

WASHINGTON STATE DEPARTMENT OF HEALTH

Accounting and Reporting Manual for Hospitals Chapter 5000



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Preface

5001

The operating budget is the foundation for day-to-day planning and control. The planning of daily operations involves five basic budgetary documents:

1. Units of service forecast
2. Expense budget
3. Reclassification and cost allocation
4. Prospective rate setting
5. Revenue budget

We frequently use the operating budget synonymously with the expense budget. However, in planning the operations of an institution, expenses are not the sole concern. The administration must also include the volume of services provided and the revenue generated from these services.

The Statistical Budget

5100

Reliable statistical data concerning the expected volume and scope of activities is essential for determining staffing requirements and cost estimates. This requires formal written procedures for each activity describing the gathered data and the method of accumulation. Review written procedures and revise each year, so they are current and contribute to efficient measurement of operations.

For the planning, controlling, and reporting functions budget, we organize the units of service by departmental or cost center structure. You must follow this concept as it is the basis of performance reporting and determining prospective rates (Section 5400). Hospital management may also use these units of service to compare planned and actual operating results during the budget year.

In some cases, it might not be practical for an individual hospital to develop continuing reliable statistics, such as weighing or counting laundry and linen items. In these situations, you can have two or more test periods to collect actual statistics. The test periods selected must reasonably represent the average workload in the department. The projection of the test period results to annual estimates is then representative of the workload for the current and budget years. You must consider changes in services rendered for the budget year using the current or prior year's test data for projections in the budget.

Responsibility For the Statistical Budget

5101

The controller of budget director handles the units of service forecast. It is important that it is reviewed with the appropriate department heads. The department heads must feel that the forecast is realistic if they are using the statistical forecast to budget expenses. In addition,

department heads generally have valuable suggestions for preparing the forecast. They are close to the activities of the department and knowledgeable in the factors affecting their workload.

Hospital management should review and approve the units of service forecast after preparing it.

Budget Timetable **5102**

The units of service forecast must begin early in the budget cycle. You must complete the units of service forecast must prior to the development of other parts of the operating budget. It is very important you obtain updated historical data early to avoid delays in the preparation of the expense, cost finding, and revenue budgets.

Standard Unit of Measure Requirements **5110**

The purpose of the Standard Unit of Measure is to provide a uniform statistic for measuring costs. The Standard Unit of Measure for revenue-producing cost centers attempts to measure the volume of services rendered to patients. The Standard Unit of Measure for non-revenue-producing cost centers attempts to measure the volume of support services rendered to patient care departments. You should not confuse Standard Units of Measure with allocation statistics used to allocate the costs of non-revenue cost centers to each other and to the revenue-producing centers.

The table in Figure 1 is a listing of the Standard Units of Measure for each cost center required for reporting, where applicable. In addition, these statistics should divide into inpatient, and outpatient components. The outpatient statistics may subdivide further into the following groupings: (1) private referred, (2) clinic, (3) emergency, (4) day care, and (5) home care.

These terms are defined as follows:

A Private Referred Outpatient: A person admitted exclusively to a special diagnostic or therapeutic facility or service of the hospital for diagnosis or treatment on an ambulatory basis upon referral of a physician.

A Clinical Outpatient: A person admitted to the clinical service of the hospital for diagnosis or treatment, on an ambulatory basis, in a formally organized unit of a medical or surgical specialty or subspecialty.

An Emergency Outpatient: A person admitted to the emergency, accident or equivalent service of the hospital, for diagnosis and treatment of a condition. This may require immediate physician, dentist or allied services.

A Day Care Outpatient: A person participating in a surgical, psychiatric, or medical day or night care program and is not included in the daily inpatient census.

A Home Care Outpatient: A person receiving services at their residence from representatives of an organized home care program of the hospital (see cost center description 7400).

Figure 1

Table Of Standard Units of Measure

Cost Center	Standard Unit of Measure	Acct. No.
Daily Hospital Services		
Intensive/Coronary Care Patient Days	Patient days	6010
Semi-Intensive Care	Patient days	6030
Acute Care	Patient days	6070
Alternative Birthing Cen	Patient days	6100
Physical Rehabilitation	Patient days	6120
Psychiatric	Patient days	6140
Chemical Dependency Serv	Patient days	6150
Nursery	Newborn Patient days	6170
Skilled Nursing	Patient days	6200
Swing Beds	Patient days	6210
Hospice Inpatient Serv	Patient days	6330
Other Daily Hosp Serv	Patient days	6400
Ancillary Services		
Labor and Delivery	Procedures	7010
Surgical Services	Operating minutes	7020
Recovery Room	Recovery minutes	7030
Anesthesiology	Operating minutes	7040
Central Services	None	7050
Intravenous Therapy Serv	None	7060
Laboratory	Billable tests	7070
Electrodiagnosis	Billable tests	7110
Magnetic Resonance Image	Mri relative value unit	7120
CT Scanning Services	Ct relative value unit	7130
Radiology - Diagnostic	Relative value units	7140
Radiology - Therapeutic	Relative value units	150
Nuclear Medicine	Relative value units	7160
Pharmacy	None	7170
Respiratory Services	Number of Treatments	7180
Dialysis	Number of Hours of Treatment	7190
Physical Therapy	Number of Treatments	7200
Psychiatric Day Care	Visits	7220
Emergency Room	Visits	7230
Ambulance	Occasions of Service	7240
Short Stay Unit	Short stay patients	7250
Clinics	Visits	7260
Occupational Therapy	Number of Treatments	7310
Speech Pathology	Number of Treatments	7320
Recreational Therapy	Number of Treatments	7330

