory, radiology and imaging, or other ancillary services departments. Such cost is included in "Clinical laboratory," "Radiology and imaging," and "Other ancillary services";
- Cost of pharmaceuticals, medical supplies and equipment sold to patients primarily for use outside the practice and not used in providing medical/surgical services. Examples include prescription drugs, hearing aids, optical goods, and orthopedic supplies. Such cost is included in "Cost of sales and/or cost of other medical activities"; or
- The cost of any equipment subject to depreciation. Such cost is reported as a subset in "Information technology," "Furniture and equipment," "Clinical laboratory," "Radiology and imaging," and "Other ancillary services."

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Building and occupancy cost [6100, 6120-6190]

Cost of general operation of buildings and grounds.

Included:

- Rental, operating lease, and leasehold improvements for buildings and grounds;
- Interest paid on loans for real estate used in practice operations;
- Cost of utilities such as water, electric power, space heating fuels, etc.;
- Cost of supplies and materials used in housekeeping and maintenance; and
- Other costs such as building repairs and security systems.

Not included:

- Interest paid on short-term loans, which is included in “Miscellaneous operating cost”;
- Interest paid on loans for real estate not used in practice operations, such as nonmedical office space in practice-owned properties. Such interest is included in “Nonmedical cost”;
- Cost of producing revenue from sources such as parking lots or leased office space from practice owned properties. Such cost is included in “Nonmedical cost”; or
- Depreciation costs.

Building depreciation cost [6110-6113]

Depreciation cost for buildings and grounds.

Not included:

- Interest paid on short-term loans, which is included in “Miscellaneous operating cost”;
- Interest paid on loans for real estate not used in operations such as nonmedical office space in practice-owned properties;
- Rental, operating lease, and leasehold improvements for buildings and grounds;
- Interest paid on loans for real estate used in ASC operations;
- Cost of utilities such as water, electric power, and space heating fuels;
- Cost of supplies and materials used in housekeeping and maintenance; or
- Other costs such as building repairs and security systems.

Furniture and equipment cost [6200, 6220-6230, 7100, 7120, 7130, 7710, 7712-7713]

Cost of furniture and equipment in general use in the practice.

Included:

- Rental cost of furniture and equipment used in reception areas, patient treatment/exam rooms, physician offices, and administrative areas; and
- Other costs related to clinic furniture and equipment, such as maintenance cost.

Not included:

- Cost of specialized furniture and equipment dedicated for exclusive use in the information technology, clinical laboratory, radiology and imaging, or other ancillary services departments. Such cost is reported as a subset in “Information technology,” “Clinical laboratory,” “Radiology and imaging,” and “Other ancillary services”; or
- Depreciation costs.

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Furniture and equipment depreciation cost [6210, 7110, 7711]

Depreciation cost of furniture and equipment in general use in the practice.

Included:

- Depreciation cost of furniture and equipment used in reception areas, patient treatment/exam rooms, physician offices, and administrative areas.

Not included:

- Cost of specialized furniture and equipment dedicated for exclusive use in the information technology, clinical laboratory, radiology and imaging, or other ancillary services departments. Such cost is included in "Information technology," "Clinical laboratory," "Radiology and imaging," and "Other ancillary services"; or
- Other costs related to clinic furniture and equipment such as maintenance cost.

Administrative supplies and services cost [6300-6336, 6346, 6350-6353, 6356, 6358, 6361, 6363-6524, 7230-7240, 7730]

Cost of printing, postage, books, subscriptions, administrative and medical forms, stationery, payroll services, practice regulatory, licensure and accreditation, employee relations dinners, picnics, entertainment, practice uniforms, business vehicle/ transportation, recruiting, job position classified advertising, moving costs and other administrative supplies and services.

Included:

- Purchased medical transcription services; and
- Purchased answering services.

Professional liability insurance premiums cost [6720-6726]

Premiums paid or self-insurance cost for malpractice and professional liability insurance for practice physicians, advanced practice providers, and employees.

Other insurance premiums cost [6700-6718]

Cost of other policies such as cyber insurance, fire, flood, theft, casualty, general liability, officers' and directors' liability, and reinsurance.

Legal fees cost [6342]

Fees for professional legal services performed on a one-time or sporadic basis and are not employees of the organization.

Included:

- Fees related to legal services paid to attorneys who are not employees of the organization.

Consulting fees cost [6345]

Fees for professional consulting services performed on a one-time or sporadic basis.

Included:

- Fees for management, financial, and other outside consulting services.

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Outside professional fees cost [6340-6341, 6343-6344, 7830-7839]

Fees for professional services performed on a one-time or sporadic basis.

