

<u>TABLE OF CONTENTS</u>	<u>SUB-SECTION</u>	<u>PAGE</u>
Preface	.01	1
Prescribed Accounting Principles	.02	1
Basic Concepts	.03-.20	1
Accounting Entity	.03	1
Continuity of Activities	.04	1
Accounting Period	.05	2
Objective Evidence	.06	2
Conservatism	.07	2
Consistency	.08	2
Full Disclosure	.09	3
Materiality	.10	3
Basis of Valuation	.11	3
Accounting Principles	.21-.50	4
Accrual Accounting	.21	4
Matching of Revenue and Expenses	.22	4
Deductions from Operating Revenue	.23	5
Fund Accounting	.24	6
Unrestricted Fund	.241	6
Plant Replacement and Expansion Fund	.242	7
Specific Purpose Fund	.243	9
Endowment Fund	.244	9
Inter-fund Transactions	.245	9
Long-Term Security Investments	.25	12
Pooled Investments	.26	12
Inventories	.27	16
Accounting for Property, Plant Equipment	.28	17
Classification of Fixed Asset Expenditures	.281	17
Basis of Valuation	.282	17
Accounting Control	.283	17
Capitalized Policy	.284	18
Minor Equipment	.285	18
Interest Expense During Period of Construction	.286	19
Depreciation Policies	.287	19
Timing Differences	.29	20
Accounting for Pledges	.30	22
Self Insurance	.31	22
Related Organizations	.32	23
Debt Financing for Plant Replacement and Expansion Purposes	.33	23
Discounts and Premiums on Bond Issues	.331	23
Financing Charges	.332	24
Accounting for Debt Proceeds	.333	24

<u>TABLE OF CONTENTS</u> (Continued)	<u>SUB-SECTION</u>	<u>PAGE</u>
Sinking and Other Required Funds	.334	24
Early Debt Retirement	.335	25
Specialized Accounting Areas	.51-.99	25
Direct Recording of Costs	.51	25
Building and Fixtures	.511	25
Movable Equipment	.512	25
Salary and Payroll Related Employee Benefits	.513	26
Employee Benefits (Non-Payroll Related)	.514	27
Medical Supplies	.515	27
Drugs	.516	28
Plant Maintenance	.517	28
Data Processing	.518	28
Central Patient Transportation	.519	29
Hospital Research and Education Costs	.52	29
Grant Accountability	.521	29
Overhead Allocation	.522	30
Affiliated School Contracts	.523	31
Insurance Education-Nursing	.53	31
In-service Education-Non Nursing	.54	32
Physician Remuneration	.55	32
Financial Arrangements	.551	32
Work Arrangement	.552	33
Allocations to Other Institutional Programs (OIPs) and Auxiliary Enterprises (AEs)	.56	35
Capital Facilities	.57	35

PREFACE .01

This Manual is intended to establish a foundation for uniform accounting and reporting for hospitals. It thus becomes necessary to set forth certain basic accounting principles and concepts to be followed throughout the Manual. This section deals with the most significant of these principles and concepts.

PRESCRIBED ACCOUNTING PRINCIPLES .02

The accounting principles and concepts described in this chapter reflect the current state of the art in hospital accounting. The accounting principles and concepts have been drawn from existing systems wherever possible. The options that are currently available under Generally Accepted Accounting Principles (GAAP) have in several instances been limited or restricted. These modifications have been made to allow for more detailed and precise accounting practices so that a uniform accounting and reporting system for hospitals could be established.

Any accounting principles and concepts not specifically discussed in this Manual should be accounted for according to GAAP as interpreted in the opinions of the American Institute of Certified Public Accountants (AICPA) and in the statements by the Financial Accounting Standards Board (FASB).

BASIC CONCEPTS .03–.20

ACCOUNTING ENTITY .03

A fundamental accounting concept is that of the accounting entity or unit. For accounting purposes, the hospital is presumed to be an entity capable of buying, selling and taking other economic actions which are to be accounted for separately from the personal affairs of those responsible for the hospital's administration. The hospital itself is the primary unit for which the accounting records are maintained. However, most departments of the hospital usually assume sufficient importance to require separate treatment as subordinate entities or units of accountability for planning and control purposes.

CONTINUITY OF ACTIVITIES .04

Another basic accounting concept is that of continuity of activity, or the going concern. The assumption being that the hospital will continue to function indefinitely. It then becomes necessary to divide the life of the hospital into accounting periods, to determine revenues earned and expenses incurred during each period and to measure the amounts of assets and obligations at the end of each period.

ACCOUNTING PERIOD .05

The basic accounting period is one year. This period shall consist of 12 consecutive calendar months.

A hospital beginning operations must select an initial accounting period beginning on the first day of operation, through the last month preceding the hospital's selected fiscal year. For example, a hospital beginning operations August 15, 1978, selecting a fiscal year beginning January 1, would have an initial fiscal period running from August 15, 1978 through December 31, 1978. It would then move to the standard January 1 to December 31 fiscal year.

OBJECTIVE EVIDENCE .06

Information produced by the accounting process should be based, to the extent possible, upon objectively determined facts. Transactions should be supported by properly executed documents such as charge slips, purchase orders, suppliers' invoices, cancelled checks, etc. Such documents serve as objective evidence of transactions and should be retained as a source of verification of the data in the accounting records.

Certain determinations that enter into the accounting records are based on estimates. The estimates should be based on past experiences modified by expected future considerations. Examples would include recognition of estimated provisions for depreciation and bad debts.

Books, papers, records, or other data relevant to matters of hospital ownership, organization, and operation must be maintained. The data must be maintained in an ongoing recordkeeping system which allows for the data to be readily verified by qualified auditors.

CONSERVATISM .07

Conservatism is a quality of judgment to be exercised in evaluating the uncertainties and risks present in the hospital entity to assure that reasonable provisions are made for potential losses in the realization of recorded assets and in the settlement of actual and contingent liabilities. However, conservatism is not a justification for deliberate understatement.

CONSISTENCY .08

Consistency refers to continued uniformity, during a period and from one period to another, in methods of accounting, mainly in valuation bases and methods of accrual, as reflected in the financial statements of an accounting entity, e.g., change from F.I.F.O. inventory method to L.I.F.O. method. Consistency is very important to the development and analysis of trends on a year to year basis and as a means of forecasting. However, consistency does not require continued adherence to a method or procedure that is incorrect or no longer useful, nor does it preclude a justifiable and desirable change in accounting and reporting methods or procedures unless otherwise specified in this manual.

FULL DISCLOSURE .09

The concept of full disclosure requires that all significant data be clearly and completely reflected in accounting reports. If, for example, a hospital were to change its method of accounting for certain transactions, within the limitations of this manual, and if the change had a material effect on the reported financial position or operating results, the nature of the change in method and its effect must be disclosed when reporting costs to any agency.

MATERIALITY .10

Materiality is an elusive concept with the dividing line between material and immaterial amounts subject to various interpretations. It is clear, however, that an amount is material if its exclusion from the financial statements would cause misleading or incorrect conclusions to be drawn by users of the statements.

BASIS OF VALUATION .11

Historical cost is the basis used in accounting for the valuation of all assets and in recording all expenses (except fair market value in the case of donations and imputed value in the case of non paid workers). Historical cost, simply defined, is the amount of cash or cash equivalents given in exchange for properties or services at the time of acquisition. It is the basis for the valuation of assets and for the recording of most expenses. Cost ordinarily has been the basis of accounting for assets and expenses because it is a permanent and objective measurement that reflects the accountability of management for the utilization of hospital funds.

Hospitals, however, frequently acquire property, equipment, services and supplies by donation. The property, equipment, service and/or supply is considered donated when acquired without the hospital making any payment for it in the form of cash, property or services.

