Table 5.1

Discharges, Total Days of Care, Total Charges, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Calendar Years 1972-2004

Type of Entitlement and Year	Discharges: Number in Thousands	Discharges: Rate per 1,000 HI Enrollees	Total Days of Care: Number in Thousands	Total Days of Care: Rate per 1,000 HI Enrollees	Total Days of Care: Per Discharge
All Beneficiaries					
1972	6,380	302	77,198	3,656	12.1
1973	6,984	300	81,529	3,499	11.7
1974	7,629	319	87,523	3,658	11.5
1975	8,001	325	89,275	3,623	11.2
1976	8,465	334	93,480	3,693	11.0
1977	8,808	338	96,825	3,711	11.0
1978	9,216	344	99,372	3,712	10.8
1979	9,642	351	102,469	3,750	10.7
1980	10,279	366	109,175	3,890	10.6
1981	10,660	368	110,806	3,827	10.4
1982	11,109	382	113,047	3,889	10.2
1983	11,436	387	112,011	3,786	9.8
1984	10,896	363	96,485	3,217	8.9
1985	10,027	328	86,339	2,822	8.6
1986	10,044	322	86,910	2,784	8.7
1987	10,110	317	89,651	2,815	8.9
1988	10,256	316	90,873	2,804	8.9
1989 [3]	10,148	307	89,902	2,721	8.9
1990	10,522	312	92,735	2,749	8.8
1991 [4]	10,737	312	92,935	2,699	8.7
1992 [4]	10,958	312	91,990	2,616	8.4
1993 [4]	10,979	306	87,883	2,446	8.0
1994 [4]	11,282	335	84,742	2,516	7.5
1995 [4]	11,435	340	80,056	2,378	7.0
1996 [4]	11,474	345	75,660	2,272	6.6
1997 [4]	11,527	353	73,029	2,239	6.3
1998 [4]	11,355	355	70,055	2,192	6.2
1999 [4]	11,605	365	70,508	2,219	6.1
2000 [4]	11,720	363	70,330	2,175	6.0
2001 [4]	12,231	366	72,607	2,171	5.9
2002 [4]	12,607	365	74,566	2,158	5.9
2003 [4]	12,858	363	75,230	2,126	5.9
2004 [4]	12,918	359	74,606	2,072	5.8
			Average Annual Rate of Change		
1972-1983 [6]	5.4	2.3	3.4	0.3	-1.9
1983-2004 [6]	0.6	-0.4	-1.9	-2.8	-2.5
1972-2004	2.2	0.5	-0.1	-1.8	-2.3

Table 5.1—Continued

Discharges, Total Days of Care, Total Charges, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Calendar Years 1972-2004

Total Charges		Program Payments					
Amount in Millions	Per Discharge	Amount in Millions	Per Discharge[1]	Per HI Enrollee	Per Day	Percent of Total Charges	Percent of Total Medicare Payments [2]
$7,401	$1,160	$5,576	$874	$264	$72	75.3	69.5
8,494	1,216	6,446	923	277	79	75.9	69.7
10,471	1,373	7,837	1,027	328	90	74.8	69.7
13,073	1,634	9,748	1,218	396	109	74.6	67.0
15,951	1,882	11,803	1,394	466	126	74.1	67.0
19,157	2,170	13,944	1,583	534	144	73.0	68.1
22,408	2,431	16,008	1,737	598	161	71.4	68.0
26,120	2,709	18,463	1,915	672	180	70.7	66.7
31,992	3,112	22,099	2,150	787	202	69.1	66.4
38,164	3,580	25,936	2,433	907	234	68.0	65.0
46,369	4,174	30,601	2,755	1,053	271	66.0	63.6
54,127	4,733	34,338	3,003	1,161	307	63.4	64.3
52,901	4,855	38,500	3,533	1,284	399	72.8	65.1
53,397	5,332	40,200	4,009	1,314	466	75.2	62.9
59,376	5,911	41,781	4,160	1,338	481	70.4	60.7
68,490	6,775	44,068	4,359	1,383	492	64.3	58.1
78,536	7,657	46,879	4,571	1,446	516	59.7	57.6
88,038	8,676	49,091	4,838	1,486	546	55.8	52.3
102,544	9,746	53,708	5,281	1,593	579	52.4	53.0
117,616	10,954	58,750	5,610	1,706	632	50.0	53.0
131,451	11,996	64,810	6,057	1,843	705	49.3	53.7
139,375	12,695	67,260	6,257	1,872	765	48.3	52.0
146,074	12,948	70,624	6,377	2,097	833	48.3	48.2
149,502	13,074	74,836	6,656	2,223	935	50.1	47.1
152,854	13,322	78,546	6,953	2,359	1,038	51.4	47.0
159,285	13,818	80,725	7,118	2,475	1,105	50.7	46.0
163,541	14,402	78,364	7,021	2,452	1,119	47.9	46.6
178,399	15,373	79,013	6,920	2,486	1,121	44.3	47.4
196,017	16,725	81,231	6,971	2,513	1,155	41.4	46.6
227,145	18,572	88,323	7,262	2,641	1,216	38.9	44.7
271,750	21,555	94,194	7,507	2,726	1,263	34.7	43.7
310,889	24,180	98,432	7,691	2,781	1,308	31.7	42.3
341,749	26,455	102,648	7,985	2,850	1,376	30.0	40.2
Average Annual Rate of Change							
19.8	13.6	18.0	11.9	14.4	14.0	---	---
9.2	8.5	5.4	4.8	4.4	7.4	---	---
12.7	10.3	9.5	7.2	7.7	9.6	---	---

Table 5.1—Continued

Discharges, Total Days of Care, Total Charges, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Calendar Years 1972-2004

Type of Entitlement and Year	Discharges: Number in Thousands	Discharges: Rate per 1,000 HI Enrollees	Total Days of Care: Number in Thousands	Total Days of Care: Rate per 1,000 HI Enrollees	Total Days of Care: Per Discharge
Aged Beneficiaries					
1972	6,380	302	77,198	3,656	12.1
1973	6,751	313	78,987	3,662	11.7
1974	7,033	320	80,880	3,677	11.5
1975	7,285	324	81,592	3,631	11.2
1976	7,607	332	84,438	3,684	11.1
1977	7,850	334	86,967	3,705	11.1
1978	8,133	339	88,557	3,692	10.9
1979	8,478	345	91,239	3,717	10.8
1980	9,051	361	96,772	3,855	10.7
1981	9,400	367	98,223	3,838	10.4
1982	9,817	376	100,431	3,846	10.2
1983	10,152	381	99,740	3,740	9.8
1984	9,705	358	86,062	3,174	8.9
1985	8,918	322	76,926	2,779	8.6
1986	8,917	316	77,240	2,733	8.7
1987	9,000	312	79,804	2,769	8.9
1988	9,146	312	80,938	2,761	8.8
1989 [3]	9,026	302	79,784	2,671	8.8
1990	9,351	307	82,179	2,696	8.8
1991 [4]	9,510	306	81,994	2,641	8.6
1992 [4]	9,663	306	80,818	2,559	8.4
1993 [4]	9,628	300	76,719	2,393	8.0
1994 [4]	9,802	331	73,278	2,471	7.5
1995 [4]	9,879	336	68,842	2,340	7.0
1996 [4]	9,853	341	64,610	2,237	6.6
1997 [4]	9,873	351	62,184	2,212	6.3
1998 [4]	9,683	354	59,286	2,169	6.1
1999 [4]	9,873	365	59,577	2,204	6.0
2000 [4]	9,913	361	59,002	2,152	6.0
2001 [4]	10,289	364	60,470	2,139	5.9
2002 [4]	10,510	361	61,515	2,113	5.9
2003 [4]	10,648	359	61,553	2,075	5.8
2004 [4]	10,595	353	60,436	2,016	5.7
			Average Annual Rate of Change		
1972-1983 [6]	4.3	2.1	2.4	0.2	-1.9
1983-2004 [6]	0.2	-0.4	-2.4	-2.9	-2.5
1972-2004	1.6	0.5	-0.8	-1.8	-2.3

Table 5.1—Continued

Discharges, Total Days of Care, Total Charges, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Calendar Years 1972-2004

Total Charges		Program Payments					
Amount in Millions	Per Discharge	Amount in Millions	Per Discharge[1]	Per HI Enrollee	Per Day	Percent of Total Charges	Percent of Total Medicare Payments [2]
$7,401	$1,160	$5,576	$874	$264	$72	75.3	69.5
8,227	1,219	6,245	925	290	79	75.9	69.1
9,614	1,367	7,209	1,025	328	89	75.0	70.3
11,853	1,627	8,859	1,216	394	109	74.7	67.9
14,263	1,875	10,589	1,392	462	125	74.2	67.7
17,072	2,175	12,455	1,587	531	143	73.0	69.1
19,772	2,431	14,182	1,744	591	160	71.7	68.9
22,938	2,706	16,251	1,917	662	178	70.8	67.7
28,114	3,106	19,460	2,150	775	201	69.2	66.6
33,564	3,571	22,814	2,427	891	232	68.0	62.3
40,875	4,164	27,008	2,751	1,034	269	66.1	64.6
47,851	4,713	30,398	2,994	1,140	305	63.5	65.1
46,964	4,839	34,188	3,523	1,261	397	72.8	65.6
47,371	5,312	35,738	4,007	1,291	465	75.4	63.3
52,623	5,901	37,030	4,153	1,310	479	70.4	60.9
60,900	6,766	39,350	4,372	1,365	493	64.6	58.6
69,920	7,645	41,918	4,583	1,430	518	60.0	58.1
78,204	8,665	43,747	4,847	1,465	548	55.9	52.9
90,948	9,726	47,842	5,270	1,570	582	52.6	53.4
103,871	10,922	52,278	5,601	1,684	638	50.3	53.3
115,789	11,982	57,494	6,058	1,821	704	49.7	54.1
122,083	12,681	59,281	6,253	1,849	764	48.6	52.2
126,880	12,944	61,691	6,375	2,081	831	48.6	48.3
129,319	13,091	64,987	6,656	2,209	928	50.3	47.1
131,673	13,364	67,860	6,961	2,349	1,050	51.5	47.0
136,777	13,854	69,547	7,124	2,473	1,118	50.8	46.4
139,738	14,432	67,204	7,022	2,458	1,134	48.1	46.5
152,293	15,426	67,588	6,918	2,500	1,134	44.4	47.5
165,964	16,742	69,088	6,995	2,519	1,171	41.6	46.5
191,263	18,590	74,742	7,291	2,643	1,236	39.1	44.5
226,904	21,590	79,120	7,550	2,718	1,286	34.9	43.4
257,787	24,211	82,195	7,742	2,771	1,335	31.9	42.0
281,096	26,531	85,034	8,051	2,837	1,407	30.3	39.9
Average Annual Rate of Change							
18.5	13.6	16.7	11.8	14.2	14.0	---	---
8.8	8.6	5.0	4.8	4.4	7.6	---	---
12.0	10.3	8.9	7.2	7.7	9.7	---	---

Table 5.—Continued

Discharges, Total Days of Care, Total Charges, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Calendar Years 1972-2004

Type of Entitlement and Year	Discharges: Number in Thousands	Discharges: Rate per 1,000 HI Enrollees	Total Days of Care: Number in Thousands	Total Days of Care: Rate per 1,000 HI Enrollees	Total Days of Care: Per Discharge
Disabled Beneficiaries					
1974 [5]	596	309	6,643	3,446	11.1
1975	716	330	7,683	3,544	10.7
1976	858	359	9,042	3,780	10.5
1977	958	366	9,858	3,764	10.3
1978	1,083	388	10,815	3,872	10.0
1979	1,164	400	11,230	3,858	10.0
1980	1,228	414	12,403	4,186	10.1
1981	1,260	420	12,583	4,196	9.9
1982	1,292	437	12,616	4,271	9.8
1983	1,284	440	12,272	4,206	9.6
1984	1,191	413	10,423	3,614	8.8
1985	1,109	381	9,413	3,238	8.5
1986	1,127	381	9,670	3,269	8.6
1987	1,109	366	9,847	3,249	8.9
1988	1,111	358	9,936	3,203	8.9
1989 [3]	1,122	354	10,118	3,191	9.0
1990	1,171	360	10,556	3,245	9.0
1991 [4]	1,227	362	10,941	3,230	8.9
1992 [4]	1,294	362	11,173	3,122	8.6
1993 [4]	1,352	350	11,165	2,891	8.3
1994 [4]	1,480	367	11,465	2,846	7.7
1995 [4]	1,556	367	11,214	2,646	7.2
1996 [4]	1,621	367	11,051	2,505	6.8
1997 [4]	1,654	368	10,845	2,411	6.6
1998 [4]	1,673	362	10,769	2,333	6.4
1999 [4]	1,732	365	10,931	2,306	6.3
2000 [4]	1,807	368	11,328	2,309	6.3
2001 [4]	1,942	376	12,137	2,347	6.2
2002 [4]	2,098	385	13,051	2,395	6.2
2003 [4]	2,210	386	13,677	2,387	6.2
2004 [4]	2,323	385	14,171	2,348	6.1
			Average Annual Rate of Change		
1974-1983 [6]	8.9	4.0	7.1	2.2	-1.6
1983-2004 [6]	2.9	-0.6	0.7	-2.7	-2.1
1974-2004	4.6	0.7	2.6	-1.3	-2.0

[1]Beginning in 1990, the average program payment per discharge does not reflect discharges with covered services, but for whom no program payments were reported.