Included:

- Fees for accounting services; and
- Fees for actuarial consultants, and other professional fees not listed.

Not included:

- Information services, architectural and public relations consultant fees. Such costs are included in "Information technology," "Building and occupancy," and "Promotion and marketing";
- Cost for contracted support staff, which is reported as "Total contracted support staff,"; or
- Cost for contracted physicians and locum tenens, which is reported as "Total physician" cost.

Promotion and marketing cost [6600]

Cost of promotion, advertising and marketing activities, including patient newsletters, information booklets, flyers, brochures, yellow page listings, and public relations consultants.

Clinical laboratory cost [7400-7440]

Cost of clinical laboratory and pathology procedures defined by CPT codes 80047-89398, 36415, and 36416.

Included:

- Rental and/or depreciation cost of major furniture and equipment subject to capitalization;
- Repair and maintenance contract cost;
- Cost of supplies and minor equipment not subject to capitalization;
- Other costs unique to the clinical laboratory; and
- Cost of purchased laboratory technical services for fee-for-service patients.

Not included:

- Cost of purchased laboratory technical services for capitation patients. Such cost should be reported as "Purchased services for capitation patients."

Radiology and imaging cost [7300-7340]

Cost of diagnostic radiology and imaging procedures defined by diagnostic radiology CPT codes 70010-76499, diagnostic ultrasound CPT codes 76506-76999, diagnostic nuclear medicine CPT codes 78012-78999, echocardiography CPT codes 93303-93355, noninvasive vascular diagnostic studies CPT codes 93880-93998, and electrocardiography CPT codes 93000-93042.

Included:

- Rental and/or depreciation cost of major furniture and equipment subject to capitalization;
- Repair and maintenance contract cost;
- Cost of radiological diagnostics (isotopes);
- Cost of supplies and minor equipment not subject to capitalization. This amount is the net after subtracting the revenue from silver recovery from X-ray film and processing fixer;
- Other costs unique to the radiology and imaging department; and
- Cost of purchased radiology technical services for fee-for-service patients.

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Not included:

- Cost of purchased radiology technical services for capitation patients. Such cost should be reported as "Purchased services for capitation patients"; or
- Cost of procedures for radiation oncology CPT codes 77261-77799 or therapeutic nuclear medicine CPT codes 79005-79999. Such costs are included in "Other ancillary services".

Other ancillary services cost [7500-7640]

Operating costs for all ancillary services departments except clinical laboratory and radiology and imaging.

Included:

- Operating costs for departments such as physical therapy, optical, ambulatory surgery, radiation oncology, therapeutic nuclear medicine, etc.;
- Rental and/or depreciation cost of major furniture and equipment subject to capitalization;
- Repair and maintenance cost;
- Cost of supplies and minor equipment not subject to capitalization;
- Other costs unique to the ancillary services departments; and
- Cost of purchased "other ancillary" technical services for fee-for-service patients.

Not included:

- Cost of purchased "other ancillary" technical services for capitation patients. Such cost should be reported as "Purchased services for capitation patients";
- Cost of physical therapy and orthopedic items, such as crutches and braces, sold to patients. Such cost is included in "Cost of sales and/or cost of other medical activities"; or
- Cost of optical items, such as eyeglasses and contact lenses, sold to patients. Such cost is included in "Cost of sales and/or cost of other medical activities."

Billing and collections purchased services cost [6354-6355, 6357, 6930]

When a medical practice decides to purchase billing and collections services from an outside organization as opposed to hiring and developing its own employed staff to conduct billing and collections activities, the cost for such purchased services is considered "Billing and collections purchased services."

Included:

- Claims clearinghouse cost.

Management fees paid to an MSO or PPMC cost [6360, 6362]

Medical practices may receive management or other services from an MSO, PPMC, hospital or other parent organization in return for a fee. The fee could be a contracted fixed amount, a percentage of collections or any other mutually agreed upon arrangement.

Included:

- Fees paid to an MSO/PPMC, hospital or parent organization for management services including management, administrative, and/or related support services; and
- The cost of support staff employed by the MSO/PPMC, if these costs were not reported separately in the "Employed Support Staff" section.

Not included:

- The cost of support staff employed by the MSO/PPMC, if these costs were reported in the "Employed Support Staff" section.

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Miscellaneous operating cost [7740]

Operating cost not included previously.

Not included:

- Federal or state income taxes, which are included in "Nonmedical cost;" or
- Principal paid on loans.

