**Hospital Charge Information Listing**

***These charges are estimated as of 10/01/2018 and are subject to change.***

To better inform our patients, Day Kimball Hospital is providing a current list of charges which reflect the most commonly performed tests, services or procedures here at Day Kimball Hospital.

**Please note that charges do not always represent what a patient will owe**. A patient's financial responsibility can vary widely depending upon several factors:

* ***Hospitals Contracted Rates with each Insurance Carrier***
  + Through negotiations, the hospital and insurance companies agree contractually to fees that will be paid (or “allowed”) for each service.
    - **An example**: hospital charges $230 for an x-ray of the ankle, but insurance carrier A has contractually agreed upon (or only allows) $100 as the maximum to be paid to the hospital for this x-ray as payment in full.
* ***Employer Health Insurance Benefit Design*** 
  + An employer will decide its employees’ responsibilities for any deductibles, coinsurance or copayments based upon the insurance plan chosen. Using the x-ray example above, the health insurance benefit design determines how much of that $100 is paid by the patient and how much is paid by the insurance company.
    - **Deductible example**: the patient must pay $100 directly to the hospital if the yearly deductible has not yet been met.
    - **Coinsurance example**: if there is no deductible (or if it has been met for the year) but the patient has a 20% coinsurance requirement, the insurance company would pay the hospital $80 and the patient would pay the hospital $20, (or 20% of $100).
* ***Personal Health Insurance Benefit Design through an Insurance Plan purchased on the Exchange or Marketplace***
  + A patient’s plan selection through the Exchange or Marketplace will define any deductibles, coinsurance or copayments required. Payments due to the hospital will follow the same example as shown above for *Employer Health Insurance Benefit Design*

**BILLING POLICIES**

Day Kimball Healthcare wants to ensure that its patients receive the full benefits of all insurance coverage as well as consideration under our financial assistance programs. Before you are billed, we submit your claims to all active insurance carriers based upon the information that is provided to us at the time of service.

In addition to your hospital bill, you may receive separate bills for physician or other professional service providers involved in your hospital care.

Financial Assistance is available for those who qualify. If you are not able to pay the amount you owe in full, you may contact our financial counseling team at (860) 963- 6337 option 2 to apply for financial assistance or to determine a payment plan that fits your needs. Emergent services will never be delayed or withheld on the basis of your ability to pay.

**EMERGENCY SERVICES-**

Emergency Department charges are based on the level of emergency care provided to our patients. Each level reflects the intensity of services, and amount of resources required to provide treatment.

Each Emergency Room Visit is unique; therefore, there may be supplies; drugs, testing, or additional procedures which may be required for a particular emergency treatment. Such services or procedures are above and beyond the average charges listed below.

Additionally; the average charges listed do not include fees for Emergency Department Physicians; Radiologist, or other consulting Physicians who will bill separately for their services.

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| **LEVEL OF SERVICE** | **AVERAGE CHARGE per EMERGENCY ROOM VISIT** |
| LEVEL 1 | $315 |
| LEVEL 2 | $413 |
| LEVEL 3 | $1,186 |
| LEVEL 4 | $2,688 |
| LEVEL 5 | $3,549 |
| CRITICAL CARE, INITIAL CARE | $6,016 |

**INPATIENT CARE**-

Inpatient Care charges are based on the length of stay; level of acuity of the patient, and services provided during the patients stay.

Each Inpatient stay is unique; therefore, there may be supplies; drugs, testing, or additional procedures which may be required for a particular Inpatient Care. Such services are above and beyond the average charges listed below.

Additionally, the average charges listed do not include fees for Emergency Department physicians; Radiologists, Anesthesiologists, and consulting Physicians who will bill separately for their services.