The property, equipment, service and/or supply should be valued at the fair market value which is the price that the asset would cost by bona fide bargaining between well-informed buyers and sellers at the date of donation (regardless of date of receipt). Failure to give accounting recognition to donated properties and services results in an understatement of hospital assets, revenues and expenses.

Many hospitals receive the services of members of an organization of non paid workers that has arrangements with the hospital for the performance of services. The services are in positions customarily held by full-time employees, and are performed on a regularly scheduled basis. The fair value of donated services must be recorded when there is the equivalent of an employer-employee relationship and an objective basis for valuing such services. The value of services donated by organizations must be evidenced by a contractual relationship which provides the basis for valuation. The amounts recorded are not to exceed those paid others for similar work.

The value of services of a type for which hospitals generally do not remunerate individuals' performances, are not included as operating costs (e.g., donated services of individuals such as volunteers and trustees).

ACCOUNTING PRINCIPLES .21-.50

ACCRUAL ACCOUNTING .21

In order to provide the necessary completeness, accuracy and meaningfulness in accounting data, accrual basis of accounting is required. Accrual accounting is the recognizing and recording of the effects of transactions and other events on the assets and liabilities of the hospital entity in the time periods to which they relate rather than only when cash is received or paid. For example, the writing off to expense each year of 1/3 of the cost of a three year insurance policy.

MATCHING OF REVENUE AND EXPENSES .22

Determination of the net income of an accounting period requires measurements of revenue, revenue deductions, and expenses associated with the period. Hospital revenue must be recorded in the period in which it is earned; that is, in the time period during which the services are rendered to patients and a legal claim arises for the value of the services.

Once the revenue determination is made, a measurement must be made of the amount of expense incurred in rendering the services on which the revenue determination was based. Unless there is such a matching of revenue and expense, the reported net income of a period is meaningless.

The requirement that revenue deductions must also be matched properly against the gross revenues of the accounting period is sometimes overlooked. During the accounting period, patients' accounts receivable will be debited and revenue accounts will be credited, at the hospital's full established rates, for all services rendered to patients. Some of these accounts receivable will remain unpaid at the end of the accounting period. A majority of these accounts will be collected in cash from the patients or from their third-party payors, but the remainder eventually will be written off as deductions from revenue.

It is important that these revenue deductions be given accounting recognition in the same period that the related revenues were recorded, even though certain of these revenue deductions cannot be precisely determined.

Revenue and expenses are to be matched not only for the hospital as a whole, but also for each cost center. The cost center is an accounting device for accumulating items of cost or revenue that have common characteristics. A cost center may or may not be a department within the hospital. A cost center, such as depreciation, is an example where the cost center would not be a department of the hospital. The costs of the functions and activities included in each cost center description are to be included in the cost center. Revenue relative to such functions and activities must be included in the matching revenue center. For example, expenses related to the Laboratory functions (activities) are to be included in Laboratory Services cost center (Account 7210) and related revenue are to be included in Laboratory Services revenue center (Account 4210).

DEDUCTIONS FROM OPERATING REVENUE

.23

In many instances, the hospital receives less than its full established charges for the services it renders. It is essential that accounting information reflect both the gross revenue and revenue "adjustments" resulting from inability to collect established charges for services provided. These revenue "adjustments" are called Deductions from Revenue and are of the following primary categories:

1. Provision for Bad Debts—These deductions represent estimated amount of current revenues that will not be realized as a result of credit losses.
2. Contractual Adjustments—These adjustments represent the differences between full established charges for individual services and the contractual rates received or to be received from third-party payors for services rendered.
3. Charity Service—These deductions represent the difference between full established charges and amounts received or to be received from indigent patients, voluntary agencies, or governmental units on behalf of specific indigent patients.
4. Policy Discounts—These deductions represent adjustments for items such as courtesy allowances and employee discounts from the hospital's full established charges for services.

5. Administrative Adjustments—These adjustments represent amounts of patient service revenue posted but not billed to patients because the cost of billing and collection would exceed the amounts received.
6. Prospective Rate Adjustments—These adjustments represent, essentially, revenue lost or gained due to variances from approved rates (price variance) and variances in approved volumes (volume variance). Revenue lost due to negative variances in rates and underachieving in approved volumes will be recouped, wholly or in part, by the hospital through increases in prospective rates. Similarly, revenue gained due to positive variances in rates and overachieving in approved volumes will be paid back, wholly or in part, by the hospital through reductions in prospective rates.

The above items must be recorded and reported as deductions from gross operating revenue on an accrual basis rather than as expenses.

FUND ACCOUNTING

.24

Many hospitals receive, from donors and other third-parties, income, gifts, bequests and grants that are restricted as to use. When funds with donor-imposed restrictions are received, they must be accounted for separately. This would not preclude the pooling of assets for investment purposes.

For Balance Sheet reporting, donor-restricted funds must be recorded separately in the appropriate restricted fund classifications. For income statement purposes, expenses relating to donor-restricted activities must be recorded in the Unrestricted Fund, and the earned share relative to such current year donor-restricted activities must be recorded as "Other Operating Revenue" unless otherwise restricted by covenant agreement. Hospitals receiving no restricted income, gifts, bequests, or grants need not use separate fund accounting.

Restricted funds generally fall into three categories: Plant Replacement and Expansion Fund, Specific Purpose Fund, and Endowment Fund. The accounts within each restricted fund are self-balancing, as each fund constitutes a separate subordinate accounting entry. The following sections outline the conditions and events which require separate accountability and the required accounting treatment for transactions within the established funds.

Unrestricted Fund .241

The Unrestricted Fund is used to account for funds derived from the day-to-day activities of the hospital and unrestricted contributions. Funds which originate from unrestricted gifts or previously accumulated income may be designated by the governing board for special uses. If the governing board designates assets in this manner, it should be recognized that the board also has the authority to rescind its action. For this reason, such funds must be accounted for in the Unrestricted Fund as "Board-Designated Assets". All other funds within the Unrestricted Fund must be accounted for as Operating Funds. A separate structure of accounts in the Unrestricted Fund has been provided for Operating Funds and Board Designated Assets. The term "restricted" should not be used in connection with board or other internal hospital appropriations or designations of assets.

Plant Replacement and Expansion Fund .242

Resources restricted by donors and other third-parties for the acquisition or construction of plant assets or the reduction of related debt must be accounted for in the Plant Replacement and Expansion Fund.

When expenditures for plant assets are made by the Unrestricted Fund for the Plant Replacement and Expansion Fund, a transfer must be made from the Plant Replacement and Expansion Fund to match such expenditures if such funds are available. The entries to record such expenditures and the required transfer in both funds are as follows:

Unrestricted Fund

June 30	<u>Account</u>	<u>Dr.</u>	<u>Cr.</u>
Construction in Progress	1260	\$1,000	
Other Accounts Payable	2029		\$1,000
Due from Plant Replacement and Expansion Fund	1073	\$1,000	
Transfer from Restricted Funds for Capital Outlay	2294		\$1,000

Plant Replacement and Expansion Fund

Transfer to Unrestricted Fund for Capital Outlay	2695	\$1,000	
Due to Operating Fund	2581		\$1,000

To record construction expenses incurred and related inter-fund transfer entries.

Due to/due from accounts are to be used only as an interim measure and should be reduced within a reasonable period of time by a transfer of assets (generally cash or investments) between the respective funds.

Plant Replacement and Expansion Fund

July 3	<u>Account</u>	<u>Dr.</u>	<u>Cr.</u>
Due to Operating Fund	2851	\$1,000	
Cash	1510		\$1,000

Unrestricted Fund

Cash	1010	\$1,000	
Due from Plant Replacement and Expansion Fund	1073		\$1,000
To record transfer of cash from Plant Replacement and Expansion Fund to the Operating Fund.			