Cost allocated to medical practice from parent organization

When a medical practice is owned by a hospital, integrated delivery system, or other entity, the parent organization often allocates indirect costs to the medical practice. These indirect costs may have different names depending on the situation. Examples of alternative names are "shared services costs" or "uncontrollable costs." These costs may be arbitrarily assigned to the medical practice may be the result of negotiations between the practice and the parent organization, or the result of some sort of cost accounting system. Often, these indirect costs include a portion of the salaries of the senior management team of the parent organization, a portion of corporate human resources costs, or a portion of corporate marketing costs.

Depending on the type of cost, the cost may be allocated to the medical practice as a function of the ratio of medical practice FTE to total system FTE, the ratio of medical practice square footage to total system square footage, or the ratio of medical practice gross charges to total system gross charges. Depending on the culture of the integrated system, these indirect costs may or may not even show up on the financial statements of the medical practice.

Not included:

- Cash loans made to subsidiaries.

Total General Operating Cost

The sum of "Information technology cost," "Drug supply cost," "Medical and surgical supply cost," "Building and occupancy cost," "Building depreciation cost," "Furniture and equipment cost," 'Furniture and equipment depreciation cost," "Administrative supplies and services cost," "Professional liability insurance premiums cost," "Other insurance premiums cost," "Legal fees cost," "Consulting fees cost," "Outside professional fees cost," "Promotion and marketing cost," "Clinical laboratory cost," "Radiology and imaging cost," "Other ancillary services cost," "Billing and collections purchased services cost," "Management fees paid to MSO or PPMC cost," "Miscellaneous operating cost," and "Cost allocated to medical practice from parent organization."

Total Operating Cost

The sum of "Total support staff cost" and "Total general operating cost."

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Total advanced practice provider compensation cost [8410-8416, 8419, 8510-8516, 8519]

Advanced practice providers are specifically trained and licensed providers who can provide medical care and billable services. Examples of advanced practice providers include audiologist, certified registered nurse anesthetists (CRNAs), clinical nurse specialists (CNSs), clinical social worders (CSWs), dieticians/nutritionists, midwives, nurse practitioners, occupational therapists, optometrist, physical therapists, physician assistants, psychologists and surgeon assistants. The total compensation paid to advanced practice providers who comprise the "Advanced practice provider," cost.

Included:

- Compensation for both employed and contracted advanced practice providers;
- Compensation for full-time and part-time advanced practice providers;
- Provider wages reported as direct compensation in
  - Box 5 on the W2.
  - Box 7 on the 1099.
  - Box 1 plus Box 4 minus Box 12 minus Box 13 from the provider's K-1 form 1065.
  - Box 5 (Medicare wages and tips) from the provider's W-2 plus Box 1 minus Box 11 minus Box 12 from the provider's K-1 form 1120S.
- Bonus and/or incentive payments, research stipends, honoraria, distribution of profits; and
- Voluntary employee salary deductions used as contributions to 401(k), 403(b), or Section 125 plans.

Not included:

- Amounts included in "Advanced practice provider benefit cost,";
- Expense reimbursements;
- Fringe benefits paid by the medical practice (such as retirement plan contributions, life and health insurance, automobile allowances); or
- Any employer contributions to a 401(k), 403(b), or Keogh Plan.

Total advanced practice provider benefit cost [8417-8418, 8420-8480, 8517-8518, 8520-8580]

The total benefits paid to advanced practice providers.

Included:

- Employer's share of FICA, payroll, and unemployment insurance taxes;
- Employer's share of health, disability, life, and workers' compensation insurance;
- Employer payments to defined benefit and contribution, 401(k), 403(b), and nonqualified retirement plans;
- Deferred compensation paid or expensed during the year;
- Dues and memberships in professional organizations, state, and local license fees;
- Allowances for education, professional meetings, travel, automobile; and
- Entertainment, country/athletic club membership, travel for spouse, etc.

Not included:

- Voluntary employee salary deductions used as contributions to 401(k) and 403(b) plans; or
- Expense reimbursements

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Total physician compensation cost [8110-8116, 8119, 8210-8216, 8219, 8310-8316, 8319, 8610-8616, 8619]

The total compensation paid to physicians

Included:

- Compensation for shareholders/partners, associates on salary, employed physicians, contract physicians, locum tenens, residents, and fellows;
- Compensation for full-time and part-time physicians;
- Provider wages reported as direct compensation in
  - Box 5 on the W2.
  - Box 7 on the 1099.
  - Box 1 plus Box 4 minus Box 12 minus Box 13 from the provider's K-1 form 1065.
  - Box 5 (Medicare wages and tips) from the providers W-2 plus Box 1 minus Box 11 minus Box 12 from the provider's K- 1 form 1120S.
- Bonus and/or incentive payments, research stipends, honoraria, distribution of profits;
- Voluntary employee salary deductions used as contributions to 401(k), 403(b),or Section 12 plans; and
- Compensation attributable to activities related to revenue in "Nonmedical revenue.