[2]Based on total Medicare program payments.

[3]Represents the only year that the Medicare Catastrophic Coverage Act of 1988 was in effect.

[4]This table was revised from earlier editions for years 1991-1998 to exclude discharges from short-stay hospitals that were paid for by Medicare managed care plans, thus yielding fee-for-service utilization only for those years. Data for years prior to 1991 were not revised. However, these managed care enrollees were included in calculating all user rates per enrollee until 1994. Beginning with 1994, Medicare managed care enrollees are excluded from all calculations.

[5]Effective July 1, 1973, Medicare coverage was extended to disabled beneficiaries under the Social Security and Railroad Retirement Programs. Coverage was also extended to persons under 65 years of age who require dialysis or a kidney transplant for end stage renal disease. Public Law 95-292 removed the under age 65 restriction for persons with end stage renal disease, effective October 1978.

[6]Average annual rates of change are provided for periods before and after 1983 to show the impact of the prospective payment system's implementation (beginning October 1, 1983) on short-stay hospital utilization.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services.
HI is hospital insurance.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 5.1—Continued

Discharges, Total Days of Care, Total Charges, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Calendar Years 1972-2004

Total Charges		Program Payments					
Amount in Millions	Per Discharge	Amount in Millions	Per Discharge[1]	Per HI Enrollee	Per Day	Percent of Total Charges	Percent of Total Medicare Payments[2]
$857	$1,438	$628	$1,054	$326	$95	73.3	64.0
1,220	1,704	889	1,242	410	116	72.9	59.6
1,688	1,967	1,214	1,415	508	134	71.9	61.2
2,085	2,176	1,489	1,554	569	151	71.4	60.5
2,636	2,434	1,826	1,686	654	169	69.3	61.6
3,182	2,734	2,212	1,900	760	197	69.5	59.9
3,878	3,158	2,639	2,149	891	213	68.1	58.6
4,600	3,651	3,122	2,478	1,041	248	67.9	58.9
5,494	4,252	3,593	2,781	1,216	285	65.4	56.6
6,276	4,887	3,940	3,068	1,350	321	62.8	58.7
5,937	4,987	4,312	3,621	1,495	414	72.6	61.5
6,026	5,435	4,462	4,023	1,535	474	73.9	59.9
6,752	5,991	4,751	4,216	1,606	491	70.4	59.0
7,590	6,843	4,718	4,254	1,557	479	62.2	54.1
8,617	7,759	4,961	4,468	1,600	499	57.6	53.8
9,834	8,764	5,344	4,763	1,685	528	54.3	48.2
11,596	9,904	5,866	5,371	1,809	556	50.6	49.7
13,746	11,206	6,473	5,680	1,912	592	47.1	50.5
15,661	12,101	7,316	6,051	2,086	665	46.7	50.6
17,292	12,794	7,978	6,294	2,107	726	46.1	50.2
19,193	12,971	8,933	6,390	2,218	776	46.5	47.4
20,182	12,968	9,849	6,655	2,324	878	48.8	46.8
21,181	13,067	10,686	6,901	2,422	967	50.5	47.3
22,508	13,609	11,178	7,084	2,485	1,031	49.7	47.0
23,803	14,231	11,160	7,012	2,418	1,036	46.9	47.0
26,106	15,074	11,425	6,933	2,410	1,045	43.8	47.1
30,053	16,629	12,143	6,835	2,475	1,072	40.4	47.1
35,882	18,475	13,581	7,106	2,626	1,119	37.8	45.8
44,846	21,380	15,074	7,287	2,767	1,155	33.6	45.5
53,102	24,028	16,237	7,442	2,834	1,187	30.6	43.8
60,653	26,107	17,614	7,681	2,918	1,243	29.0	41.9
Average Annual Rate of Change							
24.8	14.6	22.6	12.6	17.1	14.6	---	---
11.4	8.3	7.4	4.5	3.7	6.7	---	---
15.3	10.1	11.8	6.8	7.6	9.0	---	---

Table 5.2

Discharges, Coinsurance Days, Coinsurance Payments, and Deductible Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Selected Calendar Years 1985-2004

Type of Entitlement and Year	Discharges			Coinsurance Days			Coinsurance Payments				Deductible Payments in Thousands
	Number	Number With Coin-surance	Percent With Coin-surance	Number	Percent of TDOC	Per Discharge With Coin-surance	Amount in Thousands	Per Discharge With Coin-surance	Per Day With Coin-surance	Per HI Enrollee	
All Beneficiaries											
1985	10,333,990	201,340	1.9	2,230,005	2.6	11.1	386,145	1,918	173	13	2,867,199
1987	10,109,560	186,300	1.8	2,223,675	2.5	11.9	506,323	2,718	228	16	3,818,919
1989 [1]	10,147,665	9,075	0.1	140,285	0.2	15.5	39,013	4,299	278	1	3,607,489
1990	10,521,925	159,405	1.5	1,990,245	2.1	12.5	495,351	3,107	249	15	4,519,088
1991	10,887,700	208,650	1.9	2,564,295	2.7	12.3	740,119	3,547	289	21	4,938,491
1993	11,157,860	190,640	1.7	2,230,130	2.5	11.7	678,846	3,561	304	19	5,407,178
1994 [2]	11,470,605	181,110	1.6	2,015,355	2.4	11.1	637,692	3,521	316	19	5,656,015
1995 [2]	11,680,885	164,535	1.4	1,738,950	2.1	10.6	535,923	3,257	308	16	5,880,735
1996 [2]	11,795,535	149,265	1.3	1,492,815	1.9	10.0	472,289	3,164	316	14	6,066,239
1997 [2]	11,919,085	144,780	1.2	1,400,900	1.9	9.7	454,071	3,136	324	14	6,274,527
1998 [2]	11,677,045	137,380	1.2	1,288,950	1.8	9.4	412,001	2,999	320	13	6,157,044
1999 [2]	11,604,590	137,940	1.2	1,278,785	1.8	9.3	423,526	3,070	331	13	6,077,414
2000 [2]	11,719,960	145,880	1.2	1,379,135	2.0	9.5	492,771	3,378	357	15	6,214,175
2001 [2]	12,230,660	156,340	1.3	1,454,450	2.0	9.3	530,950	3,396	365	16	6,579,229
2002 [2]	12,607,370	162,690	1.3	1,506,820	2.0	9.3	578,659	3,557	384	17	6,959,581
2003 [2]	12,857,535	168,950	1.3	1,531,665	2.0	9.1	594,767	3,520	388	17	7,299,864
2004 [2]	12,918,130	169,810	1.3	1,517,310	2.0	8.9	607,671	3,579	400	17	7,660,837
Aged Beneficiaries											
1985	9,181,575	167,205	1.8	1,877,450	2.4	11.2	322,772	1,930	172	12	2,575,432
1987	9,000,415	154,295	1.7	1,868,520	2.3	12.1	419,639	2,720	225	15	3,435,293
1989 [1]	9,025,585	7,825	0.1	121,505	0.2	15.5	34,131	4,362	281	1	3,254,277
1990	9,351,115	130,485	1.4	1,655,100	2.0	12.7	410,189	3,144	248	13	4,062,061
1991	9,654,955	171,485	1.8	2,134,965	2.6	12.4	602,694	3,515	282	19	4,428,249
1993	9,797,540	151,855	1.5	1,798,310	2.3	11.8	678,846	3,544	299	21	4,805,070
1994 [2]	9,981,910	140,710	1.4	1,587,770	2.1	11.3	490,226	3,484	309	17	4,988,249
1995 [2]	10,110,745	125,305	1.2	1,348,065	1.9	10.8	407,180	3,250	302	14	5,160,234
1996 [2]	10,154,130	109,210	1.1	1,118,230	1.7	10.2	347,960	3,186	311	12	5,300,481
1997 [2]	10,238,610	105,800	1.0	1,041,835	1.6	9.8	325,899	3,080	313	12	5,469,574
1998 [2]	9,981,860	97,640	1.0	930,890	1.5	9.4	287,393	2,943	309	11	5,343,214
1999 [2]	9,872,680	97,240	1.0	921,210	1.5	9.5	296,315	3,047	322	11	5,245,762
2000 [2]	9,912,740	102,475	1.0	982,075	1.7	9.6	339,119	3,309	345	12	5,335,548
2001 [2]	10,288,530	109,450	1.1	1,025,070	1.7	9.4	359,299	3,283	351	13	5,619,671
2002 [2]	10,509,835	112,105	1.1	1,045,585	1.7	9.3	381,837	3,406	365	13	5,892,427
2003 [2]	10,647,510	113,995	1.1	1,040,375	1.7	9.1	384,424	3,372	370	13	6,142,079
2004 [2]	10,594,875	112,690	1.1	1,014,715	1.7	9.0	385,968	3,425	380	13	6,386,647

See footnotes at end of table

Table 5.2—Continued

Discharges, Coinsurance Days, Coinsurance Payments, and Deductible Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Type of Entitlement: Selected Calendar Years 1985-2004

Type of Entitlement and Year	Discharges			Coinsurance Days			Coinsurance Payments				Deductible Payments in Thousands
	Number	Number With Coin-surance	Percent With Coin-surance	Number	Percent of TDOC	Per Discharge With Coin-surance	Amount in Thousands	Per Discharge With Coin-surance	Per Day With Coin-surance	Per HI Enrollee	
Disabled Beneficiaries											
1985	1,152,415	34,135	3.0	352,555	3.7	10.3	63,373	1,857	180	22	291,768
1987	1,109,145	32,005	2.9	355,155	3.6	11.1	86,684	2,708	244	29	383,625
1989[1]	1,122,080	1,250	0.1	18,780	0.2	15.1	4,881	3,905	260	2	353,212
1990	1,170,810	28,920	2.5	335,145	3.2	11.6	85,162	2,945	254	26	457,027
1991	1,233,645	37,165	3.0	429,330	3.9	11.6	137,425	3,698	320	41	510,241
1993	1,360,320	38,785	2.9	431,820	3.9	11.1	140,702	3,628	326	36	602,109
1994[2]	1,488,695	40,400	2.7	427,585	3.8	11.0	147,466	3,650	345	37	667,766
1995[2]	1,570,140	39,230	2.5	390,885	3.5	10.0	128,743	3,282	329	30	720,502
1996[2]	1,641,405	40,055	2.4	374,585	3.4	9.4	124,329	3,104	332	29	765,758
1997[2]	1,680,475	38,980	2.3	359,065	3.3	9.2	128,172	3,288	357	28	804,953
1998[2]	1,695,185	39,740	2.3	358,060	3.3	9.0	124,608	3,136	348	27	813,830
1999[2]	1,731,910	40,700	2.4	357,575	3.3	8.8	127,211	3,126	356	27	831,652
2000[2]	1,807,220	43,405	2.4	397,060	3.5	9.1	153,652	3,540	387	31	878,628
2001[2]	1,942,130	46,890	2.4	429,380	3.5	9.2	171,651	3,661	400	33	959,558
2002[2]	2,097,535	50,585	2.4	461,235	3.5	9.1	196,822	3,891	427	35	1,067,155
2003[2]	2,210,025	54,955	2.5	491,290	3.6	8.9	210,343	3,828	428	37	1,157,786
2004[2]	2,323,255	57,120	2.5	502,595	3.5	8.8	221,703	3,881	441	37	1,274,191

[1]The general provisions of the Medicare Catastrophic Coverage Act of 1988 affecting cost sharing were only in effect for calendar year 1989. Special provisions covered hospital stays that transitioned the effective dates.

