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PREFACE 1001

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

PRESCRIBED ACCOUNTING PRINCIPLES 1010

The accounting principles and concepts incorporated in this manual are based on the Proposed Audit and Accounting Guide "Audits of Providers of Health Care Services", March 15, 1988, prepared by the Health Care Committee and the Health Care Audit Guide Task Force for the American Institute of Certified Public Accountants and it should be referenced for guidance on principles and concepts not covered in this manual.

Although they are not included in this Manual, the accounting principles and concepts recommended in the Opinions of the Accounting Principles Board of the American Institute of Certified Public Accountants should serve as reference sources for specific questions on accounting policies and concepts. Furthermore, pronouncements by the Financial Accounting Standards Board should also be reflected in the hospital's accounting policies and concepts, as appropriate. This Manual published by the Office shall be the official and binding interpretation of accounting and reporting treatment within the hospital accounting and reporting system and shall take precedence over the AICPA Hospital Audit and Accounting Guide.

MATCHING OF REVENUE AND EXPENSES 1100

Determination of the net income of an accounting period requires measurements of revenue, deductions from revenue, 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 accomplishment (revenue) and effort (expense), the reported net income of a period may be meaningless.

The requirement that deductions from revenue 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.

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

Deductions from revenue result in the following three instances:

1. A hospital may agree to accept less than 100% of charges as payment in full through a contractual arrangement. The difference between gross charges and the agreed upon payment, which may include patient liability, is referred to as a contractual adjustment.

2. A hospital may write-off an account as bad debt because the party in debt, although determined able to pay, refuses to pay. Provisions created to estimate this amount are a deduction from revenue.

3. A hospital may treat a patient who does not have the ability to pay for the services rendered. This type of care is written-off as charity care, which is also a deduction from revenue.

Revenues and expenses are to be matched not only for the hospital as a whole, but also for each revenue/cost center. That is, the costs of the functions and activities included in each cost center description are to be included in that cost center. Revenue relative to such functions and activities must be included in the matching revenue account. For example, revenue for functions (activities) included in the Clinical Laboratory Services (Account 7500) are to be included in Clinical Laboratory Services revenue (Account 4500).

ACCRUAL ACCOUNTING 1101

In order to provide the necessary completeness, accuracy, and meaningfulness in accounting data, a full accrual basis of accounting and reporting is required for all accounting and statistical data.

A good example of accrual accounting is that the hospital is to record all revenue earned for those patients in-house on the last day of the reporting period. The related deductions from revenue and expenses are to be accrued. Recording revenue based on third-party payor paid claims summaries is not accrual accounting and must be avoided.

ACCOUNTING PERIOD 1102

The basic accounting period recognized by this Manual is one year. This may consist of twelve monthly periods, thirteen four-week periods, or any other yearly accounting period used by the hospital.

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INTERDEPARTMENTAL SERVICES 1103

Interdepartmental services are defined in terms of the utility provided by one hospital department to another prior to, and extraneous to, the scope of cost allocation. The term "interdepartmental services" refers to the process of assigning costs directly to appropriate cost centers. The objective of accounting for interdepartmental services is the establishment of a proper distribution of direct costs prior to the cost allocation process. It is a process of assigning costs as opposed to allocating costs, and deals with matching revenues and expenses not only for the hospital as a whole, but also within a cost center of the hospital.

Transfers of supplies and pharmaceuticals are to be made at invoice cost. Invoice cost is defined as that cost which includes purchase price, net of trade discounts and duties, freight, and other incidental costs if material and practically determinable. Any generally accepted inventory costing method (i.e., FIFO, LIFO, specific identification, etc.) is allowed, as long as it is consistent with that of the preceding reporting period.

It is recommended that such transfers be made on a monthly basis. However, if monthly transfers are not made, it is required that an entry be made at the end of the reporting period to reflect all such transfers during the reporting period.

It should be noted that responsibility accounting may be maintained as to departmental costs before and after interdepartmental transfers by the use of the interdepartmental transfer natural classifications of expense (.91 - .98), if direct transfers to and from specific natural classifications are not made.

Central Services and Supplies 1103.1

Central Services and Supplies (Account 8380) is the overhead cost center where the cost of all supplies purchased is recorded. The direct cost of medical and surgical supplies issued by this cost center, for which a separate charge is made to patients, must be transferred from this cost center to the Medical Supplies Sold to Patients cost center (Account 7470). The related revenue must be reported in the Medical Supplies Sold to Patients revenue center (Account 4470). This requirement applies regardless of which cost center the item is used in. For example, the cost and revenue related to surgical supplies for which the patient is charged must not be recorded in the Surgery and Recovery Services cost/revenue center, but in the Medical Supplies Sold to Patients revenue/cost center.

Medical and surgical supplies and materials issued by Central Services and Supplies for which a separate charge is not made to a patient must be accounted for as an interdepartmental transfer to the cost centers using the supplies and materials.

The invoice cost of reusable items issued by Central Services and Supplies should be prorated over the items' expected number of uses and charged to using cost centers on this basis. It may be desirable to compute a combined invoice cost for reusable items and non-reusable items grouped together (such as surgery packs consisting of various reusable and non-reusable items) and make transfers based on the combined invoice cost rather than on an individual item basis.

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Pharmacy 1103.2

Pharmaceutical supplies and materials issued by the Pharmacy for which a separate Pharmacy charge is made to a patient must be accounted for as a cost of supplies and materials to the Drugs Sold to Patients cost center (Account 7710), and the related revenue must be reflected in the Drugs Sold to Patients revenue center (Account 4710).

Pharmaceutical supplies and materials issued by the Pharmacy for which a separate charge is not made to a patient must be accounted for as an interdepartmental transfer at invoice cost to the cost center using the supplies and materials.

Plant Maintenance 1103.3

The cost of significant, non-routine repairs and maintenance work directly assignable to a single cost center (such as repairing an X-ray machine, major alterations not capitalized, etc.) must be transferred to the using cost center. These costs include all direct expenses assigned to Plant Maintenance (Account 8460).

A work order system should be established in order to account for such non-routine work in the Plant Maintenance cost center. Basic to the work order system would be an established hospital policy defining a dollar value of "significant." Cost would be transferred on the basis of the number of labor hours required to complete the work order. A predetermined burden rate would then be multiplied by the number of labor hours. This burden rate would be calculated by dividing the total direct costs by the total labor hours. These may be budgeted totals or the last year's total adjusted for volume changes.

Other Interdepartmental Services 1103.4

The uniform accounting and reporting system requirements do not allow for the reclassification of expenses related to routine repairs and maintenance, a centralized printing and duplicating service, or non-patient meals. Such direct transfers of expenses, even when identifiable by cost center, are contrary to the Accounting Manual requirements since they result in non-comparable data among hospitals at the direct cost level and thus defeat the purpose of uniform accounting. You may, however, transfer such costs for internal budgeting and cost control, so long as the transactions are reversed when preparing the annual disclosure report.

Reclassification of expenses, when appropriate, may be made using either the actual natural classification accounts or the transfer subclassification accounts. However, when preparing the trial balance expense worksheets (report pages 17 and 18) in the annual disclosure report, these credits must be applied against the related natural expense category. Since transfers are made at cost, an expense category cannot be credited for more than the accrued debits; thus, no negative expenses should appear.