Not included:

- Full-time physician administrators. Such positions should be included as "General administrative," in the Employed Support Staff section.
- Amounts included in "Total physician benefit cost,";
- Provider consultant cost;
- Expense reimbursements;
- Fringe benefits paid by the medical practice (such as retirement plan contributions, life and health insurance, automobile allowances); or
- Any employer contributions to a 401(k), 403(b), or Keogh Plan.

Total physician benefit cost [8117-8118, 8120-8180, 8217-8218, 8220-8280, 8317-8318, 8320-8380, 8617-8618, 8620-8680]

The total benefits paid to physicians.

Included:

- Employer's share of Federal Insurance Contributions Act (FICA), payroll, and unemployment insurance taxes;
- Employer's share of health, disability, life, and workers' compensation insurance;
- Employer payments to defined benefit and contribution, 401(k), 403(b), and nonqualified retirement plans;
- Deferred compensation paid or expensed during the year;
- Dues and memberships in professional organizations, state, and local license fees;
- Allowances for education, professional meetings, travel, and automobile; and
- Entertainment, country/athletic club membership, and travel for spouse

Not included:

- Voluntary employee salary deductions used as contributions to 401(k) and 403(b) plans; or
- Expense reimbursements

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*Work RVUs

Include:

- RVUs for the "physician work RVUs" only; including any adjustments made as a result of modifier usage;
- Work RVUs for all professional medical and surgical services performed by providers;
- Work RVUs for the professional component of laboratory, radiology, medical diagnostic, and surgical procedures;
- Work RVUs for all procedures performed by the medical practice. For procedures with either no listed CPT code or with an RVU value of zero, RVUs can be estimated by dividing the total gross charges for the unlisted or unvalued procedures by the practice's known average charge per RVU for all procedures that are listed and valued;
- Work RVUs for procedures for both fee-for-service and capitation patients;
- Work RVUs for all payers, not just Medicare;
- Work RVUs for purchased procedures from external providers on behalf of the practice's fee-for-service patients;
- Anesthesia practices should provide the physician work component of the RVU for flat fee procedures only such as lines, blocks, critical care visits, intubations, and post-operative management care;
- All RVUs associated with professional charges, including both medically necessary and cosmetic RVUs; and
- Work RVUs produced from physician-administered chemotherapy drugs (do not include if the chemotherapy drugs were administered by anyone other than the physician).

Do not include:

- RVUs for "malpractice RVUs" "or practice expense RVUs;
- RVUs for other scales, such as McGraw-Hill, California;
- RVUs for purchased procedures from external providers on behalf of the practice's capitation patients;
- RVUs that have been weighted by a conversion factor. Do not weigh the RVUs by a conversion factor;
- RVUs where the Geographic Practice Cost Index (GPCI) equals any value other than one. The GPCI must be set to 1.000 (neutral); or
- RVUs produced by the administration of chemotherapy drugs by someone other than the physician (i.e. nurses, techs, etc.)

*Total RVUs

Include:

- RVUs for the "physician work RVUs," "practice expense," and "malpractice RVUs," including any adjustments made as a result of modifier usage;
- RVUs for all professional medical and surgical services performed by physicians, advanced practice providers, and other physician extenders such as nurses and medical assistants;
- RVUs for the professional component of laboratory, radiology, medical diagnostic, and surgical procedures;
- For procedures with either no listed CPT code or with an RVU value of zero, RVUs can be estimated by dividing the total gross charges for the unlisted or unvalued procedures by the practice's known average charge per RVU for all procedures that are listed and valued;
- RVUs for procedures for both fee-for-service and capitation patients; and
- RVUs for all payers, not just Medicare.

Do not include:

- RVUs for other scales such as McGraw-Hill, California;
- The technical component (TC) associated with any medical diagnostic, laboratory, radiology, or surgical procedure. If your practice cannot break this out, report RVUs and select the appropriate response to the question regarding technical component. If you can report total RVUs without technical component, answer 0% for the technical component question; or
- RVUs where the Geographic Practice Cost Index (GPCI) equals any value other than one. The GPCI must be set to 1.000 (neutral).

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*Total ASA units

ANESTHESIOLOGY SPECIALTIES ONLY

For anesthesiology practices, provide the American Society of Anesthesiologists (ASA) units. The ASA units for a given procedure consist of three components:

- Base unit;
- Time in 15-minute increments; and
- Risk factors.