[2]Beginning with 1994, Medicare enrollees in managed care plans are not included in the denominator used to calculate utilization rates and average payments.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. TDOC is total days of care. HI is hospital insurance.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 5.3

Enrollees, Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Demographic Characteristics, Medicare Status, and Discharge Status: Calendar Year 2004

Demographic Characteristics, Medicare Status, and Discharge Status	Discharge[1]		Total Days of Care			Program Payments			
	Number in Thousands	Rate Per 1,000 HI Enrollees[2]	Number in Thousands	Percent	Per Dis-charge	Amount in Millions	Percent	Per Discharge[3]	Per Day
Total	12,918	359	74,606	100.0	5.8	$102,648	100.0	$7,985	$1,376
Age									
Under 65 Years	2,272	376	13,869	18.6	6.1	17,199	16.8	7,669	1,240
65-69 Years	1,916	227	10,640	14.3	5.6	16,418	16.0	8,616	1,543
70-74 Years	1,969	284	10,810	14.5	5.5	16,849	16.4	8,591	1,559
75-79 Years	2,237	369	12,827	17.2	5.7	18,924	18.4	8,481	1,475
80-84 Years	2,134	467	12,452	16.7	5.8	16,791	16.4	7,884	1,348
85 Years or Over	2,390	602	14,007	18.8	5.9	16,467	16.0	6,904	1,176
Sex									
Male	5,623	353	32,584	43.7	5.8	47,950	46.7	8,577	1,472
Female	7,295	363	42,022	56.3	5.8	54,698	53.3	7,529	1,302
Race[4]									
White	10,644	349	59,977	80.4	5.6	83,369	81.2	7,862	1,390
Other	2,225	409	14,355	19.2	6.5	18,890	18.4	8,572	1,316
Medicare Status									
Aged[5]	10,595	353	60,436	81.0	5.7	85,034	82.8	8,051	1,407
Disabled[6]	2,323	385	14,171	19.0	6.1	17,614	17.2	7,681	1,243
Discharge Status									
Alive	12,423	N/A	70,356	94.3	5.7	95,549	93.1	7,729	1,358
Dead	495	N/A	4,250	5.7	8.6	7,100	6.9	14,398	1,671

[1]Excludes discharges for managed care enrollees that were paid by the managed care plan.

[2]Medicare enrollees in managed care plans are not included in the denominator used to calculate utilization rates.

[3]The average program payment per discharge does not reflect discharges with covered services, but for whom no program payments were reported.

[4]Excludes unknown race.

[5]Includes aged persons with end stage renal disease (ESRD).

[6]Includes disabled persons with ESRD and persons entitled to Medicare because of ESRD only.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. Numbers may not add to totals because of rounding. HI is hospital insurance. NA is not available.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 5.4

Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Area of Residence: Calendar Year 2004

	Discharges[1]		Total Days of Care			Program Payments		
Area of Residence	Number	Per 1,000 HI Enrollees[2]	Number	Per 1,000 HI Enrollees[2]	Per Discharge	Amount in Thousands	Per Discharge[3]	Per HI Enrollee[2]
All Areas[4]	12,918,130	359	74,606,025	2,072	5.8	$102,648,046	$7,985	$2,850
United States	12,777,235	364	73,613,095	2,096	5.8	102,127,159	8,031	2,907
Northeast	2,525,355	369	16,293,810	2,380	6.5	22,851,437	9,104	3,338
Midwest	3,263,720	370	17,639,970	1,999	5.4	24,894,288	7,653	2,820
South	5,272,900	386	30,215,245	2,209	5.7	38,932,181	7,415	2,847
West	1,715,260	297	9,464,070	1,637	5.5	15,449,252	9,071	2,672
New England	635,860	332	3,646,805	1,907	5.7	5,544,863	8,773	2,899
Connecticut	160,825	327	970,010	1,975	6.0	1,562,687	9,753	3,182
Maine	69,525	303	377,425	1,642	5.4	519,393	7,491	2,260
Massachusetts	292,405	365	1,639,375	2,047	5.6	2,499,118	8,613	3,120
New Hampshire	50,590	275	299,035	1,623	5.9	427,030	8,497	2,317
Rhode Island	39,575	352	238,485	2,121	6.0	330,633	8,430	2,940
Vermont	22,940	245	122,475	1,306	5.3	206,000	9,017	2,197
Middle Atlantic	1,889,495	383	12,647,005	2,563	6.7	17,306,573	9,216	3,508
New Jersey	425,120	383	2,872,895	2,588	6.8	3,781,225	8,964	3,406
New York	814,480	366	5,990,390	2,694	7.4	8,516,392	10,535	3,830
Pennsylvania	649,895	406	3,783,720	2,364	5.8	5,008,954	7,733	3,129
East North Central	2,329,365	379	12,762,850	2,079	5.5	18,123,287	7,808	2,952
Illinois	658,500	421	3,642,495	2,327	5.5	5,033,192	7,681	3,215
Indiana	299,750	345	1,656,465	1,906	5.5	2,201,635	7,372	2,533
Michigan	538,625	375	3,027,255	2,105	5.6	4,589,614	8,550	3,192
Ohio	588,385	392	3,202,915	2,135	5.4	4,424,596	7,537	2,949
Wisconsin	244,105	319	1,233,720	1,610	5.1	1,874,248	7,696	2,446

See footnotes at end of table.

Table 5.4—Continued

Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Area of Residence: Calendar Year 2004

Area of Residence	Discharges[1]		Total Days of Care			Program Payments		
	Number	Per 1,000 HI Enrollees[2]	Number	Per 1,000 HI Enrollees[2]	Per Discharge	Amount in Thousands	Per Discharge[3]	Per HI Enrollee[2]
West North Central	934,355	348	4,877,120	1,814	5.2	$6,771,000	$7,270	$2,519
Iowa	147,975	319	774,825	1,668	5.2	1,019,890	6,910	2,196
Kansas	133,805	350	698,360	1,825	5.2	923,554	6,918	2,414
Minnesota	204,355	349	962,525	1,642	4.7	1,559,739	7,672	2,661
Missouri	311,885	399	1,727,760	2,209	5.5	2,197,547	7,064	2,810
Nebraska	70,895	286	382,790	1,543	5.4	585,183	8,269	2,359
North Dakota	29,030	285	149,705	1,469	5.2	224,007	7,751	2,198
South Dakota	36,410	297	181,155	1,476	5.0	261,077	7,201	2,128
South Atlantic	2,708,670	370	15,655,295	2,138	5.8	20,942,320	7,762	2,861
Delaware	43,700	357	284,060	2,322	6.5	386,355	8,885	3,158
District of Columbia	26,855	405	186,330	2,810	6.9	278,192	10,540	4,196
Florida	896,990	369	5,229,455	2,149	5.8	6,621,477	7,406	2,721
Georgia	350,810	360	2,001,375	2,056	5.7	2,683,794	7,680	2,757
Maryland	263,495	403	1,395,980	2,136	5.3	2,544,854	9,715	3,895
North Carolina	433,235	366	2,486,065	2,103	5.7	3,390,257	7,853	2,867
South Carolina	228,200	367	1,415,935	2,276	6.2	1,734,806	7,630	2,789
Virginia	327,220	348	1,895,385	2,015	5.8	2,372,488	7,278	2,522
West Virginia	138,165	422	760,710	2,326	5.5	930,094	6,755	2,844
East South Central	1,066,680	413	5,999,275	2,325	5.6	7,171,119	6,744	2,779
Alabama	296,365	438	1,595,495	2,359	5.4	1,873,006	6,340	2,769
Kentucky	254,575	400	1,390,265	2,184	5.5	1,760,919	6,937	2,767
Mississippi	188,815	425	1,172,360	2,640	6.2	1,265,750	6,737	2,850
Tennessee	326,925	397	1,841,155	2,235	5.6	2,271,442	6,962	2,757
West South Central	1,497,550	397	8,560,675	2,269	5.7	10,818,741	7,265	2,867
Arkansas	176,575	386	999,670	2,183	5.7	1,164,326	6,621	2,543
Louisiana	248,245	448	1,487,825	2,684	6.0	1,709,306	6,924	3,084
Oklahoma	204,090	419	1,098,445	2,253	5.4	1,398,987	6,870	2,869
Texas	868,640	382	4,974,735	2,188	5.7	6,546,121	7,586	2,879

See footnotes at end of table.

Table 5.4—Continued

Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Area of Residence: Calendar Year 2004

Area of Residence	Discharges[1]		Total Days of Care			Program Payments		
	Number	Per 1,000 HI Enrollees[2]	Number	Per 1,000 HI Enrollees[2]	Per Discharge	Amount in Thousands	Per Discharge[3]	Per HI Enrollee[2]
Mountain	562,590	292	2,851,150	1,478	5.1	$4,399,135	$7,852	$2,280
Arizona	174,930	317	878,355	1,594	5.0	1,392,170	8,010	2,527
Colorado	111,410	306	552,550	1,518	5.0	868,403	7,819	2,385
Idaho	40,455	243	193,900	1,166	4.8	312,318	7,742	1,878
Montana	40,485	281	190,500	1,321	4.7	285,603	7,062	1,980
Nevada	61,390	302	372,475	1,830	6.1	516,335	8,460	2,537
New Mexico	56,860	267	294,515	1,385	5.2	429,103	7,575	2,018
Utah	57,745	263	267,315	1,219	4.6	441,953	7,668	2,016
Wyoming	19,315	283	101,540	1,487	5.3	153,246	7,944	2,245
Pacific	1,152,670	299	6,612,920	1,717	5.7	11,050,117	9,669	2,869
Alaska	13,005	264	81,020	1,646	6.2	143,482	11,232	2,914
California	842,015	316	5,044,420	1,891	6.0	8,349,174	10,016	3,129
Hawaii	27,460	234	186,110	1,584	6.8	238,505	8,761	2,030
Oregon	98,800	282	472,320	1,349	4.8	834,980	8,474	2,385
Washington	171,390	257	829,050	1,243	4.8	1,483,974	8,692	2,226
Outlying Areas[5]	140,895	160	992,930	1,127	7.0	520,887	3,743	591

[1]Excludes discharges for managed care enrollees that were paid by the managed care plan.

[2]Medicare enrollees in managed care plans are not included in the denominator used to calculate utilization rates and average payments.

[3]The average program payment per discharge does not reflect discharges with covered services, but for whom no program payments were reported.

[4]Includes 50 States and outlying areas.