Electromyography	Number of Procedures	7340
Observation Unit	Hours of Stay	7350

Cost Center	Standard Unit of Measure	Acct. No.
Air Transportation	Occasions of Service	7390
Home Care Services	Visits	7400
Lithotripsy	Number of Treatments	7410
Organ Acquisitions	Number of Acquisitions	7420
Outpatient Chemical Dep	Visits	7430
Other Ancillary Services	(Not applicable)	7490
Research And Education	None	8200
General Services	None	
Printing and Duplicating	None	8310
Dietary	Patient meals served	8320
Cafeteria	Equivalent No. Of Meals Served	8330
Laundry and Linen	No. Of Dry & Clean Lbs Processed	8350
Social Services	None	8360
Central Transportation	None	8370
Purchasing	None	8420
Plant	Number of Gross Square Feet	8430
Housekeeping	None	8460
Communications	None	8470
Data Processing	None	8480
Other General Services	None	8490
Fiscal Services	None	
Accounting	None	8510
Patient Accounts	None	8530
Admitting	None	8560
Other Fiscal Services	None	8590
Administrative Services		
Hospital Administration	None	8610
Employee Health Services	None	8620
Public Relations	None	8630
Management Engineering	None	8640
Personnel	None	8650
Auxiliary Groups	None	8660
Chaplaincy Services	None	8670
Medical Library	None	8680
Medical Records	None	8690
Medical Staff	None	8700
Utilization Management	None	8710
Nursing Administration	None	8720
Nursing Float Personnel	None	8730
Inserv Education-Nursing	None	8740
Inserv Education-Other	None	8750
Comm Health Education	None	8770

Other Administrative Unassigned Costs	None	8790
Depreciation	None	8810
Leases and Rentals	None	8820
Insurance - Hospital & Professional Malpractice	None	8830
Insurance - Other	None	8840
Licenses and Taxes	None	8850
Interest-Working Capital	None	8860
Interest - Other	None	8870
Employee Benefits	None	8880
Amortization	None	8890
Other Unassigned Expense	None	8900

Statistical Forecasting

5120

You must base the forecasting of units of service on hospital management information. This information includes historical data, internal factors, and external factors.

Historical Forecasting Techniques

5121

Historical statistics are essential as they provide a base to forecast from. If adequate data collection procedures are in effect over a three- to five-year period, then historical data will provide important trend information to determine the projections.

The first step in projecting the forecasts based on historical activity is the accumulation of data. This may be simple if proper statistics are maintained. Otherwise, you will have to reconstruct it from data that is available. The number of years' data entered is dependent on the change experienced by the department.

If there is considerable change in the departmental output due to the introduction of new procedures and other factors, it is better to use a shorter span of historical data to base the forecasting. Historical data includes the prior year and the current year data. If output change is more uniform over the years, then you can use three to five years of historical data.

Forecasts based on historical data may use one or more forecasting techniques. A simple method is to plot the measure of activity on a graph, following past trends as closely as possible.

Historical statistics, when used as a means for forecasting units of service cannot reflect future major external changes that are likely to occur in the hospital's service area. It also does not reflect changes in internal programs and policies.

Internal Factors

5121.1

Internal factors affecting the forecasting and historical trends can include:

- Plans to close a unit
- Restrict admission of patients with certain types of illnesses
- Reorganization of units
- Dedicating beds to certain purchasers of services
- Opening of new services
- Construction disruption

External Factors

5121.2

In developing the units of service, you must assess significant external factors that might influence the forecast. These factors could include:

- Unusual growth or decline in the hospital's service area population and occupancy
- Alterations in the medical staff's composition
- Expansion of competing hospital facilities
- Economic fluctuations (i.e. a major employer of the area opening or closing a plant)
- Breakthroughs in medical procedures
- Extraordinary event, such as a declared public health emergency and changes in the health care delivery system (value-based services).

The hospital must consider any unusual external factors that might affect admission, length of stay, outpatient services, or ancillary services within its service area.

Reconciliation And Finalization of Historical Forecast

5122

Once you complete the preliminary historical forecast, you must adjust it to reflect any internal and external factors the hospital knows about, but did not incorporate in the forecast. If changes from past trends show, you must adjust the forecast accordingly. The controller should not deviate from historical trends unless the deviation is supported by other factors.

During this phase, you should discuss the resulting preliminary forecasts with the department head to secure cooperation and to gain any additional insight. The department heads must believe that the forecast is reasonable if they budget departmental expenses using the forecast.

Based on all the information available, you must make a final forecast of units of service. You must review preliminary forecasts of units of service for non-revenue departments from historical data for possible changes due to revenue-producing activity forecasts.

We calculate dietary forecast of meals by multiplying the patient days forecast by the average number of inpatient meals per patient day. You can forecast other meals (i.e. cafeteria, meetings) can by trend analysis or as a ratio to inpatient meals.

The Expense Budget

5200

After completing the units of service budget part of the operating budget, the next task is to convert this statistical information into anticipated dollars of expense. You must keep expenses below anticipated revenue. This ensures sufficient funds for deductions from revenue and the required financial needs for debt service, replacement of physical plant, expansion of services, renovations, working capital, etc. If this is accomplished, accurate estimates of expenses become an essential part of the budget.

Expense Classifications

5210

The Department, in its prescribed system of accounts, has segregated expenses into the major classifications of:

1. Daily hospital services
2. Ancillary services
3. Research and education
4. General services
5. Fiscal services
6. Administrative services
7. Unassigned costs.