Please note:

- Adjustments should be made if the provider supervises a CRNA that is not employed by the reporting practice to avoid double reporting of ASA Units under the physician and advanced practice provider.
- Do not duplicate units for split bills. Instead, report units on a per case basis.

Total Physician FTE

The sum of "Primary care physicians FTE," "Nonsurgical specialty physicians FTE," "Surgical specialty physicians FTE."

Total Physician Cost

The sum of "Total physician compensation cost" and "Total physician benefit cost."

Total Provider FTE

The sum of "Total advanced practice provider FTE" and "Total physician FTE."

Total Provider Cost

The sum of "Total advanced practice provider cost" and "Total physician cost."

Total Medical Revenue After Operating Cost

The difference of "Total medical revenue for your practice or university department" minus "Total operating cost."

Net Practice Income or Loss

The total of "Total medical revenue after operating cost" minus "Total provider cost" plus "Net nonmedical income or loss."

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Performance

ACCOUNTS RECEIVABLE

Provide the information regarding the age of your practice's accounts receivable (to the nearest whole dollar). Do not include accounts that have been assigned to collection agencies. If your practice does not have any accounts receivable for a certain range, enter "0."

*CURRENT TO 30 DAYS

Amounts owed to the practice by patients, third-party payers, employer groups, and unions for fee-for-service activities before adjustments for anticipated payment reductions, allowances for adjustments, or bad debts. Amounts assigned to "Accounts receivable" are due to "Gross fee-for-service charges." Assigning a charge into "Accounts receivable" initiates at the time a practice submits an invoice to the payer or patient for payment. For example, if an obstetrics practice establishes an open account for accumulation of charges when a patient is accepted into a prenatal program and the account will not be invoiced until after delivery, then "Accounts receivable" will not reflect these charges until the creation of an invoice. Deletion of charges from "Accounts receivable" is done when the practice receives payment, turns over debt to a collection agency, or writes off the account as bad debt. "Accounts payable to patients and payers" are subtracted from "Accounts receivable" before reporting "Accounts receivable."

This is the net amount owed after patient refunds.

Do not include:

- Capitation payments owed to the practice by HMOs.

*31 TO 60 DAYS – SEE CURRENT TO 30 DAYS.

*61 TO 90 DAYS – SEE CURRENT TO 30 DAYS.

*91 TO 120 DAYS – SEE CURRENT TO 30 DAYS.

*OVER 120 DAYS – SEE CURRENT TO 30 DAYS.

*TOTAL ACCOUNTS RECEIVABLE

Add "Current to 30 days," "31 to 60 days," "61 to 90 days," "91 to 120 days," and "Over 120 days."

DID YOUR PRACTICE RE-AGE ACCOUNTS RECEIVABLE WHEN A BALANCE WAS TRANSFERRED TO A SECONDARY CARRIER OR THE PATIENT'S PRIVATE ACCOUNT?

Answer "Yes" if accounts receivable were re-aged when a second insurance company or the patient was billed after the first insurance company refused to pay the entire billed amount.Percent of patient population that logged in to the patient portal

The percent, in whole numbers, of the practice's patient population that not only enrolled, but also logged in to the patient portal. A patient portal is a secure, online platform where patients can perform administrative tasks associated with their care. Examples of these tasks include scheduling appointments, paying bills, accessing test results, communicating with providers and medical staff, viewing medical records, filling new prescriptions, and requesting prescription refills.

Medicare percent of charges

The sum of all fee-for-service, managed care fee-for-service and capitated charges for all services provided to Medicare patients.

Medicaid percent of charges

The sum of all fee-for-service, managed care fee-for-service and capitated charges for all services provided to Medicaid or similar state healthcare program patients.

Commercial percent of charges

The sum of all fee-for-service, managed care fee-for-service and capitated charges for all services provided patients under a commercial capitated contact.

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Workers' compensation percent of charges

Fee-for-service gross charges, at the practice's undiscounted rates, for all services provided to patients covered by workers' compensation insurance.

Charity care and professional courtesy percent of charges

Fee-for-service gross charges, at the practice's undiscounted rates, for all services provided to charity patients. Charity patients are patients not covered by either commercial insurance or federal, state, or local governmental healthcare programs.

Self-pay percent of charges

Fee-for-service gross charges, at the practice's undiscounted rates, for all services provided to patients who pay the medical practice directly. Note that these patients may or may not have insurance.

Other federal government payers percent of charges

Fee-for-service gross charges, at the practice's undiscounted rates, for all services provided to patients who are covered by other federal government payers other than Medicare.