[5]Includes Puerto Rico, Guam, Virgin Islands, residence unknown, and all other outlying areas not shown separately.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. Numbers may not add to totals because of rounding. HI is hospital insurance. Reliability of estimates - the statistics presented in this table are based on sample data and, therefore, may differ from the figures that would be obtained if a complete census of the data had been taken. The sampling error, which is primarily a measure of sampling variability that occurs by chance because only a sample rather than an entire universe is surveyed, would be relatively small for national estimates and table cells based on a large sample size. The sampling error, however, for table cell below the national level and based on a relatively small sample size could possibly reflect a large sampling error and should be utilized with caution when analyzing the data for utilization and trend purposes.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 5.5
Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Principal Diagnoses Within Major Diagnostic Classifications (MDCs): Calendar Year 2004

Principal ICD-9-CM[1] Diagnosis Within MDC	ICD-9-CM Code	Discharges[2] Number	Discharges[2] Per 1,000 HI Enrollees[3]	Total Days of Care Number	Total Days of Care Per Discharge	Program Payments Amount in Thousands	Program Payments Per Discharge[4]	Program Payments Per Day
Total All Diagnoses	---	12,918,130	359	74,606,025	5.8	$102,648,047	$7,985	$1,376
Leading Diagnoses[5]	---	7,119,665	198	41,254,070	5.8	60,022,959	8,465	1,455
Infectious and Parasitic Diseases (MDC 1)	001-139	392,370	11	3,156,210	8.0	3,825,947	9,803	1,212
Septicemia	038	264,650	7	2,296,865	8.7	2,911,955	11,061	1,268
Neoplasms (MDC 2)	140-239	654,730	18	4,684,780	7.2	7,302,714	11,187	1,559
Malignant Neoplasms	140-208,230-234	570,140	16	4,230,425	7.4	6,494,103	11,423	1,535
Malignant Neoplasm of Large Intestine and Rectum	153-154,197.5	84,700	2	824,645	9.7	1,327,816	15,711	1,610
Malignant Neoplasm of Trachea, Bronchus, and Lung	162,176.4,197.0, 197.3	91,810	3	717,560	7.8	1,127,490	12,314	1,571
Malignant Neoplasm of Breast	174-175,198.81	31,770	1	81,635	2.6	127,554	4,027	1,562
Benign Neoplasms	210-229	62,510	2	319,350	5.1	581,653	9,338	1,821
Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	559,710	16	2,931,415	5.2	3,101,806	5,575	1,058
Diabetes Mellitus	250	203,000	6	1,261,305	6.2	1,402,201	6,961	1,112
Volume Depletion	276.5	179,070	5	833,540	4.7	747,718	4,195	897
Diseases of Blood and Blood-Forming Organs (MDC 4)	280-289	158,850	4	754,255	4.7	864,434	5,559	1,146
Mental Disorders (MDC 5)	290-319	537,185	15	5,033,100	9.4	3,012,960	5,687	599
Psychoses	290-299	455,985	13	4,550,080	10.0	2,726,917	6,064	599
Alcohol Dependence Syndrome	303	19,250	1	111,660	5.8	56,532	2,985	506
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	201,445	6	1,260,540	6.3	1,302,045	6,494	1,033

See footnotes at end of table.

Table 5.5—Continued

Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Principal Diagnoses Within Major Diagnostic Classifications (MDCs): Calendar Year 2004

Principal ICD-9-CM[1] Diagnosis Within MDC	ICD-9-CM Code	Discharges[2] Number	Discharges[2] Per 1,000 HI Enrollees[3]	Total Days of Care Number	Total Days of Care Per Discharge	Program Payments Amount in Thousands	Program Payments Per Discharge[4]	Program Payments Per Day
Diseases of the Circulatory System (MDC 7)	390-459	3,519,965	98	17,844,590	5.1	$33,110,758	$9,439	$1,856
Heart Disease	391-392.0, 393-398,402,404, 410-416,420-429	2,466,295	68	12,318,465	5.0	24,787,667	10,083	2,012
Acute Myocardial Infarction	410	371,455	10	2,236,585	6.0	4,784,742	12,910	2,139
Coronary Atherosclerosis	414.0	610,250	17	2,321,390	3.8	7,471,206	12,288	3,218
Other Ischemic Heart Disease	411-413, 414.1-414.9	55,815	2	159,295	2.9	345,205	6,224	2,167
Cardiac Dysrhythmias	427	418,355	12	1,632,850	3.9	3,149,158	7,550	1,929
Congestive Heart Failure	428.0	668,600	19	3,691,435	5.5	4,847,787	7,273	1,313
Cerebrovascular Disease	430-438	573,265	16	2,803,015	4.9	3,822,629	6,689	1,364
Diseases of the Respiratory System (MDC 8)	460-519	1,536,070	43	9,889,220	6.4	11,258,284	7,355	1,138
Acute Bronchitis and Bronchocolitis	466	31,555	1	132,780	4.2	105,152	3,339	792
Pneumonia	480-486	639,275	18	4,034,025	6.3	4,057,480	6,366	1,006
Asthma	493	101,425	3	508,025	5.0	452,344	4,479	890
Diseases of the Digestive System (MDC 9)	520-579	1,295,965	36	7,395,860	5.7	9,186,671	7,123	1,242
Appendicitis	540-543	20,600	1	115,075	5.6	180,844	8,807	1,572
Non Infectious Enteritis and Colitis	555-558	101,145	3	591,595	5.8	696,672	6,929	1,178
Diverticula of Intestine	562	152,895	4	875,610	5.7	996,908	6,539	1,139
Cholelithiasis	574	117,630	3	635,955	5.4	980,203	8,360	1,541
Diseases of the Genitourinary System (MDC 10)	580-629	669,030	19	3,309,965	4.9	3,542,766	5,315	1,070
Calculus of Kidney and Ureter	592	35,715	1	111,615	3.1	175,146	4,927	1,569

See footnotes at end of table.

Table 5.5—Continued

Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Principal Diagnoses Within Major Diagnostic Classifications (MDCs): Calendar Year 2004

Principal ICD-9-CM[1] Diagnosis Within MDC	ICD-9-CM Code	Discharges[2] Number	Discharges[2] Per 1,000 HI Enrollees[3]	Total Days of Care Number	Total Days of Care Per Discharge	Program Payments Amount in Thousands	Program Payments Per Discharge[4]	Program Payments Per Day
Diseases of the Skin and Subcutaneous Tissue (MDC 12)	680-709	219,065	6	1,356,740	6.2	$1,167,019	$5,352	$860
Cellulitis and Abscess	681-682	165,435	5	920,755	5.6	759,046	4,606	824
Diseases of the Musculoskeletal System and Connective Tissue (MDC 13)	710-739	824,335	23	3,562,385	4.3	7,104,859	8,645	1,994
Osteoarthrosis and Allied Disorders	715	374,065	10	1,472,605	3.9	3,638,629	9,743	2,471
Intervertebral Disc Disorders	722	84,765	2	317,520	3.7	666,299	7,884	2,098
Congenital Anomalies (MDC 14)	740-759	11,125	(6)	55,585	5.0	163,248	14,780	2,937
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	833,665	23	2,679,245	3.2	3,198,048	3,866	1,194
Injury and Poisoning (MDC 17)	800-999	1,097,940	30	6,515,195	5.9	9,738,346	8,915	1,495
Fractures, All Sites	800-829	453,100	13	2,642,345	5.8	3,578,142	7,918	1,354
Fracture of Neck of Femur	820	229,485	6	1,464,575	6.4	2,126,932	9,280	1,452
Poisoning by Drugs, Medicinal and Biological Substances	960-989	47,895	1	171,460	3.6	204,718	4,310	1,194
Supplementary Classification of Factors Influencing Health Status and Contact with Health Services	V01-V82	390,860	11	4,124,590	10.6	4,724,393	12,131	1,145

[1]ICD-9-CM is *International Classification of Diseases, 9th Revision, Clinical Modification.* Although as many as 10 codes are reported on the HCFA Form-1450, only the principal diagnosis (first listed) has been used.

[2]Excludes discharges for managed care enrollees that were paid by the managed care plan.

[3]Medicare enrollees in managed care plans are not included in the denominator used to calculate the utilization rates.

[4]The average program payment per discharge does not reflect discharges with covered services, but for whom no program payments were reported.

[5]Specific diagnostic categories were selected for presentation because of frequency of occurrence or because of special interest. The leading classifications were developed by the National Center for Health Statistics.

[6]Less than 1 discharge per 1,000 enrollees.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. Numbers may not add to totals because of rounding. HI is hospital insurance.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 5.6

Number of Discharges with a Procedure, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Principal Procedure Within Major Procedure Classifications (MPCs): Calendar Year 2004

Principal ICD-9-CM Procedure[1] Within MPC	ICD-9-CM Code	Discharges[2] Number	Discharges[2] Per 1,000 HI Enrollees[3]	Total Days of Care Number	Total Days of Care Per Discharge	Program Payments Amount in Thousands	Program Payments Per Discharge[4]	Program Payments Per Day
Total All Procedures	---	7,438,640	207	49,080,680	6.6	$76,800,973	$10,372	$1,565
Leading Procedures[5]	---	3,626,665	101	21,083,910	5.8	35,045,873	9,703	1,662
Operations on the Nervous System (MPC 1	01-05	183,690	5	1,165,995	6.3	1,841,913	10,059	1,580
Spinal Tap	03.31	39,235	1	280,405	7.1	264,442	6,770	943
Operations on the Endocrine System (MPC 2	06-07	24,625	1	87,065	3.5	162,983	6,652	1,872
Operations on the Eye (MPC 3	08-16	11,660	(6)	49,405	4.2	78,971	6,820	1,598
Operations on the Ear (MPC 4)	18-20	2,975	(6)	15,765	5.3	22,536	7,575	1,430
Operations on the Nose, Mouth, and Pharynx (MPC 5)	21-29	32,770	1	158,150	4.8	215,828	6,656	1,365
Operations on the Respiratory System (MPC 6)	30-34	293,465	8	3,686,370	12.6	6,227,728	21,287	1,689
Bronchoscopy with or Without Biopsy	33.21-33.24,33.27	70,955	2	673,215	9.5	684,339	9,675	1,017
Operations on the Cardiovascular System (MPC 7)	35-39	1,989,260	55	11,662,755	5.9	25,465,628	12,865	2,184
Removal of Coronary Artery Obstruction	36.0	381,280	11	1,144,545	3.0	5,018,760	13,194	4,385
Coronary Artery Bypass Graft	36.1	129,870	4	1,261,160	9.7	3,547,099	27,383	2,813
Cardiac Catheterization	37.21-37.23	304,995	8	1,263,440	4.1	2,032,971	6,692	1,609
Insertion, Replacement, Removal, and Revision of Pacemaker Leads or Device	37.7-37.8	153,635	4	765,715	5.0	1,976,571	12,891	2,581
Hemodialysis	39.95	202,365	6	1,082,590	5.3	1,222,720	6,126	1,129
Operations on the Hemic and Lymphatic System (MPC 8)	40-41	45,510	1	410,055	9.0	586,313	12,944	1,430

See footnotes at end of table.