The natural classification of expenses for all departments will include:

1. Salaries and wages
2. Employee benefits
3. Professional fees
4. Supplies\

5. Purchased services – utilities
6. Purchased services – other
7. Depreciation
8. Leases and rentals
9. Other direct expenses.

The natural classification of salaries and wages prescribed in the system of accounts will include:

1. Management and supervision
2. Technician and specialist
3. Registered nurses
4. Certified nursing assistants
5. Physicians
6. Non-physician medical practitioners
7. Other salaries and wages
8. Non-work time

We also present the job classifications and natural classifications for these jobs in the system of accounts. Before discussing the components and methods of determining the expense budget, hospital management must recognize the benefits of flexible budgeting within their institution.

Flexible Budgeting

5220

The flexible budget is management's most effective tool in controlling costs. It would assist the hospital personnel in preparing and monitoring the operating budget. We recommend a flexible budget for monitoring and controlling costs.

The total costs of departments will vary according to the volume of service rendered. If the volume of service increases in a department, their total costs will tend to increase. If the volume of service decreases, total costs will tend to decrease. There are a few departments whose total costs are not influenced measurably (if at all) by the volume of patient service. An example is the administrative service department.

Departmental costs, are unlikely to vary in direct proportion to the percentage change in the volume of patient services. The percentage change in costs is generally lower than the percentage change in service volume. This is due to fixed and semi-variable costs in most hospital departments.

You can categorize individual costs incurred by departments into three classes: 1.) fixed, 2.) variable, and 3.) semi-variable. Fixed costs tend to remain constant in total amount, regardless of fluctuations in the volume of service rendered (within some relevant range). The variable costs increase as the volume of service rises and decrease as the volume of service diminishes. This variation may range from a disproportionate percentage increase (or decrease) with an increase (or decrease) in volume of services. This is a semi-variable cost, to a proportionate percentage change, which is a purely variable cost.

In the dietary department, you need a department head (dietitian) whether the hospital serves 5,000 or 6,000 meals per month. The salary of the department head is a fixed cost, as it would not change over this range of service volume.

The raw food costs for 6,000 meals, however, is about 20 percent more than the raw food cost for 5,000 meals. You would consider this cost as purely variable. In this case, the most changes by approximately the same percentage as the change in volume of service.

In other situations, the percentage of volume may change more than the percentage of cost. For example, if each food service employee handles a daily maximum of 125 trays, the cost of food service would not increase by 100 percent if 600 meals were served instead of 300. The 300 trays would require the employment of three food servers, but an additional food server is not needed until the volume of service exceeded 375 trays (125 trays x 3 employees).

If you served 600 meals, you would only need five food service employees. Although the volume of service increased by 100 percent, the number of meal servers increased by about 66 percent. This cost has both fixed and variable characteristics, and is referred to as a semi-variable (sometimes semi-fixed) cost.

This cost is also variable because it reflects an overall increase in response to an increase in volume. However, it also has fixed tendencies. The cost is fixed, for example, in the 251-375 range of service volume. Any number of trays served within this relevant range requires the use of three food servers. Theoretically, when the volume of service reaches 376 trays and is less than 501 trays, an additional food server is needed. The cost increases abruptly by the amount of compensation paid to the additional employee.

See below for the effects of changes in service volume on fixed, variable, and semi-variable costs (unrelated to the previous illustration and semi-variable costs):

Dietary Department Costs	Total Costs	Per Meal Cost	Total Cost	Per Meal Cost
Fixed	\$2,500	\$.50	\$2,500	\$.42
Variable	\$2,000	\$.40	\$2,400	\$.40
Semi-variable	\$1,000	\$.20	\$1,100	\$.18
Total	\$5,000	\$1.00	\$6,000	\$1.00

As a note, the fixed costs are the same in total amount at both levels. An increase in service volume within this range caused no change. However, the change in service volume reduced the cost per unit (meal) because of spreading fixed costs over a greater number of units of

production. Fixed costs stay the same in total, but the fixed cost per unit of volume will decrease as volume increases and will increase as volume decreases.

The variable costs (e.g. raw food costs) are purely variable. That is, they vary in proportion to the change in volume. For example, they increase by 20 percent as volume increases by 20 percent. The result is a unit cost that does not change with a change with volume. The total cost changes in the same direction as volume and by the same percentage.

Semi-variable costs, in total, change in the same direction and relatively the same percentage as volume, rather than the same percentage. The semi-variable costs are approximately the same per unit, usually tending slightly lower per unit if volume increases significantly.

When we examine the total costs of the department, the amount increases (from \$5,500 to \$6,000) as expected. But it is not in the same percentage as the change in volume. As a result, the total unit cost per meal declines. This is due primarily to the more economical (greater) use of fixed resources.

Each day the hospital must be ready to provide the quantity of services in each department that the patient load demands. Traditionally, management determines the number of personnel hours employed to provide these services. Management attempts to retain a fixed number of personnel, regardless of the daily varying service volume, rather than hiring and laying off employees as the volume changes. Hospitals, combined with the constant monthly occupancy, maintain a large proportion of fixed costs, or readiness to serve costs. This applies in most departments, and a smaller proportion of variable costs.

However, current management philosophy advocates a more flexible staffing arrangement. This includes utilizing staff pools, float personnel, and variable work schedules to more effectively use personnel consistent with workload demands. This moves a part of the fixed costs to a semi-variable or variable base to more appropriately reflect changes in cost resulting from changes in volume.

The application of flexible budgeting for the hospital will help in the forecasting or budgeting of operating expenses. This will provide more useful data to determine prospective rates and, for hospital management, measure the actual results of operations.

The development of the operating expense budget should include:

- Development of staffing plans for all departments
- Computing the salary budget based on the staffing plans
- Forecasting the non-salary expenses.