Unrestricted Fund

July 5	<u>Account</u>	<u>Dr.</u>	<u>Cr.</u>
Other Accounts Payable	2029	\$1,000	
Cash	1010		\$1,000
To record payment of the liability.			

If cash is disbursed for plant assets directly from the Plant Replacement and Expansion Fund, the plant assets must nonetheless be recorded in the Unrestricted Fund, with the accompanying credit made to Fund Balance. In the Plant Replacement and Expansion Fund, Fund Balance would be debited, and a cash account credited. No entries would be made to the inter-fund payable or receivable accounts, nor would any cash be transferred between funds.

The preferred method of accounting for the expenditure of restricted Plant Replacement and Expansion funds is specified above. However, because of restrictions placed on construction funds by certain funding authorities, such expenditures and related liabilities are required to be recorded in the Plant Replacement and Expansion Fund. If expenditures for plant assets are recorded in the Plant Replacement and Expansion Fund, the plant assets must be transferred to the appropriate asset account in the Unrestricted Fund, with the accompanying credit made to the Unrestricted Fund Balance. In the Plant Replacement and Expansion Fund, Fund Balance would be debited, and the temporary account(s) credited. No entry would be made to the inter-fund payable or receivable accounts. (Accounts have not been provided in this manual for recording such expenditures and related liabilities. Hospitals may establish such accounts as necessary.)

Income earned and any net realized gains on investments must be reflected as an addition to the fund balance if so specified by the donor. If available for general operating purposes, they must be included in non-operating revenue in the Unrestricted Fund:

Specific Purpose Fund .243

Funds received which are restricted for a specific operating purpose must be accounted for in the Specific Purpose Fund. These resources must be recorded as other operating revenue in the period in which expenditures are made for the purpose specified by the donor.

Income earned and any net realized gains on investment must be recorded as an addition to Fund Balance if required to conform to the donor's instructions or as non-operating revenue of the Unrestricted Fund if such revenue is available for general purposes.

Endowment Fund .244

Funds classified as endowment include:

- pure endowment (principal is to remain intact in perpetuity).
- term endowments (principal is available for use upon the
- passage of time or the occurrence of an event).

When term endowments become available to the governing board for unrestricted purposes, they must be recorded as non-operating revenue; if these funds are restricted, they must be transferred to the appropriate restricted fund.

Income earned on endowment fund investment must be accounted for in accordance with donor's instructions if restricted, or as non-operating revenue in the Unrestricted Fund if not restricted.

Inter-fund Transactions .245

As is shown in the Chart of Accounts, the only liability accounts included in the restricted funds (i.e., all funds other than the Unrestricted Fund) are liabilities to other funds (with the exception of the Endowment Fund, which allows for the inclusion of certain liabilities on Endowment Fund assets and the Plant Replacement and Expansion Fund for certain covenant agreements as explained in Section 100.242).

Thus, virtually all liabilities incurred by the hospital are to be recorded in the Unrestricted Fund. When these liabilities apply to restricted fund activities, a receivable from the applicable restricted fund activities must be recorded within the Unrestricted Fund. A payable to the Unrestricted Fund (or transfer of funds if paid immediately) as well as a reduction of the restricted fund balance is recorded within the applicable restricted fund.

Except for expenses incurred in conformity with covenant agreements, all expenses relating to restricted fund activities must be recorded in the Unrestricted Fund in the cost center category to which they apply. This is true whether the actual expenditures of cash are made from the Unrestricted Fund or a restricted fund. Separate cost centers must be established within each of these categories to record restricted activities for which separate accounting are required by the terms of the grant or gift. Sufficient account numbers have been allowed so that specific restricted fund activities may be segregated. Transfers from these restricted funds to match those expenses must be made in one of the following accounts:

Transfers from Restricted Funds for Research Expenses (Account 5020)

Transfers from Restricted Funds for Education Expenses (Account 5280)

Transfers from Restricted Funds for Other Operating Expenses (Account 5880)

EXAMPLE

In the following example, assume that \$200 of consulting costs were incurred (this consulting was performed by a non-related organization) for restricted research activities, recorded as an expense and a liability in the Unrestricted Fund, and subsequently paid.

SECTION 100
ACCOUNTING PRINCIPLES AND CONCEPTS

UNRESTRICTED FUND

June 1	<u>Account</u>	<u>Dr.</u>	<u>Cr.</u>
Research	8010	\$ 200	
Accounts Payable	2020		\$ 200
Due from Specific Purpose Fund	1074	\$ 200	
Transfers from Restricted Funds for Research Expenses	5020		\$ 200

SPECIFIC PURPOSE FUND

June 1			
Transfers to Operating Fund for Operating Purpose	2797	\$ 200	
Due to Operating Fund	2781		\$ 200

To record the expense and related liability for costs incurred in restricted research activities in the Operating Fund and record an inter-fund liability and reduction in fund balance in the specific purpose fund.

UNRESTRICTED FUND

June 10	<u>Account</u>	<u>Dr.</u>	<u>Cr.</u>
Cash	1010	\$ 200	
Due from Specific Purpose Fund	1074		\$ 200

SPECIFIC PURPOSE FUND

June 10			
Due to Operating Fund	2781	\$ 200	
Cash	1710		\$ 200

To record the transfer of cash to the Operating Fund

UNRESTRICTED FUND

June 15	<u>Account</u>	<u>Dr.</u>	<u>Cr.</u>
Accounts Payable	2020	\$ 200	
Cash	1010		\$ 200
To record the payment of the liability			

LONG-TERM SECURITY INVESTMENTS .25

Long-Term Security Investments are to be valued at hospital cost if purchased or, if acquired by donation, at the fair market value at the date of the gift. If there is evidence of a permanent decline in value, an appropriate reduction in carrying value must be made by charging the necessary expense account(s). The market value of long-term security investments at year-end must be disclosed.

POOLED INVESTMENTS .26

Investments of various funds may be pooled unless prohibited by law or the terms of a donation or grant. Gains/losses and investment income on pooled investments must be distributed to participating funds on a basis utilizing market value at least annually.

To illustrate the market value method of distributing gains/losses and income on pooled investments, assume the following facts:

1. A hospital decides to create a pool of investments from funds provided from the following sources:

	<u>*Market Value at Inception of Pool</u>	
	<u>Amount</u>	<u>% to Total Pool</u>
Unrestricted Funds	\$ 1,000,000	20%
Endowment Funds (Single endowment)	\$ 3,000,000	60%
Plant Replacement and Expansion (PR&E) Funds	<u>\$ 1,000,000</u>	<u>20%</u>
	<u>\$ 5,000,000</u>	<u>100%</u>

*This serves as the initial distribution basis.

2. Gains/losses on the endowment funds must be added to or deducted from the principal; however, the investment income is available for unrestricted purposes under the terms of the gift.
3. Gains/losses and investment income for the plant replacement and expansion funds must be added to or deducted from fund balance pursuant to the wishes of the donor.
4. There were no gains/losses on the sale of investments for the first year the pool was in existence. The income generated by the pool for that year was \$400,000.
5. Any gains on investments sales and investment income are not reinvested in the investment pool. The cash is remitted to funds that are entitled to the gains and/or income.

The distribution of the income for the first year would be based on each participating fund's percentage (%) of the pool based on its contribution at market value at the initiation of the pool. Therefore, the distribution would be as follows:

	<u>Distributed To</u>	<u>Income Distributed</u>
Unrestricted Funds	(Total income of \$400,000 × 20%)	\$ 80,000
Endowment Funds	(Total income of \$400,000 × 60%)	240,000
PR&E Funds	(Total income of \$400,000 × 20%)	<u>80,000</u>
		<u>\$400,000</u>

The accounting entries necessary to account for the distribution of income from the pooled investments would be as follows:

<u>Unrestricted Fund</u>	<u>Account</u>	<u>Dr.</u>	<u>Cr.</u>
Cash	1010	\$ 320,000	
Unrestricted Income from Endowment Funds (non-operating revenue)	9040		\$ 240,000
Income, Gains and Losses from Unrestricted Investments	9040		\$ 80,000
To record the income from pooled investments for the year.			