Total percent of payer mix charges

The percentage of a practice's "Total gross charges" by type of payer. The sum of the percentages for Medicare, Medicaid, Commercial, Workers' compensation, Charity care, Self-pay, and other federal government payers must have added to 100 percent.

Number of medical procedures inside practice

The count of medical procedures performed inside the practice during the reporting period.

Gross charges for medical procedures inside practice

The gross charges for medical procedures performed inside the practice during the reporting period.

Number of medical procedures outside practice

The count of medical procedures performed outside the practice during the reporting period.

Gross charges for medical procedures outside practice

The gross charges for medical procedures performed outside the practice during the reporting period.

Number of surgery and anesthesia procedures inside practice

The count of surgery and anesthesia procedures performed inside the practice during the reporting period.

Gross charges for surgery and anesthesia procedures inside practice

The gross charges for surgery and anesthesia procedures performed inside the practice during the reporting period.

Number of surgery and anesthesia procedures outside practice

The count of surgery and anesthesia procedures performed outside the practice during the reporting period.

Gross charges for surgery and anesthesia procedures outside practice

The gross charges for surgery and anesthesia procedures performed outside the practice during the reporting period.

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Number of clinical laboratory and pathology procedures

The count of laboratory and pathology procedures performed during the reporting period.

Gross charges for clinical laboratory and pathology procedures

The gross charges for clinical laboratory and pathology procedures performed during the reporting period.

Number of diagnostic radiology and imaging procedures

The count of diagnostic radiology and imaging procedures performed during the reporting period.

Gross charges for diagnostic radiology and imaging procedures

The gross charges for diagnostic radiology and imaging procedures performed during the reporting period.

Total number of procedures

The sum of “medical procedures” (inside and outside of practice), “surgery and anesthesia procedures” (inside and outside of practice), “clinical laboratory procedures,” and “diagnositic radiology procedures.”

Gross charges for total procedures

The sum of “medical procedure charges” (inside and outside practice), “surgery and anesthesia procedure charges” (inside and outside practice), “clinical laboratory charges,” and “diagnostic radiology charges.”

Nonprocedural gross charges

The total undiscounted charges billed for services that do not involve procedures, such as consultations or evaluations.

Total gross charges

The sum of “total procedural gross charges” and “nonprocedural gross charges.”

Number of individual patients

The total number of individual patients who received services from the practice during a 12-month reporting period.

Number of patient encounters in the practice

A documented patient-provider interaction (including telehealth) for medical evaluation or treatment. Multiple same-day visits count as one encounter unless they involve different specialties/practices or unrelated conditions, which count separately.

Panel size for past 18 months

The “set of patients cared for by a physician” as the number of individual, unique patients that have been seen by any provider within the practice over the past 18 months.

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Percent of patient population that used the patient portal to do the following:

- Schedule appointments
- Pay bills online
- Access test results
- Communicate with providers and medical staff
- View, download or transmit medical records
- Fill a new prescription
- Refill prescriptions

Expected time (in hours) for staff to respond to patient portal communications

The expected number of hours staff had to respond to patient portal communications. If the amount of time varied by activity, report the average.

Average length of time (in minutes) patients spent on hold after an initial answer

The average length of time in minutes per telephone call that patients spent on hold after the call was initially answered. Average call length in minutes for inbound calls The average duration in minutes per telephone call for inbound calls, calls coming in, measured from when the call is answered and including any hold time, talk time and until the call is completed.

Average speed of answer in seconds for inbound calls

The average amount of time in seconds it takes to answer inbound telephone calls, calls coming in.

Average call abandonment percentage rate for inbound calls

The percentage rate, in whole numbers, of total inbound calls, calls coming in, that were disconnected and/or not answered.

Percent of practice's total appointments that were same-day appointments

The percent, in whole numbers, of the practice's total number of appointment slots per day that are scheduled for same-day patients to accommodate for last-minute appointment requests.

Average wait time (in minutes) the patient was in the:

- Waiting area before being brought to the exam room
- Exam room before seeing the provider

Average throughput or total cycle time for the patient from check-in to check-out

The number of minutes between when a patient arrives at the practice and when they leave the practice including time spent waiting in the waiting area, exam room and checkout time.Average scheduled appointment slot-time (in minutes) for the following:

A designated block of time allotted to providing patient care.

- **New Patient Visits:** An individual who has not previously received care from a provider in the same group practice, within the past three years.
- **Established Patient Visits:** An individual who has previously received care from a provider in the same group practice, within the past three years.
- **Preventive Care Visits:** Typically, a yearly appointment intended to prevent illness and detect health concerns early before symptoms are noticeable.