Staffing

5230

The first steps in budgeting salaries and wages is to develop a staffing plan for each revenue and non-revenue department of the hospital. The staffing plan must relate to the work expected, or the output of the department. For example, you should base a nursing staffing plan on the expected average daily census rather than on the number of beds of the unit or floor. Other department staffing levels should base staffing plans on comparable expected workloads. The

standard units of measure discussed in Section 5110 is the measure in departments where workload varies proportionately to those units of service.

An effective staffing plan is an essential element to cost control. It is the department heads' management tool in controlling the salary and wage expenses of their departments.

A written staffing plan is essential as personnel costs is 60-70 percent of the hospital's total expenses. The staffing plans must change to reflect current and future conditions since it provides the documentation for future decisions.

There are several methods of setting staffing levels which include:

1. Management engineering standards
2. Historical experience
3. Experience of other hospitals

The management engineering standards use industrial engineering work measurement techniques. These standards are for the individual hospital departments. With these standards, we can set realistic man hours or full-time equivalents per unit of service for the budget year.

The historical standards use past trends in man hours per unit of service to develop the staffing levels. This method, however, could encourage the continuation of past inefficiencies and not develop the planning tools to incur cost effectiveness.

Using hospital staffing plans for budgeting requires management to achieve performance reporting (actual versus budgeted data) in their departments. This reporting must measure the variable versus the fixed staff relationship along with productive and nonproductive hours for the payroll reporting periods.

Salary And Wage Expenses

5240

With the completion of staffing plans, the next budgeting process is to develop the Departmental Salary and Wage Budget. This budget does important segments of the department's budget preparation. It has the following purposes:

- Provides wage and salary expenses for the department on a monthly and annual basis.
- Provides a check on the vacation days used.
- Allows inclusion of overtime, shift differential, on-call and other impacts on salary and wage costs.
- It finds projected merit, longevity and other selective salary increments in the month they occur.

The salary and wage budget also summarizes the average rate and total monthly budget of each personnel classification. They use it in combination with department staffing plans which staff and budget based on units of measure. They also use it to accumulate non-work time such as vacation, holidays and sick pay.

You total the monthly salary data after you list all, regularly scheduled personnel. You should also add cost-of-living and other across-the-board pay increases to the monthly salary totals. Then, you total the hours of all these regularly scheduled personnel.

You calculate the hours and dollar amount of vacation, holiday and sick leave benefits related to all listed and totaled personnel and enter by month. Then, you enter and add the provision for planned replacement coverage to the salary totals. In this manner, the absences you do not cover are excluded from the budget dollars and hours figures.

You should insert the amount of overtime in the "Overtime Line." Overtime is the expected hours worked at an appropriate straight time rate. You add this overtime as part of the replacement coverage.

Vacation, holiday, and sick leave coverage will vary for each department in the hospital. For example, dietary will normally have more coverage than housekeeping. You can normally expect this type of coverage to vary throughout the year. During June, July and August, when occupancy is normally down, you cannot make coverage for vacation, holiday, or sick leave. Normally, the reverse is true for January and February when sick leave and holidays may need coverage, or hospitals move holiday time off to another month.

Replacement coverage should bear some relation to the vacation, holiday and sick leave budget. If you anticipate coverage being 100 percent, then the replacement coverage of salaries and wages would approximate the budgeted vacation, holiday and sick leave expenses.

You should show any shift differential, on call, etc., on separate lines of the salary worksheet and properly labeled.

The total monthly salary budget consists of the normal personnel salaries and wages without the vacation, holiday, and sick leave expenses plus replacement coverage and shift differential, etc. You should enter this amount on the departmental summary.

Non-salary Expenses

5250

The keys to budgeting or forecasting non-salary expense include:

- Knowledge of the expense distribution practice
- Deciding the relationship of these expenses to departmental units of service output
- Accuracy in forecasting units of service
- Realistic estimation of vendor price escalation
- Identifying changes in practice which may alter historic utilization of non-salary expense items

- Identifying changes in external economic conditions which may have an impact upon historical supply usage and other expenses.

The department head must thoroughly understand the budget amounts, the size of each individual expense component and the underlying assumptions used in their calculations. Department heads should have direct involvement in making decisions that influence the preparation of budget amounts. This is so they can have full responsibility in operating within the budget and understand and explain variances.

The uniform definitions in the Department's System of Accounts defines non-salary expenses in the following classifications:

- Employee Benefits
- Professional Fees
- Supplies
- Purchased Services - Utilities
- Purchased Services - Other
- Depreciation
- Leases and Rentals
- Other Direct Expenses

Departmental Expense Budgets

5251

Forecasted units of service, salary and wage and non-salary expenses calculated for the budget year, are elements needed to complete the departmental expense budgets.

If the hospital did not complete the prospective rate setting process, then you must consider these expense summaries preliminary. You must assure hospital management, the budget committee and the governing board before finalizing them. These groups want to ensure there is adequate revenues generated to take care of expense summaries and other financial needs of the hospital.

Without adequate revenues, you will need to review the expense budget to determine what reductions you can make. In many cases, this may involve putting off new programs or discontinuing existing programs that are not self-supporting. In other cases, it will involve reassessing staffing goals and revising planned wage rate increases.

The hospital's final expense budget is the basis for establishing prospective rates and measuring departmental performance during the budget year.

Budgeting Natural Expense Classifications

5251.1

You must adjust employee benefits charged directly to departments for changes in legal requirements and administrative policy. You should consider additional coverage as a change in practice, higher rates as changes in price. You should categorize them as variable expenses in departments budgeted on a variable staff basis as fixed expenses in other departments.