PR&E Fund

	<u>Account</u>	<u>Dr.</u>	<u>Cr.</u>
Cash	1510	\$ 80,000	
Fund Balance	2690		\$ 80,000
To record the income from pooled investments for the year.			

In the second year the following facts are assumed:

1. On the first day of the year the hospital decided to add \$1,000,000 of unrestricted funds to the pooled investments. On that date; but prior to making the aforementioned addition, the pooled investments had the same cost, \$5,000,000, as at inception but a market value of \$6,000,000. There were no other additions to the pool during the year.
2. There were net gains on the sale of investments of \$100,000 for the year and the investment income was \$500,000 for the same period.

Based on the above facts the distribution percentage (%) for the income and gains on pooled investments for each of the participating funds would be based on the market value of the investment pool as of the date of the last addition and would be calculated as follows:

	<u>Units</u>	<u>Revised Distribution Basis</u>	<u>% to Total Units</u>
Unrestricted Fund:			
Market value \$6,000,000 × 20% (distribution % prior to addition)	\$1,200,000		
Addition to pool at fair value as of that date	<u>1,000,000</u>		
	\$2,200,000		31.4%

	Revised <u>Distribution Basis</u>	
	<u>Units</u>	<u>% to Total Units</u>
Endowment Fund:		
Market value \$6,000,000 × 60% (distribution % prior to addition—no new additions)	\$ 3,600,000	51.4%
PR&E Fund:		
Market value \$6,000,000 × 20% (distribution % prior to addition—no new additions)	<u>1,200,000</u>	<u>17.2%</u>
	<u>\$7,000,000</u>	<u>100.0%</u>

The income and gains from pooled investments for the second year would be based on the newly computed distribution and would be as follows:

	<u>Current Distribution %</u>	<u>Gains to be Distributed</u>	<u>Income to be Distributed</u>
Unrestricted Funds	31.4%	\$ 31,400	\$ 157,000
Endowment Funds	51.4%	51,400	257,000
PR&E Funds	<u>17.2%</u>	<u>17,200</u>	<u>86,000</u>
	<u>100.0%</u>	<u>100,000</u>	<u>500,000</u>

The accounting entries necessary to reflect the above distribution would be as follows:

Unrestricted Fund

	<u>Account</u>	<u>Dr.</u>	<u>Cr.</u>
Cash	1010	\$ 445,400	
Unrestricted Income from Endowment Funds (non-operating revenue)	9050		\$ 257,000
Income, Gains and Losses from Unrestricted Investments	9040		188,400

To record the income and gains on pooled investments attributable to these funds for the year.

Endowment Fund

	<u>Account</u>	<u>Dr.</u>	<u>Cr.</u>
Cash	1810	\$ 51,400	
Fund Balance (Gains on sales of investments)	2890		\$ 51,400

To record the gains on pooled investments attributable to this fund for the year.

PR&E Fund

	<u>Account</u>	<u>Dr.</u>	<u>Cr.</u>
Cash	1510	\$103,200	
Fund Balance	2690		\$103,200

To record the gains and income on pooled investments attributable to this fund for the year.

As the above example illustrates, each time an addition is made to the investment a new distribution basis may be calculated but at least annually. This is also true for any reductions to the pool. All gains/losses and investment income from the beginning of the accounting period up to the date of the addition must be determined and distributed on the basis of account balances prior to the addition. Any gains/losses and investment income subsequent to an addition would be distributed on the new basis until another addition or reduction is made.

INVENTORIES

.27

Inventories reflect the cost of unused hospital supplies. Any generally accepted cost method (e.g., FIFO, LIFO, Average, etc.) may be used as long as it is consistent with that of the preceding accounting period.

Inventory accounting record systems are required, consistent with the method of the inventory valuation employed. Perpetual inventory records are recommended but are not required. Physical valuations must be made at least once a year and the accounting records, if applicable, adjusted to such valuations.

Inventory usage records are required to be maintained for all inventories that are distributed and used by more than one cost center in the hospital. It is recommended that the formal requisition system be used for this purpose.

ACCOUNTING FOR PROPERTY, PLANT AND EQUIPMENT .28

Classification of Fixed Asset Expenditures .281

Property, Plant and Equipment and related liabilities must be recorded in the Unrestricted Fund, since segregation in a separate fund would imply the existence of restrictions on the use of the asset. Cost of construction on progress and related liabilities must be recorded in the Unrestricted Fund as incurred except for assets and liabilities related to certain debt agreements. See Section 100.333, Accounting for Debt Proceeds.

Basis of Valuation .282

Property, Plant and Equipment must be reported on the basis of cost. Cost shall be defined as historical cost or fair market value at the date of gift of donated property in accordance with GAAP.

Accounting Control .283

To maintain accounting control over capital assets of the hospital, a plant asset ledger should be maintained as part of the general accounting records. Some items of equipment should be treated as individual units within the plant ledger when their individuality and unit cost justify such treatment. Other items of equipment, if they are similar and are used in a single cost center, may be grouped together and treated as a single unit within the ledger.

All equipment purchased for capital intensive cost centers must be segregated in the plant ledger record by cost center so that the cost of equipment and the related depreciation for each cost center is available.

Capitalization Policy

.284

If a depreciable asset has at the time of its acquisition an estimated useful life of three or more years and a historical cost of at least \$500, its cost must be capitalized, and written off ratably over the estimated useful life of the asset.

If a depreciable asset has a historical cost of less than \$500, or if the asset has a useful life of less than three years, its costs are recorded in the year it is acquired, subject to the provisions of writing off the costs of minor movable equipment. The hospital may, if it desires, establish a capitalization policy with lower minimum criteria but under no circumstances may the above criteria be exceeded. Alterations and improvements which extend the life or increase the productivity or efficiency of an asset, as opposed to repairs and maintenance which either restore the asset to or maintain it at its normal or expected service life must be capitalized and depreciated over their expected useful lives not to exceed the lives of the asset to which they are fixed. Normal repair and maintenance costs are to be reported as expense in the current accounting period.

Minor Equipment

.285

Minor equipment includes such items as waste baskets, bed pans, silverware, mops, buckets, etc. The general characteristics of this equipment are: (a) in general, no fixed location, and subject to use by various departments within a hospital; (b) comparatively small in size and unit cost; (c) subject to inventory control; (d) fairly large quantity in use; and (e) generally, a useful life of less than three years.

There are two ways in which the cost of minor equipment may be recorded:

- a. The original investment in this equipment may be capitalized and written off over three years. All subsequent purchases would be written off over three years.

- b. All purchases of minor equipment may be capitalized and depreciated over their estimated useful lives.

Once a hospital has applied one of the methods, that method must be used consistently thereafter.

Interest Expense During Period of Construction .286

Frequently hospitals borrow funds to construct new facilities or modernize and expand existing facilities. Interest costs incurred during the period of construction must be capitalized as a part of the cost of the construction. The period of construction is considered to extend to the date the constructed asset is put into use. When proceeds from a construction loan are invested and income is derived from such investments during the construction period, the amount of interest expense to be capitalized must be reduced by the amount of such income.

Depreciation Policies .287

Depreciation on plant assets used in the hospital's operations must be recorded as an operating expense in the Unrestricted Fund. The straight line method of depreciation must be used for all assets acquired after July, 1970.

The estimated useful life of a depreciable asset is its normal operating or service life in terms of utility to the hospital. Some factors to be considered in determining useful life include normal wear and tear, obsolescence due to normal economic and technological advances, climatic or other local conditions and the hospital's policy for repair and replacement. In selecting a proper useful life for computing depreciation, hospitals must utilize the most recent useful life guidelines published by the American Hospital Association. However, with the rapidly changing technology in hospitals, these recommendations may not be all inclusive; in which case, the expertise of the manufacturer or other reliable sources may be considered.