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| **INPATIENT CARE CLASSIFICATION** | **AVERAGE CHARGE per Hospital Admission** |
| INTENSIVE CARE | $19,802 |
| MEDICAL | $18,510 |
| PEDIATRIC | $7,426 |
| PSYCHIATRY | $15,283 |
| TELEMETRY | $18,591 |
| NON-MATERNITY OBSTETRICAL | $13,911 |
| **MATERNITY/NEWBORN SERVICES** | **AVERAGE CHARGE per Admission** |
| ROUTINE DELIVERY | $11,905 |
| C-SECTION DELIVERY | $16,899 |
| HIGH RISK DELIVERY | $18,014 |
| NEWBORN- WITH NO SIGNIFICANT COMPLICATIONS | $8,866 |
| NEWBORN- INTERMEDIATE CARE/HIGH RISK | $16,221 |

**SURGICAL PROCEDURES- Operating Room**

The following charges are for some of our most common procedures. Because each patient surgery is unique, there may be additional resources that may be required which could increase the charges for a surgical case. In addition, the listed average charges do not include professional fees for surgeons, physicians or anesthesiologists who will bill separately for their services.

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| GENERAL SURGERY | **GENERAL SURGERY** | **AVERAGE CHARGE PER CASE** |
| ABDOMINAL HERNIA REPAIR W/ OR W/O MESH | $6,812 |
| APPENDECTOMY | $11,150 |
| RESECTION OF GALLBLADDER | $7,858 |
| EXCISION -BREAST LESION | $8,667 |
| INGUINAL HERNIA REPAIR W/ MESH | $6,808 |
| PORT INSERTION | $6,504 |

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| ORTHOPEDIC SURGERY | **ORTHOPEDIC SURGERY** | **AVERAGE CHARGE PER CASE** |
| RELEASE OF NERVE | $6,602 |
| RELEASE OF TENDON, HAND | $4,618 |
| REPOSITION FIBULA | $13,316 |
| RELEASE SHOULDER JOINT | $16,192 |
| RELEASE KNEE JOINT | $6,284 |
| EXCISION SHOULDER JOINT | $11,108 |
| REPOSITION METATARSAL | $8,474 |
| FUSION OF CERVICAL JOINT | $55,166 |
| CERVICAL DISCECTOMY | $55,504 |

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| SURGERY ENT | **EAR NOSE AND THROAT SURGERY** | **AVERAGE CHARGE PER CASE** |
| DRAINAGE OF MIDDLE EAR W/ DEVICE | $5,618 |
| REMOVAL OF TONSILS | $5,939 |
| REMOVAL OF ADENOIDS | $5,463 |
| DRAINAGE OF MAXILLARY SINUS | $9,775 |

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| SURGERY OB/GYN | **OBSTETRIC AND GYNOCOLOGICAL SURGERY** | **AVERAGE CHARGE PER CASE** |
| DESTRUCTION OF FALLOPIAN TUBES | $5,927 |
| DESTCTION OF ENDOMETRIUM | $9,197 |
| EXCISION OF UTERUS | $9,609 |
| EXCISION OF CERVIX | $7,496 |
| EXTRACTION OF ENDOMETRIUM | $8,504 |
| RESECTION OF OVARY | $8,925 |

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| SURGERY CARDIAC | **CARDIAC SURGERY** | **AVERAGE CHARGE PER CASE** |
| INSERTION OF PACEMAKER, DUAL LEADS | $18,401 |
| REMOVAL OF PACEMAKER, SINGLE LEAD | $16.256 |
| SURGERY EYE | **CORRECTIVE EYE SURGERY** | **AVERAGE CHARGE PER CASE** |
| CATARACT SURGERY W/ IOL 1 STAGE | $5,040 |

**CLINICAL LABORATORY**

The following charges represent the Hospital’s most common laboratory tests and their associated prices.

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| **LAB EXAM** | **AVERAGE CHARGE PER EXAM** |
| COMPLETE METABOLIC PANEL (COMP) | $62 |
| BASIC METABOLIC PANEL (BMP) | $56 |
| COMPLETE BLOOD COUNT | $46 |
| LIVER FUNCTION TEST (LFT/HEPATIC FUNCTION TEST) | $60 |
| GLYCOHEMOGLOBIN ( HBA1C- DIABETIES EXAM) | $56 |
| TOTAL CHOLESTEROL PANEL (HDLP/LIPID PANEL) | $80 |
| PROTHROMBIN TIME | $18 |
| PROSTATE SPECIFIC ANTIGEN FREE (PSA FREE) | $107 |
| PROSTATE SPECIFIC ANTIGEN SCREEN (PSA SCREENING ) | $81 |
| PROSTATE SPECIFIC ANTIGEN TOTAL (PSA DIAGNOSTIC) | $107 |
| RUBELLA SCREEN | $105 |
| T4 (THYROXINE) | $35 |
| TSH | $77 |
| THROAT CULTURE | $39 |
| URINALYSIS | $29 |
| URINE CULTURE | $32 |
| URINE DRUG SCREEN | $93 |
| VITAMIN B12 | $68 |
| VITAMIN D, 25 HYDROXY | $172 |