Professional fees for medical care services (Accounts .21 and .22) will usually be variable. Other professional fees will usually be fixed.

Supplies of a medical nature (Accounts .31-.39) and food costs (accounts .41 and .42) are usually variable costs and fluctuate directly in proportion to the patient load. Other supply items are more independent of patient load variations.

Purchased medical care related services, food services, and laundry services are usually variable costs.

Repairs and maintenance, collection agency services, and management services often vary with units of service output. They may delay the department's current month units of service output and complicate cost analysis during the reporting year. The other direct expenses (Accounts .901-.999) are commonly budgeted as fixed costs.

Reclassification And Cost Finding 5300

The fourth phase of budgeting and prospective rate setting is the reclassification of unassigned expenses and the allocation of costs of non-revenue departmental expenses to the revenue departments. We commonly refer to this process as "cost finding" for hospitals.

Cost finding is the "apportionment or allocation of the cost of the non-revenue producing cost centers to each other and to the other revenue producing cost centers on the basis of the statistical data that measures the amount of service rendered by each cost center to other cost centers."

The purpose of the cost finding process is to find the total or full costs of operating the revenue departments of the hospital. The goal is to show the prospective rates for services rendered.

The cost finding phase is the process of recasting the non-revenue departmental expenses accumulated in the budgeting process to the revenue departments of the hospital. You do this procedure separate from the regular accounting system.

Objectives of cost finding 5310

The objectives of the reclassification and cost finding procedures prescribed for the hospital are:

- Provide full cost information by revenue department for review, evaluation, and establishment of rates for services
- Provide uniform information by revenue center to determine the reimbursed costs from contractual agencies
- Provide uniform information to the Department, hospital associations, contractual agencies, etc.
- Provide information to hospital management for use in making managerial decisions for prospective rate setting

The cost finding process will provide information for a variety of needs of the Department and hospital management.

Setting And Assessing Rates

5311

The reclassification and cost finding process helps hospital management assess the adequacy of rates. It does not provide the precise and absolute rates for the services billed to the patients. It is the hospital management's goal to ensure that the rates for services are reasonably related to the full cost of providing the services. In addition to the recovery of the full cost of services for each department, the rates must reflect hospital management's policies and philosophies. This should respect the recovery of deductions from revenue (bad debts, contractual adjustments, charity, etc.) and the required planned capital and service component factors for the hospital.

The process establishes an average cost per unit of service to bill to the patients. The determination of the average cost of service does not provide the information as to the unit cost of a particular type of examination or procedure.

Many revenue departments in the hospital provide more than one service and a different charge for each service (e.g. laboratory, radiology and central services). The hospital must conduct special studies or analyses to determine the unit cost of providing each individual service within that revenue department or utilize the prescribed relative value unit where applicable.

Information For Outside Reporting

5312

The reclassification and cost finding process provides uniform data for the Department, various agencies and the public. The Department must develop and report uniform financial data to the institutions of the state. This information must show comparable data for hospitals of similar sizes and services. This should be beneficial to the management of the hospitals in fulfilling their managerial responsibilities.

The uniform information is the basis of public disclosure of costs related to the rates for services rendered by the hospital.

Information For Internal Reporting

5313

Hospital management uses the cost finding data to measure their overall operating effectiveness and control costs. You will use this data to evaluate departmental performances, efficiencies and plans for future operations and new services.

Department heads should understand the cost finding procedures and the results of operation on a departmental basis. The disclosure of the indirect cost allocated to each department will tend to develop a desirable cost-consciousness of the departmental management staff.

Prerequisites Of Reclassification and Cost Finding

5320

The essential prerequisites of this process are (1) sound organizational structure, (2) uniform accounting system and (3) uniform statistical data. We have previously discussed these prerequisites in this Manual. The statistical data, discussed in Section 5100, provides the basis for departmental evaluations. We require additional uniform statistical data that is specified for the allocation of expenses in the reclassification and cost finding process. We discuss these allocation statistics in Section 5350.

As discussed in Section 5100, it is essential for the hospital during the collection of the units of service and allocation statistical data to develop and monitor this process with specific written procedures. Hospitals must develop these procedures in cooperation with each department head to ensure a practical application for the accumulation of this required data. Much of this allocation data is accumulated and used in the Medicare cost finding process. However, these procedures require a review and expansion to ensure that current and valid statistical information is available for the cost finding process.

These allocation statistics may be actual data of services for the reporting period. It may also be data from reasonable estimates for parts of the reporting periods developed from sampling techniques. These sampling techniques must develop valid data for allocation purposes for the total period. The sampling techniques must use two or more monthly periods of normal volumes of activity during the current year. You may also use the data sampling technique discussed in Section 5130.

Variations exist in the comparability of services made by certain departments to others. Therefore, you should consider the use of weighted statistics for the basis of allocations. Unless you give relatively greater weight to more complex services, the departments receiving such services would not hold the equitable share of the allocated costs.

For example, if you allocated the cost of the laundry department to cost centers on the basis of the number of dry laundry pounds processed, then the allocation would likely be inequitable. Some items cost more per pound than others to process in the laundry. For example, one of the more costly (per pound) items are coats and jackets worn by personnel in the laboratory department. These items are often starched and pressed, while other items are not.

To illustrate the impact of unweighted statistics, assume this data:

Laundry Department Cost	\$40,000
Number of Dry Pounds Processed Laboratory	\$6,000
Other Centers	\$394,000
Total	\$400,000

The average cost per pound processed is \$.10 (\$40,000 divided by 400,000 pounds). If this unweighted statistic is used in allocating the cost of the laundry department, then you should charge the laboratory cost center \$600.