For reporting purposes, each hospital must establish, and follow consistently, from year to year, a policy relative to the amount of depreciation to be taken in the years of acquisition and disposal of depreciable assets. Examples of acceptable policies are:

1. Computing first year depreciation based upon the portion of time the asset was in use during the year. That is, if a depreciable asset was received and in use in the hospital for eight months in the year of acquisition, two-thirds of a full year's depreciation expense would be recognized in that first year.

2. Recording one-half of the yearly depreciation expense in the years of acquisition and disposal, regardless of date of acquisition.
3. Recording a full year's depreciation expense if the asset was acquired in the first half of the year. If the asset was acquired in the last half of the year, no depreciation expense would be recognized.

It should be noted that depreciation expense must not be recorded until assets are put into use in hospital operations. Thus, no depreciation would be recorded relative to a new hospital building until that building was actually put into use.

TIMING DIFFERENCES

.29

Timing differences result when accounting policies and practices used in an organization's accounting differ from those used for reporting operations to governmental units collecting taxes or to outside agencies making payments based upon the reported operations. These differences must be recorded on the Hospital's records when they arise. The references relative to their acceptable accounting treatment are as follows:

- Income tax allocation—Accounting Principles Board Opinions Nos. 11, 23 and 24.

The following condensed income statement illustrates a timing difference attributable to different methods of calculating depreciation expense for financial accounting versus tax or third-party reimbursement purposes.

Assumptions:

1. Depreciation for accounting purposes is calculated on the straight-line method and amounts to \$10 for the current year.
2. Depreciation for tax and third-party reimbursement purposes is calculated on a declining balance method and amounts to \$20 for the current year.
3. The tax rate is 40%.
4. The third-party utilization is 50%.
5. The only deduction from revenue is the contractual allowance.

		Accounting <u>Records</u>	Tax/Third-Party <u>Cost Report</u>
Revenue		\$ 180	\$ 180
Deductions from Revenue	(B)	<u>30</u>	<u>25</u>
Net Revenue		\$ <u>150</u>	\$ <u>155</u>
Expenses (excluding depreciation)		110	110
Depreciation		<u>10</u>	<u>20</u>
Total Expenses before Taxes		<u>120</u>	<u>130</u>
Income before Taxes		30	25
Taxes	(A)	<u>12</u>	<u>10</u>
Net Income		\$ <u>18</u>	\$ <u>15</u>

(A) The income tax expense is comprised of three components:

1. \$10 currently payable, (2) \$4 payable in future periods representing the tax effect of the difference between depreciation expense for accounting and tax purposes ($40\% \times \$10 = \4), and (3) \$2 to be applied against tax liabilities in future periods, representing the tax effect relative to reimbursement caused by the differences between depreciation for accounting purposes and cost report purposes, computed as follows: 40% (tax effect) = 50% (third party utilization) \times $\$10$ (difference between depreciation for accounting and cost report purposes) = $\$2$ or stated another way, it is the difference between the deductions from revenue per the accounting records ($\$30$) and the Tax/Cost Report Records ($\$25$) times the tax rate of 40% . The journal entry to record these items is:

	<u>Account</u>	<u>Dr.</u>	<u>Cr.</u>
Provision for Income Taxes—Federal— Current	9411	\$10	
Provision for Income Taxes—Federal— Deferred	9412	2	
Income Taxes Payable	2090		\$10
Deferred Income Taxes Payable	2120		2

(B) The deduction from revenue (contractual adjustments) is calculated as follows:

	<u>Accounting Records</u>	<u>Tax/Cost Report</u>
Medicare Revenue ($\$180 \times 50\%$)	\$90	\$90
Reimbursable Costs:		
$\$120 \times 50\%$	60	
$\$130 \times 50\%$		65
Contractual Adjustment	<u>—</u>	<u>—</u>
	<u>\$30</u>	<u>\$25</u>

Of the \$30 contractual adjustment for accounting purposes, \$25 is the current portion and \$5 is the deferred portion. The journal entry to record this expense is:

	<u>Account</u>	<u>Dr.</u>	<u>Cr.</u>
Contractual Adjustment-Medicare	5910	\$30	
Allowance for Contractual Adjustment- Medicare	1042		\$25
Deferred Revenue-Medicare	2131		5

ACCOUNTING FOR PLEDGES .30

All pledges, less a provision for amounts estimated to be uncollectible, must be included in the hospital's accounting records. If unrestricted, they must be recorded as non-operating revenue in the period the pledge is made. If part of the pledge is to be applied during some future period, that part must be recorded in the period the pledge is received as deferred revenue. If restricted, they must be recorded in addition to the appropriate restricted fund balance. See Hospital Audit Guide.

SELF INSURANCE .31

Self Insurance by a hospital for potential losses due to unemployment, workmen's compensation and malpractice claims, asserted or otherwise, places all or part of the risk of such losses on the hospital rather than insuring against all or part of such losses with an independent insurer. Accruing for self-insured losses is governed by the Financial Accounting Standards Board's Statement No. 5 on Accounting for Contingencies.

RELATED ORGANIZATIONS .32

Auxiliaries, guilds, fund raising groups and other related organizations frequently assist hospitals. If such organizations are independent and are characterized by their own charter, bylaws, tax-exempt status and governing board or a sufficient combination of these characteristics to demonstrate their independent existence from the hospital, the financial reporting of these organizations should be separate from reports of the hospital. If such organizations are under the control of (or common control with) hospitals and handle hospital resources, their financial reports must be combined with those of the hospital.

A hospital itself may be subsidiary to or under the control of a larger organization such as university, governmental entity or parent corporation. It is typical in such situations for hospitals to receive services from these related organizations. Examples of services received are administration, purchasing, general accounting and menu planning. In addition, related organizations lease property, plant and equipment to hospitals as well as paying for various other items such as insurance. The related organization then usually charges for the service either directly or through a management fee. The direct charges must be recorded in the appropriate cost centers as billed, and the management fee must be distributed to the functional cost centers in amounts relative to the services received for which the fee is paid. When this management fee is recorded in the related functional cost centers, the natural classification of expense account .76, Management and Contracted Services, must be used.

DEBT FINANCING FOR PLANT REPLACEMENT AND EXPANSION PURPOSES .33

Debt financing for plant replacement and expansion programs may take many forms. Under the terms of most debt financing agreements the debtor is required to perform or is prohibited from performing certain acts. In many instances debt financing gives rise to special accounting treatment because of discounts and premiums on bond issues, financing charges, formal restrictions on debt proceeds, and sinking and other required funds.

Discounts and Premiums on Bond Issues .331

Discounts and Premiums arising from the issue of bonds must be amortized over the life of the related issue(s). Bond discounts must be recorded as a reduction of the related debt (Bonds Payable—Net of Unamortized Discount). Bond premium must be recorded as Other Deferred Credits, (Account 2140).

Financing Charges .332

Costs of obtaining debt financing other than discounts (e.g., legal fees, underwriting fees, special accounting costs) must be recorded as deferred costs and amortized over the life of the related debt.

Accounting for Debt Proceeds .333

Debt agreements for financing plant replacement and expansion programs may or may not require formal segregation of debt proceeds prior to their use. Proceeds which are not required to be formally segregated prior to their use must be recorded as other non-current assets in the Unrestricted Fund.

For the purposes of this manual, all funds received under covenant agreements which require formal segregation and/or separate accountability shall be recorded in the Plant Replacement and Expansion Fund until such time as the project is completed. Upon completion, the asset and related debt must be transferred to the Unrestricted Fund. See Section 100.242 for further discussion.