REVENUE AND EXPENSE RECOGNITION 1104

Generally accepted accounting principles prohibit the offsetting of expense with related revenue. Therefore, any reimbursement (rebates or refunds) must be

recorded in Other Operating Revenue. Total revenue, expense, and statistics must be recorded in the appropriate revenue/cost center. For example, when revenue is received for activities of a non-revenue producing cost center, it is to be accounted for as Other Operating Revenue. When the hospital reports to the Office, such Other Operating Revenue is entered on Report Page 14 and is subsequently offset against expense before, during and after cost allocation. (See instructions to Report Pages 14 and 20).

INCLUSIVE RATE HOSPITALS 1105

As a system of billing hospital patients, inclusive rates are in contrast to the presently widespread itemized method, the latter charging in large part on the basis of itemization of services actually used. While the possible basis for charging under inclusive rate systems are varied, the critical feature of any such system is that with the exception of accommodations, the patient's charge is independent of his utilization of particular services.

An "inclusive rate" system, then, typically conforms to the following definition, provided by the American Hospital Association:

> "Total charges consist of a rate based on type of accommodation multiplied by length of stay, regardless of utilization of ancillary services."

It is important to recognize that the adoption or utilization of an inclusive rate system results only in a modification of the patient billing and revenue accounting system. It does not eliminate the need to maintain cost center data. Thus, hospitals using inclusive rates will be required to report costs and related statistics by cost center and prepare the cost allocation report.

Revenue associated with an inclusive rate must be reclassified to the revenue centers providing the service. This reclassification should be made on the same basis used to establish the inclusive rate.

A hospital using an inclusive rate is required to report the physician component cost. The utilization of an inclusive rate charging system has real impact upon the capability of the hospital to provide the professional compensation required of all other hospitals. In certain cases, it may be necessary to maintain additional records on units or service (statistical data).

The inclusive rate hospitals are normally required to use Statistical Method A for determining Medicare reimbursable cost finding purposes to the extent required for allocation of costs on a statistical basis rather than on the ratio of cost to charges. In lieu of the cost allocation statistic, "Gross Patient Revenue" (in columns 12 and 17 of reporting forms pages 19 and 20), total direct costs shall be used.

ACCOUNTING PRINCIPLES AND CONCEPTS

CHEMICAL DEPENDENCY AFTERCARE 1106

It is common for chemical dependency treatment programs to charge one fee that includes a certain number of days treatment as an inpatient and follow-up visits once the patient is released. The patient may or may not utilize all of the subsequent visits that are offered free of additional charge. Accrual accounting mandates that a portion of the revenue be deferred for the estimated number of outpatient treatments that will occur. The revenue will be proportionately recognized each time the patient returns for follow-up treatment. Deferred revenue must be recorded in Deferred Income - Other (Account 2103.00) for income that will be recognized within one year or in Deferred Income - Other (Account 2271.00) for the portion of income that will be recognized after one year from the date of inpatient service. The amount in the deferred revenue account must be recognized as outpatient revenue over the estimated period of the follow-up visits. Count each follow-up visit as an Outpatient Chemical Dependency visit.

TIMING DIFFERENCES 1110

Timing differences result when accounting policies and practices used in an organization's accounting records differ from those used for reporting operations to governmental units collecting taxes or to outside agencies making payments based upon those reported operations.

These timing differences must be reflected on the hospital's accounting records. The two types of timing differences are included below:

- Income Tax Allocation
- Third-Party Cost Reimbursement Contracts

Example of Timing Difference:

The following condensed income statement illustrates a timing difference for third-party cost reimbursement contracts attributable to different methods of calculating depreciation expense for books, tax and third-party cost reimbursement contracts.

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 forty percent.

4.) The third-party utilization is fifty percent.

5.) The only deduction from revenue is the contractual adjustment.

ACCOUNTING PRINCIPLES AND CONCEPTS

	ACCOUNTING RECORDS	TAX/COST REPORT
Revenue	$180	$180
Deductions from Revenue	(B) 30	(B) 25
Net Revenue	150	155
Expenses (excluding Depreciation)	110	110
Depreciation	10	20
Total Expenses before taxes	120	130
Income before taxes	30	25
Taxes	(A) 12	(A) 10
Net Income	$ 18	$ 15

(A) The income tax expense is comprised of three components: (1) $10 currently payable, (2) $4 payable in future periods related to the tax effect of the difference between depreciation expense for accounting and tax purposes (40% X $10 = $4), and (3) $2 to be applied against tax liabilities in future periods, related to the tax effect of the differences in reimbursement caused by the difference between depreciation for accounting purposes and cost report purposes, computed as follows: 40% (tax effect) X 50% (third-party utilization) X $10 (difference between depreciation for accounting and cost report purposes) = $2. The journal entry to record these items is:

Dr.	Deferred Income Taxes Payable (Account 2112.00)	$ 2	
Dr.	Provision for Income Taxes (Account 9901)	$12	
Cr.	Income Taxes Payable (Account 2081.00)		$10
Cr.	Deferred Income Taxes Payable (Account 2112.00)		$ 4

ACCOUNTING PRINCIPLES AND CONCEPTS

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

	ACCOUNTING RECORDS	TAX/COST REPORT
Medicare Revenue ($180 X 50%)	$90	$90
Reimbursable Costs:		
$120 X 50%	60	
$130 X 50%	—	65
Contractual Adjustment	$30	$25

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:

Dr.	Contractual Adjustments - Medicare - Traditional (Account 5811)	$30	
Cr.	Allowance for Contractual Adjustments - Medicare - Traditional (Account 1042.00)		$25
Cr.	Deferred Revenue - Medicare Reimbursement (Account 2121.00)		$ 5

ACCOUNTING FOR PAYROLL COSTS 1115

Natural account classifications for salaries and wages and employee benefits must be maintained to complete the disclosure report pages 21 and 22, "Detail of Direct Payroll Costs."

For reporting purposes to the Office, salaries and wages include all remunerations paid in cash by the hospital to its employees for the actual hours worked. The actual hours worked are productive hours which must equal total hours paid less the hours not on the job.

Non-productive hours are to be accounted as employee benefits (sub-account number .12). Non-productive hours are hours not on the job such as vacation time, sick leave, holidays, and other paid time off. However, paid time spent attending meetings and educational activities at or away from the hospital is productive time and is to be accounted for under salaries and wages.

The disclosure report pages 21 and 22, "Detail of Direct Payroll Costs," are used to report the productive and non-productive hours. They are also used to report the average hourly rate by employee classification and cost center. Therefore, the following information is needed by employee classification and cost center:

ACCOUNTING PRINCIPLES AND CONCEPTS

1. Salaries and Wages
2. Productive Hours
3. Non-Productive Hours
4. Amounts Paid for Non-Productive Hours

Under the Office's accounting and reporting system the amount paid for overtime and the premium paid for "on call" time must be included in salaries and wages. The amount paid for non-productive hours must be accounted and reported as employee benefits. The time an employee is "on call" (standby) is not to be included in productive or non-productive hours, since only actual hours worked are to be counted. The following is an example of how to report the on-call time and its remuneration to the Office:

A Lab Technician is on standby at home for 4 hours (7 p.m. to 11 p.m.) and receives $2.00 per standby hour. At 11 p.m. he receives a call and works until 5 a.m., or 6 hours, and receives a rate of one and one-half times the regular rate of $4.00, or $6.00 per hour. In this example the standby dollars (4 hours x $2.00 = $8.00) would be salaries and wages. The standby hours (4) would not be counted either as productive or non-productive, nor would they be reported to the Office. The overtime dollars (6 hours x 1½ x $4.00 = $36.00) would be salaries and wages and the 6 overtime hours worked would be productive hours.