Assume there is a special study where 2,000 of the 6,000 pounds of laboratory laundry were jackets and coats. This is five times as expensive to process as regular laundry items. You can cite many reasons for this difference.) In this case, the weighting factors is 5 for laboratory coats and 1 for other laundry items. Therefore, the weighted average cost per pound of laundry becomes about \$.098, as shown in the table below:

Laundry Department Cost	\$40,000
Weighted Number of Dry Pounds Processed:	
Laboratory (2,000 lbs. x 5 and 4,000lbs. x 1)	14,000 lbs.
Other Centers (394,000 x 1)	394,000
Total	408,000
Weighted average cost per pound	\$.098

Using the weighted average cost per dry laundry pound processed, the laboratory cost center is charged with \$1,373 (14,000 lbs. x \$.098, rounded) as compared to the \$600 that would have been charged to it had unweighted statistics been used. Another illustration would be the required additional handling cost of soiled surgical laundry requires three pre-washes and, therefore, becomes eight times more expensive to process than regular items. In this case, the weighting factor for surgical laundry should be 8 and 1 for the other laundry items.

Many service departments require special analysis to achieve the proper weighting of services rendered to other departments. It is essential for the hospital to achieve the proper allocation statistic to determine the proper full costs for the revenue departments.

Cost Allocation Statistics 5350

Cost allocation uses statistics to distribute indirect costs to revenue producing departments. It is required that you maintain adequate statistical data to measure the performance of each center.

The definition and sources of the required statistics for allocation are:

Square feet: The number of square feet in each department of the hospital determined by a physical measurement or a measurement from blueprints. You should take floor area measurements from the center of walls to the center of adjoining corridors if a hallway services more than one department. Exclude stairwells, elevators, and other shafts. Exclude general and unused areas. Include hallways, waiting rooms, storage areas, etc., serving only one department in that department., You should maintain statistical data for changes, as a result of new construction, department relocation, expansion, or curtailment of service, in assigned area. This is so you can allow for the development of "weighted" areas for the fractional part of the year.

Meals served: Number of meals served must include only regularly scheduled meals. It should exclude snacks and fruit juices served between regularly scheduled meals.

Housekeeping hours of service: Number of hours of service must include all time spent by the housekeeping unit in maintaining the general cleanliness and sanitation of the hospital.

Nursing full-time equivalents: The sum of all hours that nursing employees are paid during the year and divided by 2,080. This is determined from payroll accounting records.

Number of dry and clean pounds processed: This statistic must include the weight of linen processed for the hospital's use.

Reclassification Of Cost Centers

5360

Reclassifications are necessary to adjust the hospital's records to meet the Department's reporting requirements, if they do not already reflect these requirements. You can make these reclassifications separate from the books of the hospital. But you must complete it before the direct cost adjustments and form preparation.

There are three types of reclassifications:

1. reclassification to obtain the required level of reporting,
2. reclassification to correct "dislocations" of a given clinical type of patient which affect revenues and costs, and
3. reclassification to correct accumulation of costs.

The first type of reclassification may be necessary to reach the required level of reporting if the hospital combines several departments. For example, smaller hospitals may combine the costs of acute and intensive care in one nursing unit cost center. In such cases, it is necessary to reclassify the total direct costs incurred in the two different types of care into two specific cost centers relating to these two types of services.

The second type is necessary when you treat "overflow" patients in cost centers other than the functional center relating to the services provided. For example, a medical or surgical acute patient treated in an intensive care unit because of occupied medical/surgical beds.

The third type of reclassification corrects the accumulation of costs. This is necessary when you record an expense associated with a particular function in a cost center different from the functional description in this Manual. For example, a reclassification is required if the dietary department recorded the costs associated with hand-feeding of patients. This is because the dietary department should record these costs in the daily services cost center relating to that patient.

In the System of Accounts, the Department permits the distribution of depreciation and employee benefits direct to the accounts within the general ledger. The Department also specifies that these expenses must be reclassified before the cost finding procedure. Expenses directly charged or transferred to the individual departments within the accounting process must be reclassified through appropriate statistical base in the reclassification procedure.

You can routinely record the revenue and expenses associated with central supplies, charged to the patients for example, in the surgery, emergency room, intensive care and other departments. These practices are acceptable for month-to-month revenue and expense control. However, as

defined in the System of Accounts, it is necessary to reclassify these revenues and expenses to the central supply department. It is also necessary to reclassify the pharmacy revenues and expenses following the System of Accounts. Other cost centers, such as nursing float and central transportation, must be reclassified before beginning the cost finding process.

The System of Accounts also provides the appropriate distribution of other operating revenues (commonly referred to as recoveries) within the reclassification process. You must offset all expense recoveries against the appropriate expense department. You must review, evaluate and possibly reclassify other expenses recorded within the general ledger system of the institution. Some of these expenses may include reallocation of dietary costs incurred in the serving of meals to patients, nursing service personnel accumulating specimens for the laboratory and many others shown in the System of Accounts.

Allocation

5370

The first allocation in the cost finding (step-down) must include interest-other, insurance-other, licenses and taxes, plant operation, maintenance, grounds, security, parking and other general services. You must distribute these costs based on the square footage of the floor area occupied by the department and cost centers serviced by these non-revenue cost centers. You can also develop weighted basis of allocation for some of the cost elements.

The second series of allocated costs must include printing and duplicating, general accounting, communications, administration, public relations, management engineering and other administrative expenses. You distribute these costs using the accumulated cost basis. The accumulated cost basis of allocation is based on the total accumulated cost for the other departments receiving services from these departments.