Sinking and Other Required Funds .334

These funds are usually established to comply with loan provisions whereby specific deposits are to be used to insure that adequate funds are available to meet future payments of:

1. Interest and principal (retirement of indebtedness funds); or
2. Property insurance, related taxes, repairs and maintenance costs, equipment replacement (escrow funds).

Funds of this nature may also be required to be held by trustees outside the hospital. Income generated from the investment of such funds may be immediately available to the hospital or such income may be held by the trustee for some future designated purpose.

For the purpose of this manual all sinking and other required funds will be accounted for in the following manner:

1. All fund assets, whether trustee or otherwise, must be recorded in the Unrestricted Fund as a long term investment.

2. All income generated from the investment of such funds must be recorded as non-operating revenue in the Unrestricted Fund, except as required in Section 100.286. Income generated from funds under covenant agreement may be accounted for as an addition to the appropriate restricted fund balance

Early Debt Retirement .335

Many bond contracts provide for the calling of any portion or all of the issue at the option of the company at a stated price, usually above par, for the purpose of enabling the corporation to reduce its indebtedness before maturity as occasion arises, or to take advantage of opportunities to borrow on more favorable terms. Bonds are often retired piecemeal through sinking fund operations.

Costs incidental to the recall of bonds before their date of maturity are considered debt cancellation costs. Such costs include bond recall penalties, unamortized bond discounts and expenses, legal and accounting fees, etc. These costs must be reduced by any unamortized bond premiums and recorded in the Unrestricted Fund in accordance with generally accepted accounting practices.

SPECIALIZED ACCOUNTING AREAS .51-.99

DIRECT RECORDING OF COSTS .51

The direct recording of costs is the process of identifying and assigning costs directly to the functional cost center generating those costs.

Buildings and Fixtures .511

The cost of all depreciation or rent/lease of buildings and fixtures is to be charged to the Depreciation and Amortization Cost Center (Account 8810) and to Leases and Rental Cost Center (Account 8820), respectively, and not accounted as direct expense of specific cost centers.

Movable Equipment .512

The cost of depreciation and rent/lease on movable equipment is to be charged to the Depreciation and Amortization Cost Center (Account 8810) and to the Leases and Rental Cost Center (Account 8820), respectively.

Salary and Payroll Related Employee Benefits

.513

The salary cost must be assigned directly to the functional cost center to which the employee is assigned (see Natural Classification Accounts, Section 200.037). For example, the salary cost of direct nursing service must be directly assigned to the patient care cost centers receiving the service. This assignment must be based on each employee's actual nursing hours performed within each patient care cost center multiplied by that employee's hourly salary rate while performing the direct nursing services.

It may not be based on the average hours worked or any other such basis. For example, a nurse is assigned to work in various hospital cost centers (pediatric acute, medical-surgical intensive care, and coronary care) during a given payroll period. The hospital must specifically identify that portion of the particular nurses' salary attributable to each cost center. (See Nursing Float Personnel cost center, Account 8992).

Payroll related employee benefits must be reported in the cost center that the applicable employee's compensation is recorded. This can be accomplished by direct assignment each pay period or by accumulating employee benefit costs in account 8993, Employee Benefits, and assigning the expenses to the appropriate cost centers at year-end. This assignment can be performed on an actual basis or upon the following basis:

- FICA—actual expense by cost center
- Pension and Retirement and Health Insurance (non-union)—gross salaries of participating individuals by cost center
- Union Health and Welfare—gross salaries of participating union members by cost center
- All other payroll related benefits—gross salaries by cost centers

For non-payroll related employee benefits, see Section 100.514.

Employee Benefits (Non-Payroll Related) .514

The cost of non-payroll related employee benefits must be allocated to the functional cost centers based upon numbers of full time equivalent employees. Refer to Appendix A-Glossary for the methodology for computing a full time equivalent employee.

Non-Payroll Related employee benefits are those which can be identified as being equally available for the benefit of the entire hospital employee population even though all employees do not avail themselves to these benefits. Examples are provisions of recreation areas, employee health services, day care centers, cafeteria, etc.

Medical Supplies .515

The invoice/inventory cost of all disposable medical and surgical supplies used in daily hospital service centers, ambulatory service centers and certain ancillary service centers (Labor and Delivery Services Account 7010 and Operating Room, Account 7040, Ambulatory Surgery, Account 7050, Speech-Language Pathology, Account 7050, Audiology, account 7580 and Intervention Cardiovascular 7510 Physical Therapy, Account 7310 are to be accounted for as a cost of the Medical Supplies Sold cost center (Account 7110). The related revenue must be reflected in the Medical Supplies Sold revenue center (Account 4110).

The disposable medical and surgical supplies consist of billable supplies and non-billable supplies. The billable disposable supplies are accounted for in sub-accounts 4111 and 7111 for revenue and expenses respectively. The non-billable disposable supplies are accounted for in sub-accounts 4112 and 7112 revenue and expenses respectively.

The overhead associated with the issuing of all medical and surgical supplies must be accounted for in the Central Services and Supply cost center (Account 8460). The cost of reusable (Non-disposable) medical and surgical supplies used in daily hospital service centers, must be accounted for in the Central Services and Supply cost center (Account 8460).

Drugs .516

All pharmaceutical supplies and materials (including IV solutions, admixtures, etc.) used in daily hospital service centers, ambulatory service centers and ancillary service centers excluding Drugs Incident to Radiology are to be accounted for as a cost of the Drugs Sold cost center (Account 7150). The related revenue is to be reflected in the Drugs Sold revenue center (Account 4150).

Drugs Incident to Radiology, i.e. contrast media, etc. is to be accounted for as a cost of the using cost center.

The pharmaceutical supplies and materials consist of billable supplies and materials and non-billable supplies and materials. The billable pharmaceuticals are accounted for in sub-accounts 4151 and 7151 for revenue and expenses respectively. The non-billable pharmaceuticals are accounted for in sub-accounts 4152 and 7152 for revenue and expenses respectively.

The overhead associated with the issuing of pharmaceutical supplies and materials (including IV solutions, admixtures, etc.) must be accounted for in the pharmacy cost center (Account 8460).

Plant Maintenance .517

All direct costs incurred in the maintenance, repair and service of buildings, grounds, parking facilities and equipment, (with the exception of that equipment used in the performance of the principal function in following capital intensive cost centers: medical/surgical intensive care, coronary care, pediatric intensive care, neo-natal intensive care, operating room, laboratory services, cardiac catheterization laboratory, radiology-diagnostic, CT scanner, radiology-therapeutic, nuclear medicine, renal dialysis and MRI scanner) are included in the Plant Operations and Maintenance cost center (Account 8410)

Data Processing .518

All the direct costs incurred in operating an electronic data processing center shall be recorded in the Data Processing cost center (Account 8994) and transferred to the using cost center on the basis of CPU (Central Processing Unit) time or some other basis. For reporting purposes this account carries a zero balance.

Central Patient Transportation

.519

Central Patient Transportation costs of transporting patients to and from Ancillary Services are considered a part of the Ancillary Services function of the hospital. Therefore, all such costs, wherever they are incurred, must be transferred to the appropriate Ancillary Services Cost Centers for reporting purposes. A central Patient Transportation Cost Center (Account 8891) is provided for those institutions wishing to identify the expense of transporting patients within the facility. If used it should contain all the direct costs of transporting patients between services in and about the hospital. However, no costs shall be reported in this account. (See Section 200, Account 8991).

The expenses incurred in transporting patients to the Daily Hospital Services areas at the time of admission are to be assigned to the Inpatient Admitting Cost Center (Account 8524). The expenses incurred in transporting patients who have been discharged are to be assigned to the Daily Hospital services functional cost center from which the patient was discharged.

HOSPITAL RESEARCH AND EDUCATION COSTS

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All direct costs incurred in conducting hospital research and formal education activities (as opposed to in-service education) must be recorded in Unrestricted Fund cost center accounts 8010–8199 (Research Expenses) or 8210–8299 (Education Expenses).