**CLINICAL LABORATORY-ALLERGEN TESTING**

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| ALLERGEN PANELS | **COMMON ALLERGEN PANELS** | **AVERAGE CHARGE PER SERVICE** |
| ALLERGEN PROFILE, CITRUS | $155.02 |
| ALLERGEN PROFILE, SHELLFISH | $186.23 |
| HYMENOPTERA PROFILE | $186.23 |
| ALLERGEN PROFILE, FISH | $217.44 |
| ALLERGENS(7) NUTS | $217.44 |
| ALLERGENS (9) NUTS | $279.87 |
| ALLERGEN PROFILE, BASIC FOOD | $331.89 |
| SEASONAL ALLERGENS, SPRING TREE | $372.46 |
| ALLERGENS, ZONE 1 | $900.99 |
| ALLERGENS (39) (CUSTOM FOR DR. CHARON) | $1,211.03 |

**RADIOLOGY**

The following charges represent the Hospital’s most common radiological procedures. These charges do not include the cost of any contrast agent or isotope, if required. All interpretations of these exams will be billed separately by the radiologist.

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| XRAY- RADIOLOGICAL IMAGING | **XRAY- RADIOLOGICAL IMAGING** | **AVERAGE CHARGE PER EXAM** |
| ABDOMEN | $235 |
| ANKLE | $235 |
| BARIUM SWALLOW | $252 |
| BONE DENSITY (DEXA) | $489 |
| CERVICAL SPINE | $242 |
| CERVICAL SPINE - W/OBLIQUES | $242 |
| CHEST X-RAY 2 VIEW FRONTAL & LATERAL | $152 |
| DORSAL SPINE | $237 |
| ELBOW | $147 |
| FINGER, SINGLE | $147 |
| FOOT | $147 |
| FOREARM | $147 |
| HAND | $147 |
| HIP | $147 |
| KNEE | $235 |
| LOWER LEG | $147 |
| LUMBAR SPINE ROUTINE | $242 |
| LUMBAR SPINE W OBLIQUES MINIMUM- 4 VIEW | $235 |
| PELVIS 1 OR 2 VIEWS | $242 |
| RIBS ONE SIDE | $242 |
| SHOULDER | $235 |
| WRIST | $147 |

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| MAMMOGRAPHY IMAGING- XRAY/ULTRASOUND  /MRI | **MAMMOGRAPHY XRAY/ULTRASOUND/MRI** | **AVERAGE CHARGE PER EXAM** |
| MAMMOGRAM SCREEN DIGITAL (used for both 2D and 3D) | $427 |
| MAMMOGRAM DIAGNOSTIC DIGITAL | $652 |
| MAMMOGRAM DIAGNOSTIC DIGITAL (1 BREAST) | $280 |
| MAMMOGRAM DIAGNOSTIC EXTRA VIEWS | $280 |
| BREAST ULTRASOUND BILATERAL | $310 |
| BREAST ULTRASOUND UNILATERAL | $245 |
| MRI-BREASTS W/WO CONTRAST | $4349 |
| 3D RENDERING TOMOSYNTHESIS ADD ON (in addition to line 1 above) | $185 |

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| ULTRASOUND IMAGING | **ULTRASOUND** | **AVERAGE CHARGE PER EXAM** |
| ABDOMINAL AORTA ULTRASOUND | $393 |
| ABDOMINAL ULTRASOUND | $404 |
| CAROTID DUPLEX W C/F | $509 |
| DOBUTAMINE-STRESS ECHOCARDIOGRAM | $1665 |
| HEAD OR NECK ULTRASOUND | $327 |
| PELVIC ULTRASOUND | $327 |
| PELVIC-NON OBSTETRICAL TRANSVAGINAL | $327 |
| PERIVASCULAR-LEG-UNILATERAL | $335 |
| PERIVASCULAR-LEG-BILATERAL | $760 |
| RENAL ULTRASOUND | $393 |
| STRESS & REST ECHOCARDIOGRAM | $1026 |
| THYROID ULTRASOUND | $327 |