The purchasing and stores department is the third non-revenue cost center distributed in the step-down process. The basis of allocation is the supply cost incurred by the unclosed revenue cost centers and the revenue departments. If you do not secure and/or handle pharmacy and dietary supplies by the purchasing department, then you must exclude these supply costs from the allocation basis for this cost center.

The dietary expenses are allocated fourth and distributed by the number of meals served.

The fifth allocation step must include the cafeteria and personnel costs. They must be allocated on the basis of hospital full-time equivalents.

The sixth allocation is housekeeping service accumulated costs. This cost center is distributed by hours of service rendered by this department to other open cost centers.

The seventh cost center of accumulated costs distributed is the laundry and linen service. The costs are distributed by dry pounds of laundry processed and issued to each open cost center. You should generally process the dry pounds of laundry on a weighted basis.

The eighth allocation in the cost finding process must include patient accounts, data processing, admitting, auxiliary groups, chaplaincy, medical library, medical records, health care review, medical staff, social services, and others. These costs are distributed by gross patient revenue

from daily hospital services and ancillary services. In the budget year, these expenses must be distributed based on the current year's gross revenue.

The final allocated cost centers include various educational programs. You assign these costs to applicable revenue departments. This is based on the number of students or the assignment of students for training.

You determine the total cost of each revenue-producing department by totaling the directly assigned expenses and expenses added through the allocation process.

Individual Service Rates 5400

As discussed in the reclassification and cost finding section (Section 5300), many revenue departments of the hospital provide more than one service. Therefore, you must allocate the total cost of services to the multiple services within the department by special cost or rate studies to determine the prospective rates.

These special studies by the hospital determine individual service rates and total departmental rate setting revenue. Hospitals use one or more of the following methods:

- Time basis
- Weighted value time basis
- Relative unit value basis
- Gross margin – cost of materials and handling
- Composite rates for changes in mix

Time Basis 5401

With over 50 percent of hospital costs being salaries, many types of services involve different amounts of time and salaries. Any pricing method must consider the effect on salary costs as a prime determinant of the rate structure. A time basis for rate distribution is logical. The surgery rate is a prime example of a hospital department that could employ a rate system related to time.

Weighted Value Time Basis 5402

In the time basis of determining rates, it was assumed that all surgery time used the same amount of personnel cost. Therefore, you use a time basis method for computing a rate for minutes of use of the surgery. If you find a widely varying amount of personnel used for different types of surgeries, then you should adjust the rates charged to a weighted basis. This is considering varying personnel costs per unit of surgery time or varying costs of equipment usage.

Laboratory Workload Unit Basis 5403

The third system of reflecting time-cost factors is the use of laboratory workload units. The laboratory workload unit basis for computing rates is the most sophisticated method of developing individual rates for a departmental area. The laboratory workload unit is a common

denominator for use in a complex, multi-service department. For each test or procedure that a department provides, you assign a unit value based on a standardized time study. You multiply the number of tasks budgeted by the number of workload units assigned to that task. This results in an aggregate, weighted value for that type of test. The sum of the aggregate weighted values divided into the total costs recovered by the department determines the computed rate per laboratory workload unit.

Finally, you should multiply the laboratory workload units assigned to each test by the computed rate per laboratory workload unit. This determines the computed rate charged for the test. You can also make revenue estimates by multiplying the computed rate per test by the estimated number of tests performed.

This method applies to departments such as laboratory, radiology, EKG, EEG or similar areas using workload units of measure.

Relative Value of Similar Services Basis 5404

Another method to weigh services is the relative value of that type of service in relationship to similar services. This type of weighing of services in hospitals assumes that a private room is more valuable to the patient's care and recovery than a two-patient room or a four-patient room. You must develop a relative value unit that recognizes the proportion that the value of each type of service is to other similar types of service. For example, a private room may be worth 1.2 times the value of a two-person or semi-private room. So, you allocate costs on the basis of the relative weight assigned to each type of accommodation.

Specific Billing Or "A La Carte" Pricing 5405

One opportunity for rate making that the hospital could take advantage of is a split of room rates or daily service charges. Hospitals can split it into a hotel service charge, a nursing service charge, and a dietary charge, where applicable. This breakdown allows the hospital to separate and charge for all hotel type services. However, you can allocate charges for nursing services on a relative value unit basis. You can base this on the proportion of time each type of illness would take in comparison to a standard diagnostic type of stay. You can make a more equitable charge for nursing services to patients with identifiable, reasonable, and equitable classifications of services.

Another factor hospitals can consider is charging for food service based upon the quantity of meals received by each patient class or by each patient. For example, you can charge a surgery patient who cannot eat anything before surgery a minimum dietary rate. You can charge a higher rate for the patient's first days of recovery to reflect the consumption of low-cost meals relative to the average meal served to all patients.

Contribution Margin 5406

The last method of computing rates is the computation of a contribution margin or "overhead" percentage or a handling fee. Many departments in a hospital, such as pharmacy or central

supply, provide materials and supplies to patients or departments. These eventually go to patients in a merchandise fashion. A pricing system for the services might include a charge for the cost of each material provided plus a percentage mark-up, surcharge, or handling fee to cover the cost of handling (variable costs). It would also cover the indirect and allocated costs, fixed costs, and the required margin of that particular department.

Composite Rates

5407

Ancillary departments perform a variety of different services at different rates. Evaluating past composite rates, mix trends, and relationships to costs is necessary to develop a reasonable composite budget rate for budgeting departmental revenues.