Table 5.6—Continued

Number of Discharges with a Procedure, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Principal Procedure Within Major Procedure Classifications (MPCs): Calendar Year 2004

		Discharges[2]		Total Days of Care		Program Payments		
Principal ICD-9-CM Procedure[1] Within MPC	ICD-9-CM Code	Number	Per 1,000 HI Enrollees[3]	Number	Per Discharge	Amount in Thousands	Per Discharge[4]	Per Day
Operations on the Digestive System (MPC 9)	42-54	1,322,945	37	9,868,590	7.5	$11,900,910	$9,029	$1,206
Endoscopy of Small Intestine with or Without Biopsy	45.11-45.14,45.16	370,390	10	2,200,395	5.9	1,874,789	5,083	852
Endoscopy of Large Intestine with or Without Biopsy	45.21-45.25	144,985	4	872,855	6.0	731,750	5,067	838
Partial Excision of Large Intestine	45.7	111,605	3	1,233,695	11.1	1,984,561	17,816	1,609
Appendectomy, Excluding Incidental	47.0	18,785	1	96,480	5.1	154,196	8,233	1,598
Cholecystectomy	51.2	124,380	3	782,655	6.3	1,219,633	9,831	1,558
Lysis of Peritoneal Adhesions	54.5	29,740	1	321,050	10.8	450,493	15,189	1,403
Operations on the Urinary System (MPC 10)	55-59	200,700	6	1,228,395	6.1	1,749,349	8,752	1,424
Cystoscopy with or Without Biopsy	57.31-57.33	18,805	1	140,290	7.5	119,762	6,392	854
Operations on the Male Genital Organs (MPC 11)[7]	60-64	100,640	6	360,505	3.6	512,546	5,107	1,422
Prostatectomy	60.2-60.6	88,185	6	294,290	3.3	400,467	4,554	1,361
Operations on the Female Genital Organs (MPC 12)[8]	65-71	110,950	6	405,185	3.7	614,017	5,547	1,515
Unilateral Oophorectomy	65.3-65.6	11,195	1	54,305	4.9	77,743	6,966	1,432
Hysterectomy	68.3-68.7,68.9	56,990	3	210,930	3.7	323,384	5,684	1,533
Obstetrical Procedures (MPC 13)	72-75	11,190	1	35,070	3.1	29,841	2,687	851
Forceps, Vacuum, and Breech Delivery	72.1,72.21,72.31, 72.71,73.6	620	(6)	1,435	2.3	870	1,403	606
Cesarean Section and Removal of Fetus	74.0-74.2, 74.4-74.99	4,740	(6)	19,015	4.0	18,280	3,906	961
Repair of Current Obstetric Laceration	75.5-75.6	1,100	(6)	2,800	2.5	1,837	1,678	656
Operations on the Musculoskeletal System (MPC 14)	76-84	1,125,205	31	6,203,160	5.5	11,342,590	10,105	1,829
Partial Excision of Bone	76.2-76.3,77.6-77.8	14,020	(6)	126,760	9.0	178,689	12,832	1,410
Reduction of Facial Fracture	76.7,79.0-79.3	204,110	6	1,217,205	6.0	1,709,867	8,394	1,405
Open Reduction of Fracture with Internal Fixation	79.3	154,365	4	929,685	6.0	1,324,015	8,594	1,424
Excision or Destruction of Intervertebral Disc	80.5	33,980	1	100,600	3.0	202,502	5,974	2,013
Total Hip Replacement	81.51	118,660	3	507,035	4.3	1,203,303	10,159	2,373
Total Knee Replacement	81.54	250,585	7	987,850	3.9	2,518,209	10,063	2,549

See footnotes at end of table.

Table 5.6—Continued

Number of Discharges with a Procedure, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Principal Procedure Within Major Procedure Classifications (MPCs): Calendar Year 2004

		Discharges[2]		Total Days of Care		Program Payments		
Principal ICD-9-CM Procedure[1] Within MPC	ICD-9-CM Code	Number	Per 1,000 HI Enrollees[3]	Number	Per Discharge	Amount in Thousands	Per Discharge[4]	Per Day
Operations on the Integumentary System (MPC 15)	85-86	283,880	8	2,262,405	8.0	$2,563,535	$9,089	$1,133
Excision of Destruction of Lesion or Tissue of Skin and Subcutaneous Tissue	86.22-86.28	99,260	3	1,061,745	10.7	1,343,990	13,622	1,266
Miscellaneous Diagnostic and Therapeutic Procedures (MPC 16)	87-99	1,652,110	46	11,221,660	6.8	12,348,688	7,523	1,100
Computerized Axial Tomography	87.03,87.41,87.71, 88.01,88.38	112,120	3	573,375	5.1	622,975	5,585	1,087
Arteriography and Angiocardiography Using Contrast Material	88.4-88.5	54,915	2	278,400	5.1	313,871	5,747	1,127
Diagnostic Ultrasound	88.7	141,515	4	773,525	5.5	800,199	5,677	1,034
Respiratory Therapy	93.9,96.7	243,990	7	2,125,605	8.7	3,175,601	13,111	1,494
Nonoperative Intubation of Gastrointestinal and Respiratory Tracts Insertion of Endotracheal Tube	96.04	49,700	1	389,500	7.8	514,336	10,394	1,321
Injection of Infusion of Cancer Chemotherapeutic Substance	99.25	39,575	1	240,020	6.1	356,876	9,073	1,487

[1]ICD-9-CM is *International Classification of Diseases, 9th Revision, Clinical Modification.* Includes surgical and non-surgical procedures. Includes invalid codes not shown separately.
[2]Excludes discharges for managed care enrollees that were paid by the managed care plan.
[3]Medicare enrollees in managed care plans are not included in the denominator used to calculate utilization rates.
[4]The average program payment per discharge does not reflect discharges with covered services, but for whom no program payments were reported.
[5]Specific leading procedure categories were selected for presentation because of frequency of occurrences or because of special interest. The leading classifications were developed by the National Center for Health Statistics.
[6]Less than 1 discharge per 1,000 enrollees.
[7]Only the male enrollment population used to calculate discharges per 1,000 HI enrollees.
[8]Only the female enrollment population used to calculate discharges per 1,000 HI enrollees.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. Numbers may not add to totals because of rounding. HI is hospital insurance.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 5.7

Discharges, Total Days of Care, and Average Charge per Discharge for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Leading Diagnosis-Related Groups (DRGs) for 2004 Calendar Years 1984, 1990, and 2004

Leading DRG Code Number in 2004	Description	Discharges: Number 1984	Discharges: Number 1990	Discharges: Number 2004	Percent Change 1984-1990	Percent Change 1990-2004	Percent Change 1984-2004
Total All DRGs	-----	10,894,925	10,521,925	12,918,130	-3.4	22.8	18.6
Leading DRGs[1]	-----	5,886,235	6,236,770	9,252,565	6.0	48.4	57.2
012	Degenerative Nervous System Disorders	56,410	25,915	84,980	-54.1	227.9	50.6
014	Intracranial Hemorrhage and Stroke with Infarct	318,405	336,080	251,875	5.6	-25.1	-20.9
015	CVA and Precerebral Occlusion without Infarct	175,530	135,850	63,330	-22.6	-53.4	-63.9
024	Seizure & Headache Age >17 with CC	55,510	53,255	64,790	-4.1	21.7	16.7
075[2]	Major Chest Procedures	28,675	31,690	47,100	10.5	48.6	64.3
076[2]	Other Respiratory System O.R. Procedures with CC	10,055	38,855	47,635	286.4	22.6	373.7
078	Pulmonary Embolism	29,405	26,050	47,275	-11.4	81.5	60.8
079	Respiratory Infections & Inflammations Age >17 with CC	51,635	129,780	163,360	151.3	25.9	216.4
082	Respiratory Neoplasms	120,990	72,840	66,150	-39.8	-9.2	-45.3
087	Pulmonary Edema & Respiratory Failure	94,770	67,520	83,370	-28.8	23.5	-12.0
088	Chronic Obstructive Pulmonary Disease	212,480	144,825	395,860	-31.8	173.3	86.3
089	Simple Pneumonia & Pleurisy Age >17 with CC	314,980	391,725	516,265	24.4	31.8	63.9
096	Bronchitis & Asthma Age >17 with CC	178,075	189,710	52,830	6.5	-72.2	-70.3
107[2,4]	Coronary Bypass Without Cardiac Cath	38,285	46,765	-----	22.1	-----	-----
107[2,4]	Coronary Bypass With Cardiac Cath	-----	-----	71,575	-----	-----	-----
109[2,4]	Coronary Bypass Without Cardiac Cath	-----	-----	51,580	-----	-----	-----
110[2]	Major Cardiovascular Procedures with CC	56,230	75,660	58,410	34.6	-22.8	3.9
116[2]	Other Perm Cardiac Pacemaker Implant	53,905	62,050	118,415	15.1	90.8	119.7
121	Circulatory Disorders with AMI & Major Comp Disch Alive	102,930	137,625	154,070	33.7	11.9	49.7
122	Circulatory Disorders with AMI & Without Major Comp Disch Alive	158,400	102,935	60,670	-35.0	-41.1	-61.7
124	Circulatory Disorders Except AMI, with Card Cath and Complex Diagnosis	31,120	113,890	131,235	266.0	15.2	321.7
125	Circulatory Disorders Except AMI, with Card Cath Without Complex Diagnosis	64,085	93,045	97,885	45.2	5.2	52.7
127	Heart Failure & Shock	515,865	586,335	692,075	13.7	18.0	34.2
130	Peripheral Vascular Disorders with CC	91,655	68,330	89,085	-25.4	30.4	-2.8
132	Atherosclerosis with CC	100,810	18,250	116,280	-81.9	537.2	15.3

See footnotes at end of table.

Table 5.7—Continued

Discharges, Total Days of Care, and Average Charge per Discharge for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Leading Diagnosis-Related Groups (DRGs) for 2004 Calendar Years 1984, 1990, and 2004

Average Total Days of Care per Discharge						Average Charge Per Discharge					
Number of Days			Percent Change	Percent Change	Percent Change	Amount			Percent Change	Percent Change	Percent Change
1984	1990	2004	1984-1990	1990-2004	1984-2004	1984	1990	2004	1984-1990	1990-2004	1984-2004
8.8	8.8	5.8	0.0	-34.1	-34.1	$4,855	$9,765	$26,280	101.1	169.1	441.3
9.5	9.3	5.7	-2.1	-38.7	-40.0	5,080	9,522	24,136	87.4	153.5	375.1
13.0	13.0	7.8	0.0	-40.0	-40.0	5,239	9,022	17,150	72.2	90.1	227.4
12.4	10.5	5.6	-15.3	-46.7	-54.8	5,591	8,971	22,045	60.5	145.7	294.3
6.1	5.5	4.5	-9.8	-18.2	-26.2	2,603	4,609	16,242	77.1	252.4	524.0
6.9	7.7	4.7	11.6	-39.0	-31.9	3,422	7,389	18,431	115.9	149.4	438.6
16.3	14.1	9.7	-13.5	-31.2	-40.5	13,500	22,075	55,424	63.5	151.1	310.5
15.4	15.0	10.7	-2.6	-28.7	-30.5	12,061	17,221	50,101	42.8	190.9	315.4
11.5	10.3	6.2	-10.4	-39.8	-46.1	6,154	9,876	21,407	60.5	116.8	247.9
12.8	12.2	8.1	-4.7	-33.6	-36.7	8,385	12,281	27,592	46.5	124.7	229.1
9.7	9.6	6.7	-1.0	-30.2	-30.9	4,860	8,785	24,724	80.8	181.4	408.7
10.0	8.3	6.4	-17.0	-22.9	-36.0	7,731	9,294	23,555	20.2	153.4	204.7
8.6	7.4	4.9	-14.0	-33.8	-43.0	4,709	6,932	15,445	47.2	122.8	228.0
9.4	8.9	5.6	-5.3	-37.1	-40.4	4,863	7,889	18,076	62.2	129.1	271.7
7.2	7.3	4.4	1.4	-39.7	-38.9	3,501	6,361	13,185	81.7	107.3	276.6
14.5	12.3	-----	-15.2	-----	-----	21,949	33,394	-----	52.1	-----	-----
-----	-----	10.4	-----	-----	-----	-----	-----	94,671	-----	-----	-----
-----	-----	7.7	-----	-----	-----	-----	-----	70,696	-----	-----	-----
16.3	15.3	8.3	-6.1	-45.8	-49.1	15,072	27,264	70,497	80.9	158.6	367.7
9.2	7.5	4.2	-18.5	-44.0	-54.3	12,002	17,112	40,842	42.6	138.7	240.3
12.2	10.0	6.2	-18.0	-38.0	-49.2	7,341	11,335	27,587	54.4	143.4	275.8
10.3	7.1	3.4	-31.1	-52.1	-67.0	5,422	7,970	16,654	47.0	109.0	207.2
7.0	5.9	4.4	-15.7	-25.4	-37.1	5,703	8,719	26,000	52.9	198.2	355.9
3.7	3.2	2.7	-13.5	-15.6	-27.0	3,220	5,370	19,479	66.8	262.7	504.9
8.7	7.9	5.1	-9.2	-35.4	-41.4	4,264	7,207	18,316	69.0	154.1	329.5
8.1	8.3	5.5	2.5	-33.7	-32.1	3,523	6,627	17,071	88.1	157.6	384.6
7.0	6.1	2.8	-12.9	-54.1	-60.0	3323	6229	11,146	87.5	78.9	235.4

Table 5.7—Continued

Discharges, Total Days of Care, and Average Charge per Discharge for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Leading Diagnosis-Related Groups (DRGs) for 2004 Calendar Years 1984, 1990, and 2004