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Average third next available appointment (in business days) for the following:

The number of business days from the start of each day to the third open appointment. This does not count days when the office is closed for business, however, days where the provider is unavailable due to vacation, administrative time, sick leave, etc. should be included in the count. Appointment slots reserved for same-day appointments, should not be included the count for third next available appointment.

- **New Patient Visits:** An individual who has not previously received care from a provider in the same group practice, within the past three years.
- **Established Patient Visits:** An individual who has previously received care from a provider in the same group practice, within the past three years.
- **Preventive Care Visits:** Typically, a yearly appointment intended to prevent illness and detect health concerns early before symptoms are noticeable.

Average number of appointment slots in a schedule per day per provider for the following:

A designated block of time allotted to providing patient care.

- **New Patient Visits:** An individual who has not previously received care from a provider in the same group practice, within the past three years.
- **Established Patient Visits:** An individual who has previously received care from a provider in the same group practice, within the past three years.
- **Preventive Care Visits:** Typically, a yearly appointment intended to prevent illness and detect health concerns early before symptoms are noticeable.
- **Same-day Appointments:** The total number of appointment slots per day that are scheduled for same-day patients to accommodate last-minute appointment requests.
- **Unfilled Appointments:** Total appointment slots that were not filled by a scheduled patient visit or purposely unscheduled per day.

Practice's no-show rate percentage

The percentage rate, in whole numbers, measuring appointments that were scheduled but patients did not show up for or reschedule their scheduled time, as a percent of total appointments.

How much did you charge for no-show appointments?

The amount charged when a patient does not show for a scheduled appointment.

How many minutes late until a patient was considered a no-show?

The number of minutes that a patient has after their scheduled appointment starts until a patient is marked as having not shown. Practice's appointment cancellation rate percentage

The percentage rate, in whole numbers, measuring appointments that were scheduled but patients or the provider/practice called to cancel their scheduled appointment, as a percent of total appointments.

Percentage of appointments that were rescheduled within 30 days of cancellation

The percentage, in whole numbers, of appointments that were rescheduled within 30 days after cancellation by either the patient or by the provider/practice.

Percent of copayments that were collected at time of service

The amount owed prior to receiving a service by the patient that typically supplements insurance coverage.

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Percent of patient due balances that were collected at time of service

The amount owed by the patient after applying the insurer's negotiated discount and the insurer's payments.

Average number of claims a biller submitted for payment in a day for:

A written request for payment submitted to a third party.

- **Commercial:** The number of commercial claims (excluding Medicare Advantage) submitted in a day.
- **Government:** The number of government claims submitted in a day. Government claims would include Medicare (excluding Medicare Advantage), Medicaid, and any other federal, state, or other government body.
- **Follow-Up:** The number of outstanding claims and unpaid balances with payers (including commercial and government) submitted in a day.

Percentage of claims that were denied on first submission

The percentage, in whole numbers, of claims that were denied by payers on first submission. A claim is a written request for payment submitted to a third party.

Average charge-posting lag time between date of service and claim drop date to payer

The number of days between when a patient was seen (date of service) and when the claim was posted for third-party payment.

Average number of patient encounters a coder processed in a day

An encounter is an instance of direct provider to patient interaction, regardless of setting (including tele-visits and e-visits), between a patient and a healthcare provider who is vested with the primary responsibility of diagnosing, evaluating, and/or treating the patient's condition, where the provider exercises clinical judgment that may or may not be billable.

Panel Size *Cardiology and Primary Care Practices Only*

The "set of patients cared for by a physician" as the number of individual, unique patients that have been seen by any provider within the practice over the past 18 months.

The following methodologies are used to calculate panel size:

- If a patient has only seen one physician in the practice, assign the patient to that physician.
- If a patient has seen more than one physician in the practice, assign the patient to the physician seen most frequently.
- If a patient has seen more than one physician in the practice the same number of times, assign the patient to the physician who did the patient's last physical.
- If a patient has not had a physical, assign him/her to the physician seen most recently.

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Value-Based Contracts Follow-Up Questions

If your organization participates in value-based contracts, you will be prompted to provide data on the following questions.

The number of contracts held by your practice by payer type:

- **Commercial:** The number of commercial payer contracts (excluding Medicare Advantage) held by your practice.
- **Government:** The number of government programs participated in by your practice. Government payers would include Medicare (excluding Medicare Advantage), Medicaid and any other federal, state, or other government body.
- **Medicare Advantage:** The number of Medicare Advantage payer contracts held by your practice. Medicare Advantage is part of the Medicare Program, and may include Part A, B and D benefits (and more). However, the benefits are instead offered through contracts with private insurers.

How many covered lives were attributed to this practice?