The composite rate is easy to develop in departments where the unit of service is the relative value unit (i.e., radiology, nuclear medicine). When establishing rates in these departments, you use an average rate for each relative value unit. Since the units of service forecast is in relative value units, you can use this same rate to calculate the departmental budget year revenue.

The total departmental revenue from daily hospital services budget on a composite room rate for each department or unit. The forecast of patient days is the total days for all types of accommodations in that department or unit. So, you may use a composite rate.

Some hospitals may prefer to forecast patient days by type of accommodation. Hospitals may apply the current rates of the accommodations to forecast the department's total rate setting revenue for the budget year.

Patient Service Revenues

5410

Patient service revenue has two major groups:

1. Revenue from daily hospital services
2. Revenue from ancillary services.

The guiding principle of patient service revenue accounting and budgeting is to assure we budget, accumulate and report revenues on time. This allows the comparison to expenses and units of service by cost center.

In addition, you may identify revenues and units of service separately as inpatient and outpatient, and possibly by major classes of purchaser. You may accumulate separation of revenues by major purchaser class with a log, rather than by actual accumulation in the general ledger. See Section 2230 for the use of the sixth digit to identify revenue by class of payer.

Patient revenues generated by the daily hospital service departments are usually attributed to inpatients. The revenue budget is normally only applicable to the inpatient sub-classifications. Patient revenues generated by the ancillary services are often attributable to both outpatients and inpatients. It is necessary to segregate the inpatient revenue from the outpatient revenue. To accomplish this, it is necessary to prepare separate units of service forecasts for the revenue projection for the inpatient and outpatient portions of these common ancillary services.

The separate inpatient and outpatient sub-classifications of units of service and revenue will be utilized not only in planning, but also in controlling operations.

Other Operating Revenue

5420

Other operating revenue has a significant impact on the hospital's budget and operation. Other operating revenue includes revenue from patients for non-patient care services, revenue from sales to persons other than patients and transfers from restricted funds for operations. You can further break down other operating revenue into cost recoveries. This includes revenue from service facilities, revenue from approved educational programs, research-related revenue, and revenue from restricted funds specifically restricted for operating costs. See Section 2410.3 for a more complete definition of other operating revenue.

Examples of cost recoveries include cafeteria income, medical record fees, sale of scrap, telephone charges, rental of space and television rentals.

Budgeting of both cost recovery and other revenues may be directly related to the number of patients and employees. One formula for forecasting these revenues is to multiply the current average revenue per patient or employee (as appropriate) times the budgeted number of patients or employees.

You must forecast other budgeted revenue for approved educational and research programs in other manners. You can forecast the tuition revenue from approved educational programs by the number of student admissions times the projected tuition rates. Accurate data is available by the budget year revenue from grants, gifts and subsidies for approved educational and research programs. If such data is lacking, you can use historic data. But you should subject it to critical review based on prospective goals and objectives.

Nonoperating Gains

5510

Non-operating gains are not directly related to patient care. Major sub-classifications of non-operating gains include (See Section 2420.9 for complete definition of non-operating gains.):

- Unrestricted contributions
- Gain from unrestricted funds investment
- Donated services
- Gains on sales of hospital property
- Net operating profit from non-related business operations
- Net rental income from facilities not used in the operation of the hospital.

You will have to develop the budgeting of non-operating gains from historical data. The budgeting of non-operating gains is subject to critical review for prospective changes discussed in the hospital's objectives.

Deductions From Revenue **5530**

The deductions from hospital revenue are contractual adjustments, charity, and other allowances.

Guidelines For Budgeting Deductions from Revenue **5531**

Hospital management must provide the required guidelines to budget these deductions from revenue. You must base the estimates on operating policies to ensure their accuracy.

Deductions for contractual adjustments are based on an analysis of the reimbursement formula for each contractual agency. In some cases, the contractual adjustments estimated in the budget year will differ from the current interim rate. This is due to patient mix changes. If the difference is significant and a change in the interim rate benefits the hospital, then you should make a request to the intermediary or program for a change. Hospitals confirm the request for change by material prepared in this budgeting process.

Hospital management must provide the required guidelines for budgeting of charity discounts and uncompensated care for Hill-Burton assisted hospitals.

Charity And Other Allowances **5532**

Once you budget gross revenue, the budgeting of deductions for charity and other allowances can proceed. You must summarize these revenue deductions for the past several years by calculating the amount for the budget year. Hospital management should review this summary and decide the budgeted amount (dependent on a percentage of revenues to be used).

Charity forecasting requires careful assessment of the impact on Hill-Burton and other regulations. It also assesses changes in hospital managements' policies.

After management reviews and approves the deductions from revenue, it is applied (in terms of percentages) to the budgeted patient service revenues.

Contractual Adjustments **5533**

You must estimate the amount of program revenue before determining the amount of contractual adjustments. This amount may approximate the amount (and percentage) for the past few years. But you must alert the hospital for significant changes in utilization and departmental mix.

You must accurately project third-party reimbursements for the budgeting process to be a worthwhile effort. Preparing the various third-party cost reports using the budgeted figures

assures the best accuracy. This is due to changes in and variances between reimbursement formulas.

The projections of units of service and revenues, and expenses explained in other sections of this Manual provide the basis for preparing these contractual agencies' reports. The hospital should ensure that any changes in the reimbursement formulas effective for the budgeted year are considered. The effort required to prepare, for example, the Medicare and Medicaid reports for the budget year may appear substantial. However, it is important to consider the total budget effort and the significant impact of these contractual adjustments on budgeted net operating revenues. For that reason, the preparation of these reimbursement reports is worth the effort. These reports can also serve as a starting point for selecting reimbursement options to maximize the hospital's reimbursement for the budget year.



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