The employee classifications for which salaries and wages and productive hours must be identified are listed and defined in Manual Section 2440.1. In addition, a table of job titles has been provided in Manual Section 2450 which references the job title to the related salary classification code.

If a nursing registry requires that the nurse be paid through the hospital's payroll system, the related payroll costs must be accounted for as if the person were an employee of the hospital.

Employee Benefits 1115.1

The cost of all payroll related employee benefits must be charged to the cost center in which the employees work. Hospitals may offer their employees a variety of benefit options to select. Consequently, the cost of benefits to the hospital is different for each employee. Any bonuses paid to employees must be recorded in the .00 to .09 Natural Classifications of Expense of the appropriate cost center where the employee works. Any severance pay must be recorded in the .19, Other (Non-Payroll Related), Natural Classifications of Expense of the appropriate cost center where the employee worked.

Accrued Paid Time-Off 1115.2

Generally accepted accounting principles and the Manual require the recording of an employee benefit expense and related liability for Paid Time Off (PTO) each pay period. The payroll liability account is debited and cash is credited when PTO is actually taken or reimbursed.

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Non-productive hours, which relate to PTO, are to be counted only when PTO is taken. Do not accrue and report non-productive hours which relate to year-end carry over. Further, do not count and report non-productive hours for an employee who is reimbursed for unused PTO at year-end or upon termination of employment. In each of these instances, the definition of non-productive hours (hours not on the job) is not being met. If the hospital's current payroll system is unable to distinguish between PTO hours taken and reimbursed, we suggest that appropriate system modifications be developed and implemented to record and report this distinction.

Reimbursements On Worker's Compensation 1115.3

Generally accepted accounting principles prohibit the direct offset of expenses with related revenue. Therefore, any reimbursement (rebate or refund) of prior years Worker's Compensation Insurance and other payroll-related benefits must be recorded in Account 5780, Other Operating Revenue. This amount is then reported on Page 14, Part III and offset on Page 20, Column 5 of the hospital disclosure report, since FTE's are the most appropriate statistical basis for distributing such revenue.

ACCOUNTING FOR PROPERTY, PLANT, AND EQUIPMENT 1120

CLASSIFICATION OF FIXED ASSET EXPENDITURES 1121

Property, plant, and equipment and related liabilities must be accounted for as part of unrestricted funds, as segregation in a separate fund would imply the existence of restrictions on asset use. All assets restricted for acquisition or construction of property, plant, and equipment must be segregated and included in the Plant Replacement and Expansion Fund until expended, at which time the asset cost shall be transferred to the Unrestricted Fund. Costs of construction in progress should be recorded in, or transferred to, the Unrestricted Fund as incurred.

Property, plant, and equipment must be valued on the basis of cost with no revaluation to reflect estimated current replacement cost. Cost shall be defined as actual historical cost, or the fair market value of donated property, plant, and equipment at the date of donation.

To establish proper accounting control over hospital equipment, a subsidiary equipment ledger must be maintained as part of the general accounting records. A trial balance of this subsidiary ledger, if properly maintained, will agree with the balances appearing in the general ledger equipment accounts. Some items of equipment should be treated as individual units in the equipment 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 unit in the equipment ledger. Accounts in the subsidiary equipment ledger must be segregated by cost center so that information will be available as to the quantity, type and cost of equipment.

CAPITALIZATION OF FIXED ASSETS 1122

Each hospital must set a standard policy with respect to the capitalization of its depreciable assets. This policy, excluding minor equipment, must meet the following specifications:

ACCOUNTING PRINCIPLES AND CONCEPTS

- Normal repair and maintenance and modernization to maintain the depreciable assets must not be capitalized if the life of the asset is not materially extended.

- Significant alterations and renovations must be capitalized and depreciated over their expected useful lives but are not to exceed the lives of the assets to which they are fixed.

- All depreciable assets shall be capitalized. An item is considered to be a depreciable asset if it has a unit cost of at least $5,000 and has a minimum useful life of two years. Hospitals may establish a capitalization policy with lower minimum criteria.

DEPRECIATION POLICIES 1123

Depreciation expense on major movable and minor equipment must be charged to the using cost center. If a piece of equipment is not directly identifiable to a particular cost center, the related depreciation expense must be recorded in the Depreciation and Amortization cost center (Account 8810-8819).

The depreciation on the plant, which includes fixed equipment, is not to be assigned as a direct cost to the cost centers occupying the building. Such depreciation must be an indirect cost and accounted and reported in Account 8810 (Depreciation and Amortization).

The method of depreciation to be used for accounting and reporting must be the straight-line method for all assets purchased after June 30, 1974.

Do not increase depreciation expense to reflect general price-level changes even if such an entry appears on your audited financial statements, as such changes are inconsistent with the above requirements.

The estimated lives used in computing depreciation should be reasonable considering the asset in question. The American Hospital Association has publications with recommended useful lives for various property and equipment used by hospitals. These guidelines may be useful in determining the life of an asset.

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

- Computing first year depreciation based upon the portion of time the asset was in use during the year. That is, if a depreciable asset were 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.

- Recording one half of the yearly depreciation expense in the years of acquisition and disposal, regardless of the date of acquisition.

- 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 or construction-in-progress until that asset was actually put into use.

HISTORICAL COST 1124

The cost of a fixed asset or "historical cost" is the amount paid to acquire the asset and to prepare it for use in the hospital. The following items, therefore, must be included under costs:

1. Billed price of the asset
2. Freight and delivery charges
3. Sales taxes
4. Installation costs, including cost of bases and foundations, alteration, renovations and force account expenditures
5. Cost of "tuning up" and trial runs
6. Reconditioning costs, in the case of used assets
7. Costs of title investigations, legal fees, and brokerage commissions
8. Architectural fees and consulting fees
9. Other activities essential to the acquisition, improvement, expansion or replacement of plant and equipment.

When an asset is donated to the hospital, its book value is the fair market value of the asset as of the date of donation. Fair market value is the price that an asset would bring through bona fide bargaining between well-informed buyers and sellers or as may be established by an appraisal of such fair market value by a recognized appraisal expert.

ABANDONMENT OF A PROJECT 1125

If a hospital abandons a project, it must be written off immediately in its entirety. The amount written off must be recorded and reported as Other Unassigned Cost (Account 8890). This is not considered an extraordinary item because it is not unusual in nature or infrequent in occurrence.

MINOR EQUIPMENT 1126

Minor equipment has the following characteristics:

a. Location generally not fixed; subject to requisition or use by various departments of the hospital.

b. Relatively small size and unit cost.

c. Subject to storeroom control.

d. Fairly numerous quantity in use.

e. A useful life of usually three years or less.

There are three ways in which the costs of minor equipment may be recorded:

a. The historical cost of this equipment may be capitalized and not depreciated. Any replacements to this base stock would be charged to operating expenses. The amount of the base stock would be adjusted. only if there were a significant change in the size of the base stock.

b. The original investment in this equipment may be capitalized and written off over 3 years. All subsequent purchases would be written off over 3 years.

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

Once a hospital has applied one of these methods, that method must be used consistently thereafter, unless a change in method is approved by the Office.