Grant Accountability

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When a separate accounting is required by law, grant contract, or donations restricted for research and educational activities separate cost centers must be maintained. Transfers from restricted funds to match the expenditures for these activities must also be segregated into separate accounts in the series 5020–5199 (Research) or 5280–5300 (Education). Thus, accountability is maintained for all restricted research and educational activities.

Overhead Allocation

.522

No allocation of indirect overhead is to be made on the books prior to cost reporting unless such allocation is required by grant contract. When a grant contract calls for the payment of direct costs plus an overhead factor, the overhead factor should be included in billing, but no allocation should be made in the hospital's accounting records.

The following example illustrates the accounting treatment of restricted grant activity.

Assume that a hospital received a specific research grant on December 1, which called for payment of direct costs incurred, plus an overhead allocation of 10 percent of such costs. At December 31, (the hospital's year end) \$150 of direct costs had been incurred. The following entries would be made in the hospital's accounting records at December 31:

Unrestricted Fund

	<u>Account</u>	<u>Dr.</u>	<u>Cr.</u>
Research	8010	\$ 150	
Cash	1010		\$ 150
Due from Specific Purpose Fund	1074	\$ 165	
Transfer from Restricted Funds for Research Expenses	5020		\$ 165

To record specific research direct costs and to set up receivable and other operating revenue from restricted fund for direct costs, plus overhead allocation.

Specific Purpose Fund

Fund Balance—Transfers to Operating Fund for Operating Purposes	2797	\$ 165	
Due to Operating Fund	2781		\$ 165

To record liability to unrestricted fund for direct research costs and overhead allocation.

If direct overhead must, by grant contract, be recorded in the Unrestricted Fund cost centers used for the recording of the direct costs of the grant activity, the natural expense classification .89 (other expenses) must be used. A separate cost center entitled "Overhead Applied" should be established in the Unrestricted Fund and credited with the amount of such overhead allocation. For accounting purposes the balance in the "Overhead Applied" cost center must be offset against the grant activity cost center, so costs remaining in the grant activity cost center are direct costs only.

Affiliated School Contracts .523

Education costs incurred relative to affiliated school contracts must be reflected in the Education series of accounts (8220–8299) in the Unrestricted Fund. Salaries, wages and stipends paid to students on approved programs (including interns and residents must be reflected in this series of accounts. Salaries, wages and stipends paid to interns and residents must be reflected in the appropriate natural classification of the Postgraduate Medical Education cost center (Account 8240). Fees paid to physicians involved primarily in approved education programs must also be recorded in the Education series of accounts, in the appropriate cost center.

IN-SERVICE EDUCATION—NURSING .53

Nursing in-service education activities are defined as educational activities conducted by the hospital for hospital nursing personnel. The cost of time spent by nursing personnel as students in such classes and activities must remain in the cost center in which their normal salary and wage costs are charged (i.e., the cost center in which they work). However, the cost (defined as salary, wages, and payroll related fringe benefits) of time spent in such classes and activities by those instructing and administering the programs must be included in the Nursing Administration Cost Center (Account 8750). For those hospitals that want to account for these costs separately and In-service Education Nursing sub-account (Account 8751 has been provided.

If instructors do not work full-time in the in-service program, the cost (as defined above) of the portion of time they spend working in the in-service education program must be included in the Nursing Administration cost center. This may be accomplished by direct distribution of these costs (by natural classification of expense category) each payroll period based upon actual hours worked.

the costs of nursing in-service education supplies (such as cassettes, books, medical supplies, etc.) and outside lecturers must also be reflected in the Nursing Administration cost center. Nursing in-service education does not include orientation of new employees. Such orientation costs must be charged to the cost center in which the new employees are, or will be assigned.

IN-SERVICE EDUCATION—NON-NURSING .54

All expenses associated with non-nursing in-service education activities must be included in the financial cost center to which the participating employees' salaries and wages are assigned, as such in-service educational activities will rarely apply to more than one functional activity.

PHYSICIAN REMUNERATION .55

Due to the numerous types of financial and work arrangements between hospitals and hospital-based physicians, comparability of costs between hospitals may be significantly impaired. This section deals with the methods that are currently used in recording costs and revenues related to the services of hospital-based physicians. The Commission recognizes that certain hospital-based physician costs are not recorded by the hospital as hospital expenses. However, the Commission contends that costs of hospital-based physicians, regardless of billing arrangement, are hospital costs and as such are to be reported to the Commission as hospital costs. The legality of the Commission contention is currently under review by the Court of Appeals and until a decision is reached, hospitals only have to report as hospital costs for their hospital-based physicians who are compensated under method 1 (Agency Arrangement), method 2 (Compensation Arrangement) and method 3 (Contracted Arrangement) described below.

Financial Arrangements .551

1. Agency Arrangement—The hospital bills patients for the physician's professional services, but records these billings as liabilities and the subsequent payment to the physician as a reduction of that liability. The hospital reflects no operating revenue or expense relative to the professional component.
2. Compensation Arrangement—The hospital bills patients for the physician's contractual professional services, including this amount as hospital revenue. All cost center expenses are paid by the hospital. The hospital remits a fee or pays a salary to the physician which is included in hospital expenses.

The compensation arrangement can be either fixed or variable. Under fixed compensation arrangement the physician is paid a specific dollar amount (salary) unrelated to volume of services rendered. Under the variable compensation arrangement the physician's compensation will be a percentage of departmental gross charges or net collections. The actual compensation received by the physician will vary in proportion to the number of procedures performed and to the total charges made by the hospital.

3. Contracted Arrangement—Under this arrangement, the physician may pay any or all expenses of the cost center. The hospital bills patients for the departmental services and remits a fee to the physician. This fee would typically be designated to cover the expenses incurred by the physician recorded as Professional Fees (Natural Classification of Expense .31) regardless of the expenses incurred by the physician.
4. Rental Arrangement—The physician bills the patients for certain of the Part A and Part B component (as defined by Medicare) and incurs all substantial direct expenses. The physician remits a fee to cover certain hospital expenses. This fee is recorded as operating revenue in the appropriate revenue center.
5. Independent/Separate Arrangement—The functions are provided by an independent physician or group of physicians. Neither revenues nor expenses are incurred by the hospital. The hospital refers patients and/or specimens to the physician or group, which is usually located on separate premises. No costs are incurred and no revenue is received under this arrangement.

Note: Compensation paid to interns and residents is not to be included in the revenue producing cost centers, but must be charged to the Post Graduate Medical Education cost center, Account 8240.

Work Arrangement

.552

The services provided by hospital-based physicians may be categorized into three general components:

1. Provider Component—provider component activities benefit patients as a group and normally are not identifiable to an individual patient. For purposes of reporting to the Commission, the provider

component can be allocated to the following activities:

- a. Research—Working on research projects (see Section 200, account number 8010).
 - b. Chief of the Medical Staff—this function includes the position of Chief of the Medical Staff. Compensation paid to other departmental chief should not be included under this function (see Section 200, account number 8720).
 - c. Medical Care Review and PSRO—this function includes peer review, quality assurance, and PSRO (see Section 200, account number 8720).
 - d. Other Administration and Supervision—this function includes supervision of departmental personnel, administration of the department, in-service education of departmental personnel and stand-by time. Generally, this function includes all provider component activities not included in a, b, and c above.
 - e. The services do not include physician availability services, except for reasonable availability services furnished in emergency rooms.
2. Physicians Part B Services—The Physicians Part B Services (i.e., Professional component) is an identifiable service that meets the following requirements:
- a) The service is personally furnished for an individual patient by a physician;
 - b) The service contributes directly to the diagnosis or treatment of an individual patient;
 - c) The service ordinarily requires performance by a physician;
 - d) In the case of anesthesiology services, the following additional conditions obtain:
 - 1) For each patient, the physician—
 - i) Performs a pre-anesthetic examination and evaluation;
 - ii) Prescribes the anesthesia plan;
 - iii) Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergency;