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| CT SCAN IMAGING | **CT SCAN** | **AVERAGE CHARGE PER EXAM** |
| ANGIO ABDOMEN & PELVIS WITH AND WITHOUT CONTRAST | $3,118 |
| CT ABDOMEN | $1,400 |
| CT ABDOMEN AND PELVIS | $1,800 |
| CT CHEST | $1,870 |
| CT EXTREMITY | $1,160 |
| CT HEAD; FACE, MANDIBLE, NECK, ORBIT, OR SINUS | $1,158 |
| CT LUMBAR | $1,291 |
| CT PELVIS | $1,409 |
| CT SPINE | $1,291 |
| LOW DOSE CT OF THE CHEST | $1,212 |
| LUNG CANCER SCREENING | $1,212 |

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| MRI/MRA IMAGING | **MRI/MRA IMAGING** | **AVERAGE CHARGE PER EXAM** |
| MRI – LS SPINE W/O CONTRAST | $2,523 |
| MRI – KNEE W/O CONTRAST | $2,239 |
| MRI – C SPINE W/O CONTRAST | $2,273 |
| MRI – HEAD W/O CONTRAST | $2,273 |
| MRI – SHOULDER W/O CONTRAST | $2,239 |
| MRA – HEAD W/O CONTRAST | $2,273 |
| MRI – LOWER EXTREMITY NO JT W/O CONTRAST | $2,239 |
| MRI – D SPINE W/O CONTRAST | $2,523 |
| MRI – ANKLE W/O CONTRAST | $2,239 |
| MRI – 3D RENDERING W/ INTERPRETATION | $697 |

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| PET SCAN | **PET SCAN** | **AVERAGE CHARGE PER EXAM** |
| PET/CT SKULL TO THIGH INITIAL | $10,875 |
| PET/CT SKULL TO THIGH SUBSEQUENT | $10,875 |

**CARDIOLOGY**

The following charges reflect the Hospital’s most commonly offered Cardiology services. The following charges do not include fees for drugs or supplies. All interpretations of these services will be billed separately by the cardiologist and/or Day Kimball Hospital on behalf of the cardiologist.

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| CARDIOLOGY SERVICES | **CARDIOLOGY SERVICES** | **AVERAGE CHARGE PER SERVICE** |
| EKG | $288 |
| EXERCISE OR DRUG INDUCED STRESS TEST | $652 |
| LEXISCAN STRESS TEST | $652 |
| DOBUTAMINE STRESS TEST | $652 |
| PERSANTINE STRESS TEST | $652 |
| ECG LOOP MONITOR CONNECT/RECORD | $646 |
| ECG LOOP MONITOR TRANSMIT/ANALYZE | $309 |
| ECG LOOP MONITOR INTERPRET/REPORT | $64 |
| ECG HOLTER MONITOR CONNECT/RECORD | $646 |
| ECG HOLTER MONITOR TRANSMIT/ANALYZE | $309 |
| ECG HOLTER MONITOR INTERPRET/REPORT | $55 |

**RESPIRATORY THERAPY AND PULMONARY FUNCTION CHARGES**

The following charges reflect the most common services offered by our Respiratory and Pulmonary departments. Patients may have additional charges depending on the services performed. The following charges do not include fees for physicians who may bill separately for the interpretation of certain tests performed.

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| **RESPIRATORY AND PULMONARY FUNCTION** | **RESPIRATORY AND PULMONARY SERVICES** | **AVERAGE CHARGE PER SERVICE** |
| AEROSOL INITIAL TREATMENT | $232 |
| AEROSOL SUBSEQUENT TREATMENT | $232 |
| ARTERIAL PUNCTURE | $292 |
| LUNG VOLUME | $435 |
| DLCO | $697 |
| PLETHYSOMOGRAPHY | $238 |
| SPIROMETRY W/ BRONCHODILATOR | $319 |
| BIPAP/CPAP | $319 |
| FLUTTER VALVE INITIAL EVAL | $232 |
| INHALATION TEACH/EVAL | $232 |

**PHYSICAL THERAPY**

The following charges reflect the most common services offered by our Physical Therapy department. Patients may have additional charges depending on the services performed. The following charges do not include fees for supplies or additional resources that may be required.