PROPERTY NOT USED IN HOSPITAL OPERATIONS **1127**

Land held for future expansion, old hospital buildings and land awaiting disposal must be included in Other Assets (Accounts 1350-1359). Do not include these items as Limited Use - Other Assets unless the governing board of the hospital has actually taken formal action to set these items apart.

PROPERTY LEASED FROM RELATED ORGANIZATIONS **1128**

When land, building, and improvements used by the hospital are leased from a related organization, the hospital must record the amount of lease or rent expense paid to the related organization in Account 8820, Leases and Rentals. For equipment that is specifically identifiable to an individual cost center, the related lease cost is to be charged to that cost center.

SEPARATE FUND ACCOUNTING **1130**

Many hospitals receive, from donors and other third-parties, gifts, bequests, and grants that are restricted as to use. When funds with donor-imposed restrictions

are received, they must be accounted for separately (however, this would not preclude the pooling of assets for investment purposes, as described in Section 1130.6).

For Balance Sheet reporting, donor-restricted funds must be reported separately in the appropriate restricted fund classifications (see page 6 of the reporting forms). For income statement purposes, donor-restricted funds for operating purposes are recognized as other operating revenue in the period expenses meeting the restriction requirements are incurred. Donor restricted funds for property, plant or equipment must be transferred from the restricted fund to the unrestricted fund balance in the period that the restrictions are satisfied. Hospitals receiving no restricted gifts, bequests, or grants need not use separate fund accounting.

This Manual provides for the separation of restricted funds into three categories: Endowment Fund, Plant Replacement and Expansion Fund, and Specific Purpose Fund. The accounts within each restricted fund are self-balancing, as each fund constitutes a subordinate accounting entity.

As will be noted 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). Thus, 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 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.

All expenses relating to restricted fund activities must be recorded in the Unrestricted Fund (whether the actual expenditures of cash are made from the Unrestricted Fund or a restricted fund), in the cost center category to which they apply. Separate cost centers must be established within each of these categories to record restricted activities for which separate accounting is 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 the restricted funds to match these expenses must be made in one of the following accounts:

Transfers from Restricted Funds for Research Expenses (Accounts 5010-5199)

Transfers from Restricted Funds for Education Expenses (Accounts 5280-5299]

Transfers from Restricted Funds for Other Operating Expenses (Accounts 5790-5799)

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.

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UNRESTRICTED FUND

June 1	Dr.	Research Projects and Administration (Account 8010.22)	$200	
	Cr.	Accounts Payable (Account 2021.00)		$200
	Dr.	Due from Specific Purpose Fund (Account 1072.00)	$200	
	Cr.	Transfers from Restricted Funds for Research Expenses (Account 5010.00)		$200

SPECIFIC PURPOSE FUND

June 1	Dr.	Transfers to Unrestricted Fund for Operating Purposes (Account 2573.00)	$200	
	Cr.	Due to Unrestricted Fund (Account 2511.00)		$200

To record the expense and related liability for costs incurred in restricted research activities in the Unrestricted Fund and record an interfund liability and reduction in fund balance in the Specific Purpose Fund.

UNRESTRICTED FUND

June 10	Dr.	General Checking Accounts (Account 1001.00)	$200	
	Cr.	Due from Specific Purpose Fund (Account 1072.00)		$200

SPECIFIC PURPOSE FUND

	Dr.	Due to Unrestricted Fund (Account 2511.00)	$200	
	Cr.	Checking Accounts (Account 1511.00)		$200

To record the transfer of cash to the Unrestricted Fund.

ACCOUNTING PRINCIPLES AND CONCEPTS

UNRESTRICTED FUND

June 15	Dr.	Accounts Payable (Account 2021.00)	$200	
	Cr.	General Checking Accounts (Account 1001.00)		$200

To record the payment of the liability.

Unrestricted Fund 1130.1

The Unrestricted Fund is used to account for the resources and day-to-day activities not required by grant or gift or other donor restrictions to be accounted for in a separate group of accounts. Unrestricted resources may be appropriated or designated by the governing board for special uses. If the governing board appropriates resources in this manner, it should be recognized that the board nevertheless has the authority to rescind its action. For this reason, such appropriations should be accounted for as part of unrestricted funds. Separate accounts in the Unrestricted Fund (Accounts 1110-1199) have been set aside for limited use assets.

The term "restricted" must not be used in connection with board or other internal hospital appropriations or designations of funds. These assets are to be categorized as assets whose use is limited and are included in the unrestricted fund. Three categories of assets whose use is limited have been identified.

1.) Board Designated Assets - These assets have been identified for a specific purpose by the governing board. The board may at any time subsequent to being identified for a specific purpose, change the purpose for which the assets have been designated.

Example:

The hospital has excess cash ($200) in their General Checking Account. The governing board decides to set aside those assets for the purpose of acquiring fixed assets. The entries would be as follows:

Dr.	Limited Use Checking Accounts (Account 1111.00)	$200		
Cr.	General Checking Accounts (Account 1001.00)			$200

To record the transfer of cash designated for the acquisition of fixed assets by the governing board.

2.) Proceeds of debt issues - This includes funds held by a trustee. These funds are set aside for use in accordance with the debt instrument.

Example:

The hospital has a debt issue for $1,100. The hospital receives $1,000 cash, and the trustee retains $100 as a condition of the debt instrument. The entries would be as follows:

Dr. General Checking Accounts (Account 1001.00)	$1000	
Dr. Limited Use Other Cash Accounts (Account 1119.00)	$100	
Cr. Bonds Payable (Account 2250.00)		$1,100

To record cash received and set up the liability related to the issuance of debt.

3.) Other assets limited as to use - Assets set aside based on agreements with third parties other than the donor or grantor. These would include assets set aside under agreements with third-party payors to meet depreciation funding requirements and assets set aside under self-insurance fund arrangements.

Example:

Similar entries to the example under Limited Use assets.

Bond Sinking Fund **1130.2**

Sinking fund assets should not be included in a restricted fund, but rather as a separate line item in the Unrestricted Fund. Typically, these are considered to be assets whose use is limited for financial statement purposes.

Example:

The bond indenture agreement requires that a sinking fund be established for retirement of the bonds. Periodically as required by the indenture agreement the hospital makes contributions to that account and the funds may be used for no other purpose than for the payment of principal and interest on the bonds. The entries would be as follows:

Dr. Limited Use Bond Sinking Fund (Account 111X.00)	$100	
Cr. General Checking Accounts (Account 1001.00)		$100

To record the transfer of funds from the general checking account to Limited Use Assets for sinking fund purposes.

ACCOUNTING PRINCIPLES AND CONCEPTS

Endowment Fund 1130.3

The Endowment Fund is maintained to account for resources given to the hospital as a permanent fund or as a term endowment. Income from endowment funds may be restricted or unrestricted, according to the endowment contract. When term endowment funds become available to the governing board for unrestricted purposes, they must be reported as non-operating revenue in Account 9090, Term Endowment Funds Becoming Unrestricted; if these funds are restricted, they should be shown as a transfer to the appropriate restricted fund and accounted for as restricted funds.

Plant Replacement and Expansion Fund 1130.4

The Plant Replacement and Expansion Fund is maintained to account for restricted donations received and expended for the acquisition or construction of new plant assets. The assets themselves are to be recorded in the Unrestricted Fund.

When expenditures for such assets are made from the Unrestricted Fund, a transfer must be made from the Plant Replacement and Expansion Fund to match the expenditures. In the following example, assume that a new wing is being constructed and funds for this construction, raised through a fund-raising drive, are recorded in the Plant Replacement and Expansion Fund.