Leading DRG Code Number in 2004	Description	Discharges: Number 1984	Discharges: Number 1990	Discharges: Number 2004	Percent Change 1984-1990	Percent Change 1990-2004	Percent Change 1984-2004
134	Hypertension	70,165	29,675	43,560	-57.7	46.8	-37.9
138	Cardiac Arrhythmia & Conduction Disorders with CC	212,265	180,470	207,185	-15.0	14.8	-2.4
139	Cardiac Arrhythmia & Conduction Disorders Without CC	28,345	73,020	77,945	157.6	6.7	175.0
141	Syncope & Collapse with CC	86,675	77,205	123,040	-10.9	59.4	42.0
142	Syncope & Collapse Without CC	11,315	39,370	52,050	247.9	32.2	360.0
143	Chest Pain	75,690	112,905	251,430	49.2	122.7	232.2
144	Other Circulatory System Diagnoses with CC	40,825	54,995	103,285	34.7	87.8	153.0
148 [2]	Major Small & Large Bowel Procedures with CC	106,455	140,245	136,465	31.7	-2.7	28.2
174	GI Hemorrhage with CC	144,620	157,895	271,270	9.2	71.8	87.6
180	GI Obstruction with CC	65,930	66,485	94,585	0.8	42.3	43.5
182	Esophagitis, Gastroent & Misc Digest Disorders Age >17 with CC	372,580	254,750	298,770	-31.6	17.3	-19.8
183	Esophagitis, Gastroent & Misc Digest Disorders Age >17 Without CC	72,525	81,770	87,155	12.7	6.6	20.2
188	Other Digestive System Diagnoses Age >17 with CC	54,075	50,110	94,345	-7.3	88.3	74.5
204	Disorders of Pancreas Except Malignancy	31,890	37,715	73,720	18.3	95.5	131.2
209 [2]	Major Joint & Limb Reattachment Procedures of Lower Extremity	149,660	257,780	475,975	72.2	84.6	218.0
210 [2]	Hip & Femur Procedures Except Major Joint Age >17 with CC	120,100	112,470	129,465	-6.4	15.1	7.8
236	Fractures of Hip & Pelvis	47,350	41,255	44,650	-12.9	8.2	-5.7
243	Medical Back Problems	200,190	112,455	105,335	-43.8	-6.3	-47.4
277	Cellulitis Age >17 with CC	58,155	66,830	113,475	14.9	69.8	95.1
294	Diabetes Age >35	141,500	92,520	100,360	-34.6	8.5	-29.1
296	Nutritional & Misc Metabolic Disorders Age >17 with CC	176,150	206,595	253,510	17.3	22.7	43.9
297	Nutritional & Misc Metabolic Disorders Age >17 without CC	13,910	47,395	44,830	240.7	-5.4	222.3
316	Renal Failure	46,410	48,670	186,170	4.9	282.5	301.1
320	Kidney & Urinary Tract Infections Age>17 with CC	137,845	157,780	222,825	14.5	41.2	61.6

See footnotes at end of table.

Table 5.7—Continued

Discharges, Total Days of Care, and Average Charge per Discharge for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Leading Diagnosis-Related Groups (DRGs) for 2004 Calendar Years 1984, 1990, and 2004

Average Total Days of Care per Discharge						Average Charge Per Discharge					
Number of Days			Percent Change	Percent Change	Percent Change	Amount			Percent Change	Percent Change	Percent Change
1984	1990	2004	1984-1990	1990-2004	1984-2004	1984	1990	2004	1984-1990	1990-2004	1984-2004
6.7	5.2	3.1	-22.4	-40.4	-53.7	$2,684	$4,011	$10,955	49.4	173.1	308.2
6.3	6.0	3.9	-4.8	-35.0	-38.1	3,376	5,848	14,802	73.2	153.1	338.4
4.9	3.9	2.4	-20.4	-38.5	-51.0	2,685	3,624	9,359	35.0	158.3	248.6
5.8	5.7	3.5	-1.7	-38.6	-39.7	2,672	4,987	13,676	86.6	174.2	411.8
4.5	4.0	2.5	-11.1	-37.5	-44.4	2,207	3,554	10,811	61.0	204.2	389.9
4.4	3.4	2.1	-22.7	-38.2	-52.3	2,427	3,577	10,287	47.4	187.6	323.9
8.3	7.3	5.8	-12.0	-20.5	-30.1	4,765	7,867	23,799	65.1	202.5	399.5
17.7	16.6	12.1	-6.2	-27.1	-31.6	12,686	23,471	60,002	85.0	155.6	373.0
7.4	7.0	4.7	-5.4	-32.9	-36.5	3,860	6,944	18,125	79.9	161.0	369.6
7.4	7.8	5.3	5.4	-32.1	-28.4	3,281	6,632	17,309	102.1	161.0	427.6
6.1	6.4	4.4	4.9	-31.3	-27.9	2,526	5,374	14,911	112.7	177.5	490.3
5.0	4.9	2.9	-2.0	-40.8	-42.0	2,103	3,630	10,416	72.6	186.9	395.3
6.4	7.5	5.6	17.2	-25.3	-12.5	3,100	7,392	20,499	138.5	177.3	561.3
8.1	8.1	5.5	0.0	-32.1	-32.1	4,050	8,099	20,004	100.0	147.0	393.9
15.6	11.1	4.5	-28.8	-59.5	-71.2	10,205	16,542	34,668	62.1	109.6	239.7
16.8	13.9	6.7	-17.3	-51.8	-60.1	8,600	14,236	32,219	65.5	126.3	274.6
12.7	10.0	4.9	-21.3	-51.0	-61.4	4,573	6,530	13,084	42.8	100.4	186.1
8.0	6.9	4.6	-13.8	-33.3	-42.5	2,858	4,657	13,803	62.9	196.4	383.0
9.1	8.6	5.4	-5.5	-37.2	-40.7	3,740	6,570	15,558	75.7	136.8	316.0
8.4	7.5	4.2	-10.7	-44.0	-50.0	3,267	5,491	13,820	68.1	151.7	323.0
8.4	8.5	4.7	1.2	-44.7	-44.0	3,556	6,840	14,591	92.4	113.3	310.3
6.9	5.3	3.1	-23.2	-41.5	-55.1	3,032	3,724	8,943	22.8	140.1	195.0
9.6	9.4	6.2	-2.1	-34.0	-35.4	5,572	9,555	22,780	71.5	138.4	308.8
8.2	8.6	5.1	4.9	-40.7	-37.8	3,581	7,174	15,482	100.3	115.8	332.3

Table 5.7—Continued

Discharges, Total Days of Care, and Average Charge per Discharge for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Leading Diagnosis-Related Groups (DRGs) for 2004 Calendar Years 1984, 1990, and 2004

Leading DRG Code Number in 2004	Description	Discharges					
		Number			Percent Change	Percent Change	Percent Change
		1984	1990	2004	1984-1990	1990-2004	1984-2004
331	Other Kidney & Urinary Tract Diagnoses Age>17 with CC	38,080	28,380	55,625	-25.5	96.0	46.1
395	Red Blood Cell Disorders Age >17	93,510	72,730	117,730	-22.2	61.9	25.9
415 [2]	OR Procedure for Infectious & Parasitic Diseases	16,165	27,735	51,850	71.6	86.9	220.8
416	Septicemia Age >17	66,180	128,085	251,915	93.5	96.7	280.7
429	Organic Disturbances & Mental Retardation	52,710	49,305	60,750	-6.5	23.2	15.3
430	Psychoses	118,455	195,595	349,555	65.1	78.7	195.1
462	Rehabilitation	9,490	106,680	312,185	1,024.1	192.6	3,189.6
468 [2]	Extensive OR Procedure Unrelated to Principal Diagnosis	166,815	75,885	52,615	-54.5	-30.7	-68.5
475	Respiratory System Diagnosis with Ventilator Support	-----	78,805	112,255	-----	42.4	-----
478 [2]	Other Vascular Procedures with CC	-----	24,230	115,855	-----	378.1	-----
493	Laparoscopic Cholecystectomy Without CDE with CC	-----	-----	62,650	-----	-----	-----
500 [2]	Back and Neck Procedures Except Spinal Fusion Without CC	-----	-----	48,870	-----	-----	-----
517 [2]	Percutaneous Cardiovascular Procedures with Non-Drug Eluting Stent without AMI	-----	-----	48,915	-----	-----	-----
524	Transient Ischemia	-----	-----	117,960	-----	-----	-----
526 [2]	Percutaneous Cardiovascular Procedures with Drug-Eluting Stent with AMI	-----	-----	66,110	-----	-----	-----
527 [2]	Percutaneous Cardiovascular Procedures with Drug-Eluting Stent without AMI	-----	-----	216,950	-----	-----	-----
533 [2]	Extracranial Procedures with CC	-----	-----	48,230	-----	-----	-----
534 [2]	Extracranial Procedures without CC	-----	-----	45,045	-----	-----	-----
All Other DRGs	-----	5,008,690	4,285,155	3,665,565	-14.4	-14.5	-26.8

[1]Based on frequency of occurrence in 2004.
[2]Represents surgical DRGs.
[3]Prior to 1999, DRG code 107 was defined as coronary bypass without cardiac cath.
[4]In 1999, the DRG code 107 was revised and defined as coronary bypass with cardiac cath. In addition, DRG code 109 was introduced and defined as coronary bypass without cardiac cath.

NOTES: Composition of some DRGs have changed over time. For complete DRG description, refer to *Diagnosis Related Groups, Version 3.0* (1984), *Version 7.0* and *8.0* (1990), *Versions 21.0* and *22.0* (2004), *Definitions Manual.* The most recent description is used in this table. TIA is transient ischemic attack. CC is complications and/or comorbidities. Cath is catheterization, AMI is acute myocardial infarction. CV is cardiovascular. Card is cardiac. G.I. is gastrointestinal. O.R. is operating room. CDE is common duct exploration. Conn is connective. Tiss is tissue. Resp is respiratory. Proc is procedure. PTCA is percutaneous transluminal coronary angioplasty. Perm is permanent. Comp is complications. Circ is circulatory. PDX is primary diagnosis. CVA is cerebrovascular accident.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 5.7—Continued

Discharges, Total Days of Care, and Average Charge per Discharge for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Leading Diagnosis-Related Groups (DRGs) for 2004 Calendar Years 1984, 1990, and 2004

Average Total Days of Care per Discharge						Average Charge Per Discharge					
Number of Days			Percent Change	Percent Change	Percent Change	Amount			Percent Change	Percent Change	Percent Change
1984	1990	20004	1984-1990	1990-2004	1984-2004	1984	1990	2004	1984-1990	1990-2004	1984-2004
7.3	7.6	5.4	4.1	-28.9	-26.0	$3,456	$7,338	$19,370	112.3	164.0	460.5
6.6	6.5	4.3	-1.5	-33.8	-34.8	3,000	5,639	15,263	88.0	170.7	408.8
19.9	21.2	13.9	6.5	-34.4	-30.2	14,476	27,339	68,798	88.9	151.6	375.3
11.4	10.7	7.4	-6.1	-30.8	-35.1	6,811	10,981	30,661	61.2	179.2	350.2
11.3	14.5	9.3	28.3	-35.9	-17.7	3,717	8,417	16,713	126.4	98.6	349.6
16.1	16.9	10.7	5.0	-36.7	-33.5	5,069	9,359	17,545	84.6	87.5	246.1
22.5	21.2	11.7	-5.8	-44.8	-48.0	9,151	15,745	24,148	72.1	53.4	163.9
16.6	19.3	12.8	16.3	-33.7	-22.9	10,595	24,871	68,641	134.7	176.0	547.9
-----	14.3	11.0	-----	-23.1	-----	-----	25,548	65,212	-----	155.3	-----
-----	10.4	7.0	-----	-32.7	-----	-----	16,682	43,826	-----	162.7	-----
-----	-----	6.0	-----	-----	-----	-----	-----	31,897	-----	-----	-----
-----	-----	2.2	-----	-----	-----	-----	-----	16,363	-----	-----	-----
-----	-----	2.5	-----	-----	-----	-----	-----	35,695	-----	-----	-----
-----	-----	3.2	-----	-----	-----	-----	-----	13,096	-----	-----	-----
-----	-----	4.3	-----	-----	-----	-----	-----	53,024	-----	-----	-----
-----	-----	2.2	-----	-----	-----	-----	-----	41,794	-----	-----	-----
-----	-----	3.6	-----	-----	-----	-----	-----	27,427	-----	-----	-----
-----	-----	1.8	-----	-----	-----	-----	-----	17,782	-----	-----	-----
8.0	8.2	5.9	2.5	-28.0	-26.3	4,590	10,120	31,692	120.5	213.2	590.5