- iv) Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;
 - v) Monitors the course of anesthesia administration at frequent intervals;
 - vi) Remains physically present and available for immediate diagnosis and treatment of emergencies; and
 - vii) Provides indicated post anesthesia care.
- 2) The physician directs no more than four anesthesia procedures concurrently, and does not perform any other services while he or she is directing the concurrent procedures.
- e. In the case of radiology services, the service is an identifiable, direct, and discrete diagnostic or therapeutic service to an individual patient, such as interpretation of x-ray plates, angiograms, myelograms, pyelograms, or ultrasound procedures, and;
- f. In the case of pathology service, the services are:
- 1) Anatomical pathology services;
 - i) Consultative pathology services that meet the requirements in paragraph (b) of this section; or
 - ii) Services performed by a physician in personal administration of test devices, isotopes, or other materials to an individual patient.
 - 2) Consultative pathology services. For purposes of this section, consultative pathology services must:
 - i) Be requested by the patient's attending physician;
 - ii) Relate to a test result that lies outside the clinically significant normal or expected range in view of the condition of the patients;
 - iii) Result in a written report included in the patient's medical record; and
 - iv) Require the exercise of medical judgment by the consultant physician.

3. Education Component—the education component is the time spent teaching and supervising student activity in an organized and approved educational program (see Section 200, account number 8210–8229). This function does not include in-service education and training of departmental personnel which is included as administration and supervision under Identified Physician Costs.

The distinction of a provider Component, Physicians Part B Services and Educational Component is consistent with the total time allocations for those functions as defined by the Medicare Professional Component Form P.C.-7 as revised in June of 1977 for Parts I, II and III of that form, respectively. A reconciliation of the detail of the Provider Component activities between the Commission and Medicare definitions will have to be made from the hospital's records.

When physicians are involved in more than one of the above functional activities, their remuneration, if any, must be recorded in the cost center for which services are paid.

For example, if a physician is paid and spends 40 percent of his time in direct care of patients, 10 percent in teaching activities, 15 percent in research, 5 percent in medical care review activities, and 30 percent in administration and supervision of the department, the reclassification of his remuneration would be as follows:

- | | |
|----|---|
| 10 | percent Education Costs (To Account 8210-8229) |
| 15 | percent Research Projects (To Account 8010-8199) |
| 5 | percent Medical Care Review (To Account 8880) |
| 30 | percent Cost Center Supervision (Remains in Patient Care cost center) |
| 40 | percent identified Physicians Part B Services (This amount must be reported in the Physicians Part B Services cost center, Account 8730.) |

Computations:

If the above physician is assigned to the Coronary Care cost center and is paid \$50,000 annually—including employee benefits, the following reclassifications would be required for reporting purposes:

- 10 percent Education Costs (To Account 8210-8299)
- 15 percent Research Projects (To Account 8010-8199)
- 5 percent Medical Care Review (To Account 8010-8199)
- 30 percent Cost Center Supervision (Remains in Patient Care cost center)
- 40 percent Professional Component (This amount must be reported in the Medical Staff Services cost center, Account 8370.)

Computation: If the above physician is assigned to the Coronary Care cost center and is paid \$50,000 annually—including employee benefits, the following reclassifications would be required for reporting purposes:

Professional Component	40% of \$50,000 = \$20,000 - to Account 8730
Education	10% of \$50,000 = \$ 5,000 - To Account 8210-8299
Research	15% of \$50,000 = \$ 7,500 - To Account 8010-8199
Medical Care Review	5% of \$50,000 = \$ 2,500 - To Account 8880
Cost Center Supervision	30% of \$50,000 = \$15,000 - Remains in Patient Care cost center

The reclassification of the Professional component from the assigned cost centers to the medical Staff Services cost center, Account 8730 is necessary in order to obtain comparable direct costs between hospitals which employ physicians and hospitals which do not. The reclassification of the other components is to obtain functional comparability.

ALLOCATIONS TO OTHER INSTITUTIONAL PROGRAMS (OIPs).

AUXILIARY ENTRPRISES (AEs) AND UNREGULATED SERVICES (URs).56

Hospitals having OIPs, AEs and URs may have general services functions that support hospital and OIPs, AEs and URs functions.

The methods used to allocate these "common" general services costs will be at the discretion of the hospital. If general service costs are maintained separately for OIPs, AEs and URs these costs should be recorded directly. For example, if housekeeping labor is recorded separately for the hospital and a nursing school, but all supplies are charged to the hospital, the nursing school labor and hospital labor should be recorded directly and supplies should be transferred via the reporting schedules contained in the forms for Budgeting, Section 600 of this manual.

CAPITAL FACILITIES

.57

In the area of making provisions for funding the replacement of Capital facilities, the Commission will use as guidelines:

- The fair market value of fixed assets utilized, including assets not owned by institutions
- The current recorded expenses relating to these assets, such as depreciation, leasing costs, financing costs, rentals, etc., including the fair rental value of assets whose use is donated
- The current and projected annual cash requirements for capital facilities, including leases, rents, and debt service requirements, as well as planned needs for the outright purchase of assets.

In order for institutions to provide this information to the Commission for the purpose of establishing this rate component, the following records must be maintained.

- Records which identify major capital facilities (including donated assets) and depreciation thereon to the functional cost centers employing them. Buildings, improvements to land and grounds, building equipment, general purpose fixtures, etc., should be carried on an institution-wide account as should minor facilities, when departmentalization would not be practicable.
- Records which similarly identify rentals, leasing expenses, etc., by functional cost center. Included in this category should be the fair rental value of assets whose use is donated.
- Estimates of the fair market value of the above assets. For those assets owned, an inventory of the current values maintained for insurance purposes would be acceptable. For leased assets with a purchase price, it may be necessary to obtain appraisals of some significant facilities if no alternative value is available.
- Capital budgets for the reporting year and for at least the following three years, including planned method of financing.
- Three-year budgets and debt amortization schedules.

Uncompensated Care

.58

Uncompensated care is defined by the Commission to include Charity Care and Bad Debts. Charity Care Services are those Commission regulated services rendered for which payment is not anticipated. Bad Debts Services are those Commission regulated services rendered for which payment is anticipated and credit is extended to the patient. (Bad Debt expense is estimated and recognized by providing an allowance for such amounts estimated to be written off.)

Charity Care: Hospitals should have a written charity care policy. Charity care patients should be identified at the time of admission or service date or as soon thereafter as possible. Charity care, as reported to the Commission, shall consist only of the difference between the hospital's approved rates and the amount, if any, received from such patients in payment.

Bad Debts: Bad Debts, as reported to the Commission, may include only the following:

1. Bad debt write-offs, made after following the provisions of the hospitals collection and write-off policy, less gross Bad Debt recoveries. (Outside collection agency, attorney expenses or any other expenses associated with the collection of patient accounts may not be written off as Bad Debts but must be reported as collection expenses in the Patient Accounting cost center.)

Hospital charges written-off for the following reasons are not bad debts and may not be included in uncompensated care reported to the Commission:

- a. Contractual allowances and adjustments associated with Commission approved differentials—i.e., prompt payment, SAAC, and the differential granted to Medicare and Medicaid.
- b. Administrative, Courtesy and Policy Discounts and Adjustments - These include, but are not limited to, reductions from established rates for courtesy discounts, employee discounts, administrative decision discounts, discounts to patients not meeting charity policy guidelines, undocumented charges and, payments for services denied by third party payers.
- c. Charges for medically unnecessary hospital services.
- d. Charges written off that are not the result of a patient's inability to pay or where the hospital has not expended a reasonable collection effort.