PLANT REPLACEMENT AND EXPANSION FUND

June 30	Dr.	Fund Balance - Capital Outlay (Account 2472.00)	$1,000	
	Cr.	Due to Unrestricted Fund (Account 2411.00)		$1,000

UNRESTRICTED FUND

	Dr.	Construction-in-Progress (Account 1250.00)	$1,000	
	Cr.	Other Accounts Payable (Account 2029.00)		$1,000
	Dr.	Due from Plant Replacement and Expansion Fund (Account 1071.00)	$1,000	
	Cr.	Fund Balance - Capital Outlay (Account 2320.00)		$1,000

To record construction expenses incurred in the construction of a new wing.

ACCOUNTING PRINCIPLES AND CONCEPTS

PLANT REPLACEMENT AND EXPANSION FUND

July 3	Dr.	Due to Unrestricted Fund (Account 2411.00)	$1,000	
	Cr.	Checking Accounts (Account 1411.00)		$1,000

UNRESTRICTED FUND

	Dr.	General Checking Account (Account 1001.00)	$1,000	
	Cr.	Due from Plant Replacement and Expansion Fund (Account 1071.00)		$1,000

To record transfer of cash from the Plant Replacement and Expansion Fund to the Unrestricted Fund.

UNRESTRICTED FUND

July 5	Dr.	Other Accounts Payable (Account 2029.00)	$1,000	
	Cr.	General Checking Account (Account 1001.00)		$1,000

To record the payment of the liability.

If expenditures for plant assets are made 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 - Capital Outlay (Account 2320.00). In the Plant Replacement and Expansion Fund, Fund Balance - Capital Outlay (Account 2472.00) would be debited, and a cash account credited. No entries would be made to the interfund payable or receivable accounts, nor would any cash be transferred between funds.

Specific Purpose Fund **1130.5**

The Specific Purpose Fund is maintained to account for funds received from outside agencies or individuals for the support of specific projects, such as specific research projects, education costs, etc. When separate accounting is required for specific grants or gifts, they must be recorded separately with the use of sub-accounts within the Fund Balance of this fund.

A Restricted Fund must be established whenever donors or other third-parties provide gifts, bequests, and grants to the facility that are restricted as to use. All costs incurred related to these activities must be expensed or, if these costs meet GAAP requirements, capitalized through the Unrestricted Fund. If these items are to

be expensed, transfers from the Restricted Fund to the Unrestricted Fund are made to match these expenditures, and are recorded as Other Operating Revenue. Report such revenue on page 14, part III of the annual disclosure report. If, however, these items are to be capitalized, a matching transfer from the Restricted Fund to the Unrestricted Fund is recorded as an equity transfer and reported as such on the Statement of Changes in Equity. In either case, don't record the grant as non-operating revenue. Finally, if the grant is received and used within a fiscal year, the amount would not appear on the year-end Restricted Fund Balance Sheet, and the Statement of Changes in Equity would show the amount being received and expensed or transferred during the year with no ending balance.

Pooled Investments **1130.6**

Investments of various funds may be pooled, unless prohibited by statute or by terms of donation or grants. Proper determination of equities requires that gains and losses on pooled investments be distributed on a basis utilizing market values. This determination should be made through the use of memorandum records.

Assets included in pooled investments must be reflected in an appropriately titled "other" current asset account (such as "Assets included in Investment Pools"). Gains and losses from investment pools in the Unrestricted Fund must be recorded in account 9060, Income, Gains, and Losses from Unrestricted Investments. Gains and losses from such investments in the restricted funds must be recorded directly in the appropriate restricted fund balance account.

LONG-TERM SECURITY INVESTMENTS 1140

Long-term security investments are to be valued at historical cost, unless there is evidence of a permanent decline in value, in which case an appropriate reduction in carrying value must be made.

JOINT VENTURES AND INVESTMENTS IN OTHER ENTITIES 1141

Many hospitals are entering into joint ventures and partnerships with physicians or other parties for a variety of reasons. How the hospital accounts for this depends primarily on two issues, percentage of ownership and influence.

The three possible methods for accounting for these investments are consolidation, the equity method, or the cost method. An investment of the above nature should be consolidated if the hospital has a controlling interest. A controlling interest usually exists if the hospital owns more than 50% of the venture. An entity would also have a controlling interest if it were the only general partner. The equity method of accounting should be used when the investor has the ability to exercise significant influence over financial and operating policies of the investee. Significant influence can generally be defined as 20-50% ownership. The cost method should be used to account for investments when the hospital owns less than 20% and significant influence does not exist.

ACCOUNTING PRINCIPLES AND CONCEPTS

For Example:

% Ownership	Significant Influence	Accounting Treatment
Less than 20%	Yes	Equity method
Less than 20%	No	Cost method
20%-50%	Yes	Equity method
20%-50%	No	Cost method
More than 50%	Yes	Consolidation
More than 50%	No*	Equity method

* This could only happen if the investor were a limited partner.

Descriptions of the three methods, consolidation, equity and cost are as follows:

Consolidation:

Under the consolidation method the results of operations and financial position are presented as if the hospital and joint venture were essentially a single enterprise. The accounting would require the elimination of any intercompany balances and transactions and the recognition of any minority interest.

Equity:

Under the equity method the hospital's investment is initially recorded at cost and then the hospital adjusts the carrying amount to recognize their share of earnings or losses of the investment after the date of acquisition. Any dividends received from the investment reduces the carrying amount of the investment.

Cost Method:

Under the cost method the hospital's investment is recorded at cost. Any dividends received which are distributed from the net accumulated earnings of the investment since the date of acquisition by the hospital are recognized as income. Dividends received in excess of earnings subsequent to the date of investment are considered a return of investment and recorded as reductions of cost of the investment.

ACCOUNTING FOR PLEDGES 1150

All pledges, less a provision for amounts estimated to be uncollectible, must be included in the hospital's accounting records. If unrestricted, revenue from pledges (net of provision for uncollectibles) must be included in Account 9040, Unrestricted Contributions. If pledges are restricted, they must be reflected in the appropriate restricted fund, less a provision for amounts estimated to be uncollectible.

ACCOUNTING PRINCIPLES AND CONCEPTS

ACCOUNTING FOR HOSPITAL RESEARCH AND EDUCATION COSTS 1170

All costs incurred in research activities and formal education activities (as opposed to inservice education a separate inservice education section follows) must be recorded in Unrestricted Fund cost center accounts 8010-8199 (Research Costs) or 8210-8299 (Education Costs).

GRANT ACCOUNTABILITY 1171

Separate cost centers should be maintained for all research and educational activities for which separate accounting is required by law, grant contract, or donation restriction. Transfers from restricted funds to match the expenditures for these activities must also be segregated into separate accounts in the series 5010-5199 (Research) or 5280-5299 (Education). Thus, accountability is maintained for all restricted research and educational activities.

OVERHEAD ALLOCATION 1172

No allocation of indirect overhead should be made on the books prior to cost finding 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 used in billing, but no allocation of indirect overhead costs should be made in the hospital's accounting records. For instance, assume that the hospital received a grant for a specific cancer research project on December 1, which called for payment of direct costs incurred, plus an overhead factor of 10% of such direct costs. At December 31 (the hospital's year end), $150 of cost had been incurred. The following entries would be made in the accounting records of the hospital at December 31:

UNRESTRICTED FUND

December 31	Dr.	Research Projects and Administration (Account 8010.XX)	$150	
	Cr.	General Checking Accounts (Account 1001.00)		$150
	Dr.	Due from Specific Purpose Funds (Account 1072.00)	$165	
	Cr.	Transfers from Restricted Funds for Research Expenses (Account 5010.xx)		$165

To record specific cancer research direct costs and set up a receivable from the restricted fund for such direct costs, plus allowable overhead factor.