Table 5.8

Number of Discharges and Total Charges for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Total Days of Care and Type of Service: Calendar Year 2004

Total Days of Care	All Services	Type of Accommodation: Routine Room and Board	Type of Accommodation: Intensive/ Coronary Care	Type of Ancillary Service: Total Ancillary	Type of Ancillary Service: Operating Room	Type of Ancillary Service: Pharmacy
			Number of Discharges			
Total	12,918,130	10,673,240	4,117,140	12,871,585	4,386,890	12,798,245
1-8 Days	10,594,800	8,621,725	3,099,770	10,557,565	3,270,020	10,497,420
9-20 Days	1,954,070	1,724,145	812,315	1,947,140	885,550	1,937,565
21-30 Days	243,550	216,920	125,760	242,260	142,415	240,330
31-40 Days	69,610	61,185	41,890	69,120	47,250	68,375
41-50 Days	27,130	23,965	17,370	26,915	19,770	26,530
51-60 Days	12,035	10,450	8,225	11,880	9,050	11,685
61-90 Days	12,155	10,645	8,520	12,010	9,260	11,725
91 Days or More	4,780	4,205	3,290	4,695	3,575	4,615
			Percent of Total Discharges [3]			
Total	100.0	82.6	31.9	99.6	34.0	99.1
1-8 Days	100.0	81.4	29.3	99.6	30.9	99.1
9-20 Days	100.0	88.2	41.6	99.6	45.3	99.2
21-30 Days	100.0	89.1	51.6	99.5	58.5	98.7
31-40 Days	100.0	87.9	60.2	99.3	67.9	98.2
41-50 Days	100.0	88.3	64.0	99.2	72.9	97.8
51-60 Days	100.0	86.8	68.3	98.7	75.2	97.1
61-90 Days	100.0	87.6	70.1	98.8	76.2	96.5
91 Days or More	100.0	88.0	68.8	98.2	74.8	96.5
			Total Charges in Thousands			
Total	$341,749,346	$58,132,232	$37,345,469	$246,274,905	$26,659,288	$50,525,094
1-8 Days	192,532,143	29,079,605	15,628,998	147,826,105	18,309,979	23,317,285
9-20 Days	95,166,183	19,340,657	12,182,824	63,643,276	5,995,302	15,974,385
21-30 Days	25,274,048	4,899,840	3,864,331	16,509,953	1,244,271	5,078,161
31-40 Days	11,420,970	1,961,179	2,011,007	7,448,806	498,697	2,429,081
41-50 Days	5,973,699	985,645	1,156,620	3,831,442	247,509	1,302,421
51-60 Days	3,445,636	533,680	702,299	2,209,661	132,191	765,763
61-90 Days	4,707,963	757,507	1,046,045	2,904,414	152,295	1,004,583
91 Days or More	3,228,701	574,116	753,340	1,901,246	79,040	653,412

See footnotes at end of table.

Table 5.8—Continued

Number of Discharges and Total Charges for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Total Days of Care and Type of Service: Calendar Year 2004

Type of Ancillary Service					
Laboratory	Radiology[1]	Supplies	Cardiology	Inhalation Therapy	Other[2]
Number of Discharges					
12,708,665	11,078,695	11,245,365	9,453,110	6,246,740	11,635,510
10,408,220	8,998,750	9,183,475	7,656,930	4,793,670	9,418,735
1,935,530	1,744,455	1,735,565	1,498,480	1,197,340	1,863,180
240,925	219,605	215,250	191,305	162,690	233,570
68,795	64,130	62,110	57,940	50,305	66,665
26,770	25,085	23,945	23,285	20,190	25,905
11,815	11,100	10,445	10,470	9,350	11,480
11,935	11,205	10,515	10,560	9,495	11,495
4,675	4,365	4,060	4,140	3,700	4,480
Percent of Total Discharges[3]					
98.4	85.8	87.1	73.2	48.4	90.1
98.2	84.9	86.7	72.3	45.2	88.9
99.1	89.3	88.8	76.7	61.3	95.3
98.9	90.2	88.4	78.5	66.8	95.9
98.8	92.1	89.2	83.2	72.3	95.8
98.7	92.5	88.3	85.8	74.4	95.5
98.2	92.2	86.8	87.0	77.7	95.4
98.2	92.2	86.5	86.9	78.1	94.6
97.8	91.3	84.9	86.6	77.4	93.7
Total Charges in Thousands					
$37,480,187	$24,485,273	$47,830,612	$19,301,880	$11,593,276	$28,399,291
21,186,703	15,593,264	33,898,741	15,081,436	4,095,186	16,343,508
10,607,477	6,240,538	9,699,267	3,308,086	3,895,814	7,922,403
2,713,581	1,376,951	2,094,488	530,405	1,397,962	2,074,130
1,237,610	571,358	886,648	185,851	771,538	868,020
624,303	277,004	436,683	81,172	438,653	423,692
354,828	146,763	249,799	42,498	273,510	244,306
461,193	180,429	337,146	47,863	408,743	312,158
294,489	98,964	227,836	24,566	311,866	211,070

Table 5.8—Continued

Number of Discharges and Total Charges for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Total Days of Care and Type of Service: Calendar Year 2004

Total Days of Care	All Services	Type of Accommodation: Routine Room and Board	Type of Accommodation: Intensive/Coronary Care	Type of Ancillary Service: Total Ancillary	Type of Ancillary Service: Operating Room	Type of Ancillary Service: Pharmacy
			Percent of Total Charges [4]			
Total	100.0	17.0	10.9	72.1	7.8	14.8
1-8 Days	100.0	15.1	8.1	76.8	9.5	12.1
9-20 Days	100.0	20.3	12.8	66.9	6.3	16.8
21-30 Days	100.0	19.4	15.3	65.3	4.9	20.1
31-40 Days	100.0	17.2	17.6	65.2	4.4	21.3
41-50 Days	100.0	16.5	19.4	64.1	4.1	21.8
51-60 Days	100.0	15.5	20.4	64.1	3.8	22.2
61-90 Days	100.0	16.1	22.2	61.7	3.2	21.3
91 Days or More	100.0	17.8	23.3	58.9	2.4	20.2
			Average Total Charge Per Discharge			
Total	$26,455	$5,447	$9,071	$19,133	$6,077	$3,948
1-8 Days	18,172	3,373	5,042	14,002	5,599	2,221
9-20 Days	48,702	11,218	14,998	32,686	6,770	8,245
21-30 Days	103,774	22,588	30,728	68,150	8,737	21,130
31-40 Days	164,071	32,053	48,007	107,766	10,554	35,526
41-50 Days	220,188	41,129	66,587	142,353	12,519	49,092
51-60 Days	286,301	51,070	85,386	185,998	14,607	65,534
61-90 Days	387,327	71,161	122,775	241,833	16,447	85,679
91 Days or More	675,461	136,532	228,979	404,951	22,109	141,584

[1]Includes magnetic resonance imaging.

[2]Includes services such as physical therapy, occupational therapy, blood administration, anesthesia, ambulance, emergency room, clinic visits, etc.

[3]Does not sum to total because one person may have many services.

[4]The total for all services is equal to the sum of routine room and board, intensive or coronary care, and total ancillary services. Total ancillary services is equal to the sum of each type of ancillary service.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 5.8—Continued

Number of Discharges and Total Charges for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Total Days of Care and Type of Service: Calendar Year 2004

Type of Ancillary Service					
Laboratory	Radiology [1]	Supplies	Cardiology	Inhalation Therapy	Other[2]
Percent of Total Charges [4]					
11.0	7.2	14.0	5.6	3.4	8.3
11.0	8.1	17.6	7.8	2.1	8.5
11.1	6.6	10.2	3.5	4.1	8.3
10.7	5.4	8.3	2.1	5.5	8.2
10.8	5.0	7.8	1.6	6.8	7.6
10.5	4.6	7.3	1.4	7.3	7.1
10.3	4.3	7.2	1.2	7.9	7.1
9.8	3.8	7.2	1.0	8.7	6.6
9.1	3.1	7.1	0.8	9.7	6.5
Average Total Charge Per Discharge					
$2,949	$2,210	$4,253	$2,042	$1,856	$2,441
2,036	1,733	3,691	1,970	854	1,735
5,480	3,577	5,589	2,208	3,254	4,252
11,263	6,270	9,730	2,773	8,593	8,880
17,990	8,909	14,275	3,208	15,337	13,021
23,321	11,043	18,237	3,486	21,726	16,356
30,032	13,222	23,916	4,059	29,252	21,281
38,642	16,103	32,063	4,533	43,048	27,156
62,992	22,672	56,117	5,934	84,288	47,114

Table 5.9

Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Total Days of Care: Calendar Year 2004

Total Days of Care	Discharges[1]		Total Days of Care			Program Payments			
	Number	Percent	Number	Percent	Per Discharge	Amount in Thousands	Percent	Per Discharge[2]	Per Day
Total	12,918,130	100.0	74,606,025	100.0	5.8	$102,648,047	100.0	$7,985	$1,376
1 Day	1,788,595	13.8	1,788,595	2.4	1.0	10,520,588	10.2	5,935	5,882
2 Days	1,837,865	14.2	3,675,730	4.9	2.0	9,649,276	9.4	5,273	2,625
3 Days	1,983,785	15.4	5,951,355	8.0	3.0	11,608,969	11.3	5,874	1,951
4 Days	1,599,595	12.4	6,398,380	8.6	4.0	10,430,968	10.2	6,543	1,630
5 Days	1,183,750	9.2	5,918,750	7.9	5.0	8,376,706	8.2	7,102	1,415
6 Days	916,990	7.1	5,501,940	7.4	6.0	7,052,051	6.9	7,719	1,282
7 Days	737,190	5.7	5,160,330	6.9	7.0	6,128,462	6.0	8,344	1,188
8 Days	547,030	4.2	4,376,240	5.9	8.0	4,926,160	4.8	9,041	1,126
9 Days	403,240	3.1	3,629,160	4.9	9.0	3,847,674	3.7	9,583	1,060
10 Days	313,830	2.4	3,138,300	4.2	10.0	3,131,680	3.1	10,020	998
11 Days	251,250	1.9	2,763,750	3.7	11.0	2,645,508	2.6	10,580	957
12 Days	201,280	1.6	2,415,360	3.2	12.0	2,221,301	2.2	11,089	920
13 Days	170,435	1.3	2,215,655	3.0	13.0	1,974,478	1.9	11,644	891

See footnotes at end of table.

Table 5.9—Continued

Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Total Days of Care: Calendar Year 2004

Total Days of Care	Discharges[1] Number	Discharges[1] Percent	Total Days of Care Number	Total Days of Care Percent	Total Days of Care Per Discharge	Program Payments Amount in Thousands	Program Payments Percent	Program Payments Per Discharge[2]	Program Payments Per Day
14 Days	156,510	1.2	2,191,140	2.9	14.0	$1,901,080	1.9	$12,205	$868
15 Days	119,855	0.9	1,797,825	2.4	15.0	1,551,200	1.5	13,004	863
16 Days	91,865	0.7	1,469,840	2.0	16.0	1,252,585	1.2	13,719	852
17 Days	78,380	0.6	1,332,460	1.8	17.0	1,104,115	1.1	14,165	829
18 Days	64,760	0.5	1,165,680	1.6	18.0	968,643	0.9	15,047	831
19 Days	53,770	0.4	1,021,630	1.4	19.0	830,591	0.8	15,561	813
20 Days	48,895	0.4	977,900	1.3	20.0	805,871	0.8	16,618	824
21-30 Days	243,550	1.9	5,928,930	7.9	24.3	5,212,771	5.1	21,556	879
31-40 Days	69,610	0.5	2,409,370	3.2	34.6	2,556,441	2.5	37,128	1,061
41-50 Days	27,130	0.2	1,214,415	1.6	44.8	1,390,530	1.4	51,934	1,145
51-60 Days	12,035	0.1	661,895	0.9	55.0	846,339	0.8	71,511	1,279
61-90 Days	12,155	0.1	873,230	1.2	71.8	1,094,797	1.1	91,884	1,254
91 Days or More	4,780	(3)	628,165	0.8	131.4	619,262	0.6	134,915	986

[1]Excludes discharges for managed care enrollees that were paid by the managed care plan.