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| PHYSICAL THERAPY | **PHYSICAL THERAPY** | **AVERAGE CHARGE PER SERVICE** |
| PT Evaluation HIGH Complexity 45 MIN | $209 |
| PT Evaluation MODERATE Complexity 30 MIN | $209 |
| PT Evaluation LOW Complexity 20 MIN | $209 |
| PT RE-EVALUATION ESTABLISHED CARE PLAN | $142 |
| FLUIDOTHERAPY | $46 |
| VASOPNEUMATIC DEVICE | $35 |
| THERAPEUTIC ACTIVITY PER 15 MIN | $94 |
| PROSTHETIC TRAINING PER 15 MIN | $128 |
| MANUAL THERAPY TECHNIQUE PER 15 MIN | $70 |
| NEURO-MUSCULAR RE-EDUCATION PER 15 MIN | $79 |
| MECHANICAL TRACTION | $38 |
| ADULT DAILY SELF CARE TRAINING MGMT-PER 15 MIN | $85 |
| E-STIM INTER UNATTENDED | $129 |
| E-STIM MANUAL ATTEND PER 15 MIN | $49 |
| PARAFIN PROCEDURE | $20 |
| ULTRASOUND PER 15 MIN | $31 |
| THERAPEUTIC EXERCISE PER 15 MIN | $76 |
| GAIT TRAINING PER 15 MIN | $65 |

**OCCUPATIONAL THERAPY**

The following charges reflect the most common services offered by our Occupational Therapy department. Patients may have additional charges depending on the services performed.

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| OCCUPATIONAL THERAPY | **OCCUPATIONAL THERAPY** | **AVERAGE CHARGE PER SERVICE** |
| OT Evaluation HIGH Complexity 45 MIN | $198 |
| OT Evaluation MODERATE Complexity 30 MIN | $197 |
| OT Evaluation LOW Complexity 20 MIN | $195 |
| OT RE-EVALUATION ESTABLISHED CARE PLAN | $131 |
| FLUIDOTHERAPY | $44 |
| VASOPNEUMATIC DEVICE | $34 |
| ORTHOTIC FIT & TRAIN PER 15 MIN | $197 |
| MANUAL THERAPY TECH PER 15 MIN | $89 |
| NEURO-MUSCULAR RE-EDUCATION PER 15 MIN | $125 |
| ADULT DAILY SELF CARE TRAINING MGMT-PER 15 MIN | $158 |
| E-STIM INTER UNATTENDED | $125 |
| E-STIM MANUAL ATTENDED PER 15 MIN | $47 |
| PARAFIN PROCEDURE | $19 |
| ULTRASOUND PER 15 MIN | $31 |
| THERAPEUTIC ACTIVITY PER 15 MIN | $120 |
| THERAPEUTIC EXERCISE PER 15 MIN | $111 |

**SPEECH THERAPY**

The following charges reflect the most common services offered by our Speech Therapy department. Patients may have additional charges depending on the services performed.

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| SPEECH THERAPY | **SPEECH THERAPY** | **AVERAGE CHARGE PER SERVICE** |
| EVALUATION OF SPEECH FLUENCY | $465 |
| DEVELOPMENT COGNITIVE SKILLS- PER 15 MIN | $176 |
| VIDEO FLUORO EVALUATION | $566 |
| AAC EVALUATION SPEECH GENERAL- 1ST HR | $496 |
| EVALUATE RECEPTIVE/EXPRESSIVE LANGUAGE | $501 |
| SPEECH SOUND LANGUAGE COMPREHENSION | $465 |
| SWALLOW TREATMENT | $309 |
| SWALLOW EVALUATION | $450 |
| SPEECH & LANGUAGE TREATMENT | $329 |