ACCOUNTING PRINCIPLES AND CONCEPTS

SPECIFIC PURPOSE FUND

December 31	Dr.	Fund Balance (Account 2571.00)	$165	
	Cr.	Due to Unrestricted Fund (Account 2510.00)		$165

To record a payable to the Unrestricted Fund for direct costs, plus allowable overhead, incurred in the specific cancer research project.

If indirect overhead must, by grant contract, be recorded in the Unrestricted Fund cost center in which direct costs of the grant activity are recorded, natural expense classification .90 (other direct 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 applications. For reports to the Office, the balance in the "Overhead Applied" cost center must be offset against the restricted activity cost center prior to completing the annual disclosure report. Thus, costs remaining in the restricted activity cost center are direct costs only.

AFFILIATED SCHOOL CONTRACTS 1173

Education costs incurred relative to affiliated school contracts must be reflected in the Education Costs series of accounts (8210-8299) in the Unrestricted Fund. Salaries, wages, and stipends paid to students on approved programs (including residents) must be reflected in this series of accounts. Salaries, wages, and stipends paid to residents should be reflected in the Medical Postgraduate Education cost center (Account 8240). Fees paid to physicians involved primarily in approved education programs must also be recorded in the Education Costs series of accounts, in the appropriate cost center.

EDUCATION 1180

INSERVICE EDUCATION - NURSING 1181

Nursing inservice education activities are defined as educational activities conducted within 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 employee benefits) of time spent in such classes and activities by those instructing and administering the programs must be included in cost center 8740 "Inservice Education Nursing."

If instructors do not work full-time in the inservice education program, the cost (as defined above) of the portion of time they spend working in the inservice education program must be included in the "Inservice Education - Nursing" cost center. This may be accomplished by direct distribution of these costs (by natural classification of expense category) each payroll period or by reclassification (based upon time spent) at year end.

ACCOUNTING PRINCIPLES AND CONCEPTS

The costs of nursing inservice education supplies (such as cassettes, books, medical supplies, etc.) and outside lecturers must also be reflected in the "Inservice Education - Nursing" cost center.

Nursing inservice education does not include orientation of new employees. Such orientation costs must be charged to the cost center in which new employees are, or will be, assigned.

INSERVICE EDUCATION - OTHER 1182

All costs relative to non-nursing inservice education activities should be included in the cost center to which they apply (e.g., Physical. Therapy, Radiology Diagnostic, etc.), as such inservice education activities will rarely apply to more than one functional activity.

PATIENT EDUCATION 1183

Patient education is those tasks which relate to teaching patients how to take care of themselves after they leave the hospital setting. The costs associated with the provision of this service are recorded in the cost center that provides the services. Any revenues generated from the provision of the service should be recorded as patient revenue in the cost center providing the service.

COMMUNITY HEALTH EDUCATION 1184

Community health education includes the sponsoring of courses in childbirth preparation, stress management, hazards of smoking, physical fitness programs, etc. The public typically participates in these classes and are not considered hospital patients. The revenues related to these programs must be recorded in the Community Health Education Revenue (Account 5770) and expenses must be recorded in the Community Health Education cost center (Account 8770).

PHYSICIAN REMUNERATION 1190

Due to the numerous types of financial and work arrangements between hospitals and hospital-based physicians (including House Staff), comparability of costs between hospitals may be significantly impaired. This section deals with the methods to be used in reporting costs and revenues related to the services of hospital-based physicians.

FINANCIAL ARRANGEMENTS 1191

Although the variations in financial arrangements between hospitals and hospital-based physicians are endless, there are six general types of such arrangements:

ACCOUNTING PRINCIPLES AND CONCEPTS

1. Joint The hospital bills patients for the physician's contractual services, including this amount as hospital revenue. All cost center expenses are paid by the hospital. The hospital remits a fee to the physician which is included in hospital expense. All payments to physicians are to be included on Report Pages 15 and 16. The portion of the physician's fee applicable to direct patient care must be reclassified into column 9 on Report Pages 15 and 16.

2. Contracted Under this arrangement, the physician may pay any or all expenses of the cost center. The hospital bills patients for the services provided and remits a fee to the physician. This fee would typically be designed to cover the expenses incurred by the physician plus his professional fee. Payments to the physician are recorded as Professional Fees (subclassification of expense .20) regardless of the expenses incurred by the physician. The reporting requirement would be the same as that described in 1 above.

3. Rental 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 non-patient revenue (revenue subclassification .9) in the appropriate other operating revenue account and reported on Report Page 14. The hospital expenses are recorded in the appropriate revenue producing cost center and entered on Report Page 17 and processed through cost finding. The non-patient revenue is offset against these expenses during cost finding as specified in the instructions to Report Page 20. Since the billing function is performed by the physician, statistics are not required to be reported.

4. Independent/Separate The cost center functions are provided by an independent group of physicians. Neither revenue nor expenses are incurred by the hospital. The hospital refers patient and/or specimens to the group which is usually located on separate premises. Since no costs are incurred and no revenue is received under this arrangement, there are no reporting requirements for revenue, expenses, or statistics.

5. Physician Clearing (Agency) Accounts The hospital bills patients for the physician's contractual services, but records these billings as liabilities and the subsequent payment to the physician as a reduction of that liability. The hospital reflects no revenue or expense relative to the professional component. Under this arrangement, no reporting of the professional component is required. However, any billing fees charged the physician must be recorded as other Operating Revenue (Account 5780).

ACCOUNTING PRINCIPLES AND CONCEPTS

6. Salaried The hospital pays at a rate not based on revenues generated. This occurs in county facilities.

WORK ARRANGEMENTS **1192**

The services provided by hospital-based physicians may be categorized into five general types:

1. Professional Component - providing direct patient care. As was previously noted, the great diversity of possible financial and work arrangements between hospitals and hospital based physicians may cause a significant lack of comparability of costs between hospitals providing the same basic services. To minimize this lack of comparability, all fees, commissions and other forms of remuneration paid to physicians for physician services (i.e., Professional Component) are to be reclassified from the cost center in which they are recorded to a separate column on the Reclassification of Physician and Student Compensation Worksheet (Report Pages 15. & 16) for separate analysis and comparison. These costs are not included in cost finding.

2. Hospital Administration - administering overall hospital activities and participating on general committees of the hospital.

3. Cost Center Supervision - supervising activities of the cost center.

4. Research - working on research projects.

5. Medical Education Supported By Hospital - teaching and supervising student activity in educational programs.

When physicians are involved in more than one of the above functional activities, their fees are recorded in the cost center in which they are assigned. Prior to cost finding, these fees are reclassified to the appropriate cost center.

For example, if a physician spent 10% of his time in educational activities, 20% in research, 20% in administrative duties outside the department, 20% in supervision of the department, and 30% in direct care of patients, the reclassification would be as follows:

10% Education Costs (Account 8210-8299)

20% Research Projects and Administration (Account 8010)

20% Hospital Administration (Account 8610)

20% Remains in the cost center (supervision)

30% Physicians Professional Component

This reclassification will be made only on the Reclassification of Physician and Student Compensation Worksheet, pages 15 & 16 of the reporting forms.