The total number, in whole numbers, of covered lives across all your practice's payer contracts.

The number of contracts held by your practice that included a risk or value-based program or reimbursement methodology by payer type:

- **Commercial:** The number of commercial payer contracts (excluding Medicare Advantage) held by your practice that included a risk or value-based program or reimbursement methodology.
- **Government:** The number of government programs participated in by your practice that included a risk or value-based program or reimbursement methodology. Government payers would include Medicare (excluding Medicare Advantage), Medicaid and any other federal, state or other government body.
- **Medicare Advantage:** The number of Medicare Advantage payer contracts held by your practice that included a risk or value-based program or reimbursement methodology. Medicare Advantage is part of the Medicare Program, and may include Part A, B and D benefits, however, the benefits are instead offered through contracts with private insurers.

How many covered lives were attributed to value-based contracts in this practice?

The total number, in whole numbers, of covered lives across all your practice's value-based contracts.

Across all payer types and all payer contracts, which specific measure(s) were a focus for your practice?

Regardless of the payer or contract, describe which quality measures were a focus for your practice.

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Among your practice's covered lives attributed under value-based contracts, what was your practice's:

- **Hospital admission rate:** Specifically, for patients under value-based contracts, indicate the percent, in whole numbers, of your practice's hospital admission rate. To calculate, divide the number of hospital admissions experienced by patients tied to value-based contracts by the total number of patients tied to value-based contracts.
- **Hospital 30-day readmission rate:** Specifically, for patients under value-based contracts, indicate the percent, in whole numbers, who experienced unplanned readmission to a hospital within 30 days of a previous hospital stay. A 30-day hospital readmission refers to when a patient is admitted to a hospital within 30 days or less of being discharged from a hospital for a previous stay. To calculate, divide the number of patients tied to value-based contracts with hospital readmission within 30 days by the total number of hospital discharges for patients tied to value-based contracts.
- **Emergency department utilization rate:** Specifically, for patients under value-based contracts, indicate the percent, in whole numbers, of your practice's emergency department utilization rate. To calculate, divide the number of inpatient and/or outpatient emergency department admissions experienced by patients tied to value-based contracts by the total number of patients tied to value-based contracts.
- **30-day post-operative infection rate:** Specifically, for patients under value-based contracts, indicate the percent, in whole numbers, of your practice's 30-day post-operative infection rate. Post-operative infection is defined as any infection that occurs within 30 days of operation and may be related to the operation itself or the postoperative course. To calculate, divide the number of post-operative infections experienced by patients tied to value-based contracts within 30 days of operation by the total number of patients tied to value-based contracts.HR management

*PRACTICE TURNOVER: LIST THE TOTAL NUMBER OF POSITIONS, THE NUMBER OF PEOPLE WHO LEFT, THE NUMBER OF PEOPLE HIRED, IF YOUR PRACTICE HAD TURNOVER AND IF YOUR PRACTICE HAD NEW HIRES FOR THE FOLLOWING POSITIONS:

Business operations support staff: Indicate the total number of business operations support staff positions at your practice, the number of people who left those positions and the number of people hired for those positions during the reporting period. This includes staff who perform the business functions of the practice, including general administration, patient accounting, general accounting, managed care administration, information technology, housekeeping, maintenance, and security.

Front office support staff: Indicate the total number of front office support staff positions at your practice, the number of people who left those positions and the number of people hired for those positions during the reporting period. This includes staff who perform the front office duties of the practice, including medical reception, secretarial functions, transcription, medical records, and other administrative support.

Clinical support staff: Indicate the total number of clinical support staff positions at your practice, the number of people who left those positions and the number of people hired for those positions during the reporting period. This includes staff who perform the clinical support duties of the practice including registered nurses (RNs), licensed practical nurses (LPNs), medical assistants, and nurse's aides who assist clinical services.

Ancillary support staff: Indicate the total number of ancillary support staff positions at your practice, the number of people who left those positions and the number of people hired for those positions during the reporting period. This includes staff who perform support duties for the ancillary services provided by the practice, including clinical laboratory, radiology and imaging, and other medical support services.

Physicians: Indicate the total number of physician positions at your practice, the number of people who left those positions and the number of people hired for those positions during the reporting period.

Advanced practice providers: Indicate the total number of advanced practice providers positions at your practice, the number of people who left those positions and the number of people hired for those positions during the reporting period. This includes audiologists, certified registered nurse anesthetists (CRNAs), dieticians/nutritionists, midwives, nurse practitioners (NPs), occupational therapists, optometrists, physical therapists, physician assistants (PAs), psychologists, and surgeon's assistants.

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