[2]The average program payment per discharge does not reflect discharges with covered services, but for whom no program payments were reported.

[3]Less than 0.05 percent.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. Numbers may not add to total because of rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 5.10

Number of Participating Short-Stay Hospitals (SSHs), Medicare Utilization and Program Payments for Beneficiaries Discharged from SSHs, by Location and Bedsize of Hospital, and by Medical School Affiliation (MSA) and Type of Control: Calendar Year 2004

Location and Bedsize of Hospital	Hospitals		Discharges[1]		Total Days of Care per Discharge	Program Payments		
	Number	Percent	Number	Percent		Amount in Thousands	Percent	Per Discharge[2]
Total All Hospitals[3]	3,893	100.0	12,792,165	100.0	5.8	$102,213,142	100.0	$8,027
1-99 Beds	1,479	38.0	1,476,565	11.5	4.6	8,115,282	7.9	5,513
100-299 Beds	1,485	38.1	4,578,710	35.8	5.6	31,610,442	30.9	6,933
300-499 Beds	589	15.1	3,527,910	27.6	6.0	29,293,395	28.7	8,343
500 Beds or More	340	8.7	3,208,980	25.1	6.4	33,194,023	32.5	10,405
Total Urban Hospitals	2,445	100.0	10,423,895	100.0	5.9	88,410,802	100.0	8,525
1-99 Beds	526	21.5	545,890	5.2	4.9	3,387,984	3.8	6,229
100-299 Beds	1,039	42.5	3,419,735	32.8	5.7	24,689,203	27.9	7,253
300-499 Beds	548	22.4	3,301,640	31.7	6.0	27,658,796	31.3	8,418
500 Beds or More	332	13.6	3,156,630	30.3	6.4	32,674,819	37.0	10,413
Total Rural Hospitals	1,448	100.0	2,368,270	100.0	5.0	13,802,340	100.0	5,844
1-99 Beds	953	65.8	930,675	39.3	4.5	4,727,298	34.2	5,094
100-299 Beds	446	30.8	1,158,975	48.9	5.2	6,921,239	50.1	5,989
300-499 Beds	41	2.8	226,270	9.6	5.8	1,634,599	11.8	7,246
500 Beds or More	8	0.6	52,350	2.2	6.0	519,204	3.8	9,932

See footnotes at end of table.

Table 5.10—Continued

Number of Participating Short-Stay Hospitals (SSHs), Medicare Utilization and Program Payments for Beneficiaries Discharged from SSHs, by Location and Bedsize of Hospital, and by Medical School Affiliation (MSA) and Type of Control: Calendar Year 2004

MSA and Type of Control	Hospitals		Discharges[1]		Total Days of Care per Discharge	Program Payments		
	Number	Percent	Number	Percent		Amount in Thousands	Percent	Per Discharge[2]
Total All Hospitals[3]	3,893	100.0	12,792,165	100.0	5.8	$102,213,142	100.0	$8,027
Voluntary	2,379	61.1	9,493,970	74.2	5.8	77,350,984	75.7	8,185
Proprietary	691	17.7	1,515,505	11.8	5.8	10,944,279	10.7	7,259
Government	823	21.1	1,782,690	13.9	5.7	13,917,879	13.6	7,843
Total Teaching Hospitals[4]	1,084	100.0	5,806,195	100.0	6.1	54,830,055	100.0	9,497
Voluntary	820	75.6	4,838,635	83.3	6.1	45,371,744	82.7	9,428
Proprietary	73	6.7	248,805	4.3	6.1	2,015,618	3.7	8,150
Government	191	17.6	718,755	12.4	6.4	7,442,693	13.6	10,423
Total Non-Teaching Hospitals	2,809	100.0	6,985,970	100.0	5.5	47,383,087	100.0	6,809
Voluntary	1,559	55.5	4,655,335	66.6	5.5	31,979,240	67.5	6,894
Proprietary	618	22.0	1,266,700	18.1	5.7	8,928,661	18.8	7,084
Government	632	22.5	1,063,935	15.2	5.3	6,475,187	13.7	6,106

[1]Excludes discharges for managed care enrollees that were paid by the managed care plan.

[2]The average program payment per discharge does not reflect discharges with covered services, but for whom no program payments were reported.

[3]Includes discharges from short-stay hospitals in the 50 States and the District of Columbia; excludes discharges from short-stay hospitals in all outlying areas.

[4]Represents hospitals with an approved resident program.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. The Medicare SSH use and cost data presented in this table are slightly different from comparable national totals shown in other SSH tables since two different sample data files were utilized to generate the data. Numbers may not add to total due to rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 5.11

Discharges, Covered Days of Care, Covered Charges, and Program Payments for Medicare Inpatient Hospital Beneficiaries, by Type of Hospital: Calendar Year 2004

	Hospitals		Discharges		Covered Days of Care		
Type of Hospital	Number	Percent	Number	Percent	Number	Percent	Per Discharge
Total All Hospitals[2]	6,312	100.0	13,643,445	100.0	81,078,760	100.0	5.9
Short-Stay Hospitals	4,133	65.5	12,924,810	94.7	72,417,095	89.3	5.6
Hospitals	4,133	65.5	12,211,365	89.5	64,484,705	79.5	5.3
Psychiatric Hospital Units[3]	NA	----	383,960	2.8	4,081,190	5.0	10.6
Rehabilitation Hospital Units[3]	NA	----	329,485	2.4	3,851,200	4.7	11.7
Specialty Hospitals	2,179	34.5	718,635	5.3	8,661,665	10.7	12.1
Childrens	80	1.3	2,725	(4)	22,380	(4)	8.2
Psychiatric	476	7.5	126,725	0.9	1,763,740	2.2	13.9
Rehabilitation	220	3.5	178,910	1.3	2,498,365	3.1	14.0
Long Term	357	5.7	125,360	0.9	3,373,680	4.2	26.9
Critical Access (formerly Short-Stay)	1,030	16.3	284,595	2.1	993,020	1.2	3.5
Religious Non-Medical	16	0.3	320	(4)	10,480	(4)	32.8

See footnotes at end of table.

Table 5.11—Continued

Discharges, Covered Days of Care, Covered Charges, and Program Payments for Medicare Inpatient Hospital Beneficiaries, by Type of Hospital: Calendar Year 2004

Type of Hospital	Covered Charges				Program Payments			
	Amount in Thousands	Percent	Per Discharge	Per Covered Day	Amount in Thousands	Percent	Per Discharge[1]	Per Covered Day
Total All Hospitals[2]	$355,870,093	100.0	$26,084	$4,389	$110,652,208	100.0	$8,147	$1,365
Short-Stay Hospitals	339,144,336	95.3	26,240	4,683	102,639,323	92.8	7,979	1,417
Hospitals	324,381,007	91.2	26,564	5,030	95,886,454	86.7	7,852	1,487
Psychiatric Hospital Units[3]	6,652,919	1.9	17,327	1,630	2,579,587	2.3	6,798	632
Rehabilitation Hospital Units[3]	8,110,410	2.3	24,615	2,106	4,173,281	3.8	12,692	1,084
Specialty Hospitals	16,725,756	4.7	23,274	1,931	8,012,885	7.2	11,151	925
Childrens	118,439	(4)	43,464	5,292	41,600	(4)	15,266	1,859
Psychiatric	1,737,447	0.5	13,710	985	729,840	0.7	5,759	414
Rehabilitation	3,899,639	1.1	21,797	1,561	2,445,654	2.2	13,672	979
Long Term	8,921,101	2.5	71,164	2,644	3,637,005	3.3	29,012	1,078
Critical Access (formerly Short-Stay)	2,044,643	0.6	7,184	2,059	1,155,308	1.0	4,060	1,163
Religious Non-Medical	4,487	(4)	14,021	428	3,479	(4)	10,871	332

[1]The average program payment per discharge does not reflect discharges with covered services, but for whom no program payments were reported.

[2]Includes inpatient short-stay hospitals (SSHs) and specialty hospitals.

[3]There were an estimated 1,392 distinct-part psychiatric units and 917 rehabilitation units participating in the Medicare Program during 2004.

[4]Less than 0.05 percent.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. The Medicare SSH use and cost data presented in this table are slightly different from comparable national totals shown in other SSH tables since two different sample data files were utilized to generate the data. Numbers may not add to total because of rounding. NA is not applicable

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 5.12

Short-Stay Hospital Discharges and Case-Mix Index, by Location and Bedsize of Hospital, and Procedure Status: Calendar Year 2004

Location and Bedsize of Hospital	Discharges	Hospital Case-Mix Index[1]
Total All Hospitals[2]	12,792,165	1.4557
1-99 Beds	1,476,565	1.2195
100-299 Beds	4,578,710	1.3518
300-499 Beds	3,527,910	1.5099
500 Beds or More	3,208,980	1.6533
Total Urban Hospitals	10,423,895	1.5015
1-99 Beds	545,890	1.3207
100-299 Beds	3,419,735	1.3789
300-499 Beds	3,301,640	1.5137
500 Beds or More	3,156,630	1.6529
Total Rural Hospitals	2,368,270	1.2543
1-99 Beds	930,675	1.1601
100-299 Beds	1,158,975	1.2720
300-499 Beds	226,270	1.4541
500 Beds or More	52,350	1.6734

[1]For hospitals participating in the Medicare prospective payment system, the hospital case-mix index is a relative measure of the hospital's average cost per case relative to the average cost per case for all hospitals in some base or reference year. The case-mix index is presented by selected provider categories to provide a means for comparing the relative complexity, severity of illness, and costliness of the cases handled in each of these provider classifications.

[2]Includes discharges from short-stay hospitals in the 50 States and District of Columbia; excludes discharges from short-stay hospitals in all outlying areas.

NOTES: The Medicare SSH use and cost data presented in this table are slightly different from comparable national totals shown in other tables in this section since two different sample data files were utilized to generate the data. Numbers may not add to total because of rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 5.12—Continued

Short-Stay Hospital Discharges and Case-Mix Index, by Location and Bedsize of Hospital, and Procedure Status: Calendar Year 2004

Location and Bedsize of Hospital	Percent of Discharges				
		With Procedures			Without
	Total	Total	Surgical	Non-Surgical	Procedure
Total All Hospitals[2]	100.0	57.6	47.3	10.3	42.5
1-99 Beds	100.0	41.6	31.9	9.7	58.4
100-299 Beds	100.0	54.0	43.9	10.1	46.0
300-499 Beds	100.0	60.9	50.8	10.1	39.1
500 Beds or More	100.0	66.3	55.2	11.1	33.7
Total Urban Hospitals	100.0	60.2	49.8	10.4	39.8
1-99 Beds	100.0	49.7	39.9	9.8	50.3
100-299 Beds	100.0	55.4	45.4	10.0	44.5
300-499 Beds	100.0	61.1	50.9	10.2	38.9
500 Beds or More	100.0	66.3	55.2	11.1	33.7
Total Rural Hospitals	100.0	45.7	35.9	9.8	54.3
1-99 Beds	100.0	36.8	27.2	9.6	63.2
100-299 Beds	100.0	49.6	39.5	10.1	50.4
300-499 Beds	100.0	57.8	48.7	9.1	42.3
500 Beds or More	100.0	67.7	56.6	11.1	32.3