ACCOUNTING PRINCIPLES AND CONCEPTS

PHYSICIAN BILLING SERVICES 1193

Many hospitals are providing billing services for physicians under an agency arrangement. Any fees charged the physicians must be recorded as Other Operating Revenue (Account 5780). Refer to Section 1191, Financial Arrangements, number 5 for further explanation.

ACCOUNTING FOR MEDICARE REIMBURSEMENT 1200

With the implementation of the Prospective Payment System (PPS), hospitals are now being paid a prospectively determined rate for each Medicare patient discharged from the hospital rather than being cost reimbursed.

Medicare reimburses hospitals using a variety of different methodologies depending on the services provided. The Prospective Payment System (PPS) was developed to reimburse for inpatient acute services based on Diagnostic Related Groupings (DRG's). Outpatient services are cost reimbursed subject to certain limitations for laboratory, radiology, and ambulatory surgery. Reimbursement for exempt units and Skilled Nursing Facilities are cost reimbursed subject to certain cost limitations.

Deductions from revenue arise as a result of the hospital's agreement to accept an amount less than gross charges as payment in full from Medicare. This reimbursement is made up of two components: the patient liability (deductibles and coinsurance) and the program liability. The contractual adjustment is the difference between gross reimbursement and gross charges. Any patient liability not collected is a bad debt, which Medicare will reimburse for if the appropriate collection proceedings have been performed. If the hospital has created a program where it waives the patient's responsibility for deductibles and coinsurance, these amounts must be written off as Administrative Adjustments (Account 5940).

Accounts receivable for Medicare patients must be written down to the net amount receivable from Medicare and the patient (deductibles, coinsurance, and non-covered charges) as soon as that amount is determinable. This may be at the point of billing or at the point of payment depending on the information available to the hospital. A reserve is required for any receivables that have not been written down as of year end.

Example journal entries for hospitals not on PIP (Periodic Interim Payments)

To record patient care services rendered:

Dr.	Patient Receivables - Medicare - Traditional (Account 1022.00)	$500	
Cr.	Revenue (Various Accounts)		$500

ACCOUNTING PRINCIPLES AND CONCEPTS

To record contractual adjustments:

Dr.	Contractual Adjustments - Medicare - Traditional (Account 5811.00)	$100	
Cr.	Patient Receivables - Medicare - Traditional (Account 1022.00)		$100

To record payment from intermediary:

Dr.	General Checking Accounts (Account 1001.00)	$350	
Cr.	Patient Receivables - Medicare - Traditional (Account 1022.00)		$350

The above example assumes there is a $50 deductible due from the patient.

To record payment from the patient:

Dr.	General Checking Accounts (Account 1001.00)	$50	
Cr.	Inpatient Receivables - Medicare (Account 1022.00)		$50

For cases involving cost settlement, the patient receivable must be reduced to reflect the interim payment rate and the contractual adjustment account is to be adjusted at year end (or quarterly) based on the expected cost report settlement.

Capital pass through payments and prior year cost settlement adjustments must be recorded in sub-accounts of Medicare Contractual Adjustments (i.e. 5813, 5814, etc.). They should be combined with 5810 for reporting purposes.

Medicare utilizes two inpatient reimbursement methodologies. The most common is a claim by claim basis. The above journal entries would be adequate for hospitals subject to this type of reimbursement. The second methodology is Periodic Interim Payments (PIP). Under this method of interim reimbursement the hospital receives a check for a fixed amount every two weeks regardless of the number of Medicare patients treated. The rate is updated on a periodic basis by the Medicare intermediary. As of July 1, 1987 the only hospitals remaining on PIP were those considered to be sole community providers or those having a 5.1 percent disproportionate share.

The recommended method of accounting for PIP is to credit Medicare PIP clearing (Account 1027) when cash is received. The PIP clearing account would be debited when the patient receivable is billed to Medicare. Receivables that have not been billed but are included in the current year cost report should be written off to the PIP clearing account. At year-end when the cost report settlement is made, the account must be reconciled to a zero balance. Any difference in the account must be written off to the contractual adjustment account.

ACCOUNTING PRINCIPLES AND CONCEPTS

Example journal entries for a hospital that had total PIP receipts of $200,000, total Medicare charges of $400,000 and related DRG reimbursement of $250,000. Of the total charges $100,000 were unbilled at year-end with DRG payments of $50,000:

To record PIP receipts

Dr.	General Checking Accounts (Account 1001.00)	$200,000	
Cr.	Medicare PIP - Clearing (Account 1027.00)		$200,000

When billing accounts receivable

Dr.	Medicare PIP - Clearing (Account 1027.00)	$200,000	
Dr.	Contractual Adjustments - Medicare - Traditional (Account 5811)	$100,000	
Cr.	Patient Receivables - Medicare - Traditional (Account 1022.00)		$300,000

At year-end:

To clear out the unbilled Accounts Receivable

Dr.	Medicare PIP - Clearing (Account 1027.00)	$50,000	
Dr.	Contractual Adjustments - Medicare - Traditional (Account 5811)	$50,000	
Cr.	Patient Receivables - Medicare - Traditional (Account 1022.00)		$100,000

To record cost settlement

Dr.	Other Receivables - Third-Party Cost Report Settlements - Medicare (Account 1051.00)	$50,000	
Cr.	Medicare PIP - Clearing (Account 1027.00)		$50,000

Note that the above example was simplistic and ignored capital pass through and deductibles and coinsurance both of which would be treated as noted in the first example. The balance remaining in accounts receivable at year-end would be the patient liability which includes deductibles, coinsurance, and non-covered charges.

ACCOUNTING PRINCIPLES AND CONCEPTS

With the implementation of the Prospective Payment System, hospitals are now being paid a prospectively determined rate for each Medicare patient discharged from the hospital rather than being reimbursed for reasonable costs. Even with this change, nothing really changed in the way Medicare gross and net revenue are calculated. Gross Medicare revenue is based on charges, net revenue is the amount paid or to be paid by all payors, and contractual adjustments are the differences.

Some hospitals under the Medicare prospective payment system (PPS) receive bi-weekly PIP amounts. These amounts are for both inpatient prospective payments and inpatient cost-based reimbursement amounts, including capital-related costs (primarily depreciation, interest, and lease payments), indirect approved medical education costs, and bad debts of Medicare inpatients for uncollectible deductibles and coinsurance. The entries to record PIP amounts are shown previously in this Section.

Logging System 1200.1

It is recommended that the hospital maintain a logging system for each of its contract payor types (Medicare, Medi-Cal, HMO/PPO's). Only through logs can a hospital adequately track activity for the various contract payor types. For each patient logged the system should record the following items:

1. Total Billed Charges
2. Patient (Census) Days by Licensed Unit (ICU, CCU, Med/Surg)
3. Deductibles and Coinsurance
4. Outliers (Medicare) Amount
5. Expected Payment Amount
6. Actual Payment Received
7. Patient Account Number

OUTLIER PAYMENTS 1201

Under PPS, Medicare provides additional reimbursement for outliers. (The following assumes that these amounts are not included in the bi-weekly PIP payments.) Outliers are DRG cases with unusually long lengths of stay or unusually high costs. Length of stay outliers are paid automatically by the fiscal intermediary whereas payment for cost outliers must be requested by the hospital. If the hospital is able to identify outliers, it should establish an asset account, Outlier Payments Due from Medicare (Account 1054) to record additional outlier payments due. The hospital-determined outlier payment amount would be debited to Outlier Payments Due from Medicare (Account 1054) and credited to Contractual Adjustments - Medicare - Traditional (Account 5811). (The credit to the Contractual Adjustments account is correct because a debit was made to this account when the non-outlier DRG payments were processed. As a result, the Contractual Adjustments - Medicare account is overstated by the amount of the outlier payment.) When the outlier payment is received, the hospital will debit General Checking Accounts (Account 1001.00) and credit Outlier Payments Due from Medicare (Account 1054).

ACCOUNTING PRINCIPLES AND CONCEPTS

If the hospital is not able to identify DRG's, it is also not able to identify length of stay outliers. When a patient's bill is submitted by the hospital, the intermediary will process the bill for both the non-outlier and outlier payments. When payment is received, the hospital will debit Cash for the outlier DRG payments, debit Medicare PIP Clearing (Account 1027) for the non-outlier DRG payment, debit Contractual Adjustments - Medicare - Traditional (Account 5811) for the excess of patient charges less non-covered charges, deductibles, and coinsurance over the non-outlier and outlier DRG payments, and credit Patient Receivables - Unbilled (Account 1021).

If the hospital is not able to identify cost outliers, the intermediary will process the bill as a non-outlier bill. The hospital may then submit an adjusted bill for the outlier portion, if medical necessity has been approved by the medical review entity. In this case, the hospital would initially debit Medicare PIP Clearing (Account 1027) the non-outlier payment, debit Patient Receivables - Other (Account 1026) for non-covered charges, deductibles and coinsurance, debit Contractual Adjustments - Medicare - Traditional (Account 5811) account for the excess of patient charges less non covered charges, deductibles and coinsurance over the non-outlier payment, and credit Patient Receivables - Unbilled (Account 1021). As a result, the Contractual Adjustments account is overstated for the outlier payment due. Therefore, the hospital will debit General Checking Accounts (Account 1001.00) and credit the Contractual Adjustments - Medicare - Traditional (Account 5811) account to correct the overstatement when the outlier payment is received.

COST BASED REIMBURSEMENT 1202

Under the Medicare Program services performed for Outpatient, Drug Rehabilitation, Psychiatric and Home Health are reimbursed based on costs subject to limitations on cost. On an interim basis the hospital receives a percentage of charges or per diem as reimbursement. At year-end the cost report is prepared; the actual cost related to those services is determined and final settlement is made.

Accounts receivable for Medicare patients must be written down to the amounts receivable from Medicare on an interim payment basis, and the patient (deductibles, coinsurance, and non-covered charges) as soon as that amount is determinable. This may be at the point of billing or at the point of payment depending on the information available to the hospital. The contractual adjustment amount will also need to be adjusted based on any program reimbursement subject to cost limitation through the cost report. A reserve is required for any receivables that have not been written down as of year-end.

Example journal entries under cost based reimbursement are as follows:

To record patient care services rendered:

Dr.	Patient Receivables - Medicare (Account 1022.00)	$100	
Cr.	Revenue (Various accounts)		$100

ACCOUNTING PRINCIPLES AND CONCEPTS

To record interim payment from intermediary:

Dr.	General Checking Accounts (Account 1001.00)	$40	
Cr.	Patient Receivables - Medicare (Account 1022.00)		$40

(Assume $20 deductible and coinsurance and Medicare pays $40 on an interim basis.)

To record contractual adjustment:

Dr.	Contractual Adjustments - Medicare - Traditional (Account 5811)	$40	
Cr.	Patient Receivables - Medicare (Account 1022.00)		$40

To record payment from patient:

Dr.	General Checking Accounts (Account 1001.00)	$20	
Cr.	Patient Receivables - Medicare (Account 1022.00)		$20

The Contractual Adjustment Account (Account 5811) is to be adjusted at year-end (or quarterly) based on expected cost report settlement.

YEAR-END CLOSING 1203

At year-end there will be Medicare patients which have been discharged but the fiscal intermediary has not been billed. Appropriate entries must be made to account for revenue earned relative to such patients.

Also, at year-end there will be Medicare patients who remain in the hospital. In order to match the revenue and expense, DRG revenue must be allocated between accounting periods. This can be done based on patient (census) days (using the hospital's patient day experience or the HCFA mean length of stay) or patient charges.

Using the hospital's patient charge experience, and assuming that the hospital can determine the DRG for each patient, the revenue allocation formula would be as follows:

$$\frac{\text{Patient Charges Incurred through Year-End}}{\text{Total Patient Charges upon Discharge}} \times \text{DRG Payment} = \text{Allocated Current Period DRG Revenue}$$

ACCOUNTING PRINCIPLES AND CONCEPTS

If the actual total patient charges are not available, the divisor should be a reasonable estimate.

If the DRG Revenue is to be allocated using the patient charges, the formula would be as follows:

$$\frac{\text{Current Period Patient Charges}}{\text{Total Patient Charges upon Discharge}} \times \text{DRG Payment} = \text{Allocated Current Period DRG Revenue}$$

To compute the final settlement of actual inpatient cost-based amounts for Medicare inpatients discharged that year, the hospital will prepare a year-end cost report. The intermediary will determine a settlement of the indirect medical education allowance.

AMBULATORY SURGICAL PROCEDURES 1204

Medicare has created a new method for reimbursing certain ambulatory surgical procedures effective for all cost reporting years ending on or after September 30, 1988. Not all outpatient surgical procedures will be subject to this new reimbursement methodology. Those applicable will be identified by the Health Care Financing Administration Common Procedures Coding System (HCPCS) procedure codes reported on the UB-82 billing form. There are approximately 60,000 different procedure codes for outpatient surgery. HCFA has identified a number of these that are subject to this reimbursement limitation. The procedures applicable may be performed in several cost centers including Emergency Services, Clinic, and Ambulatory Surgery. Included in the fixed fee reimbursement are also those services directly related to the procedures that are performed the day of the surgery.

The Ambulatory Services Center payment rates are categorized into six procedure groupings. This payment rate will be blended with actual cost. The hospital's final reimbursement will be the lower of actual cost and the blended rate as determined on the cost report filed at the end of the year. Each hospital will be reimbursed on an interim basis the same rate as for other outpatient services (a percentage of charges). The cost report will calculate the total cost for these ambulatory surgical procedures similarly to the way other outpatient costs are determined. The total payment for the procedures based on the blended rates must be tracked by the hospital and input in the cost report similarly to the DRG payments for inpatient services.

The hospital should account for this in the same manner as for cost reimbursed services. Accounts receivable should be written down to the interim payment amount, and the contractual adjustment account should be adjusted based on the cost report settlement.

ACCOUNTING FOR LEASES 1210

Often a hospital will obtain the use of land, buildings, or equipment by entering into an agreement to lease them from an outside party. If the amount paid is

merely to obtain the use of the asset for the period of the lease, it is properly treated as expense and charged to the using cost center. For example, the expense for leasing an x-ray machine and duplicating machine would be charged to Radiology - Diagnostic and Printing and Duplicating, respectively. If the cost cannot be identified as belonging to a specific cost center, such as leasing the building, the amount of the lease must be charged to account number 8820, Leases and Rentals. However, when a lease agreement is used as a way for a hospital to obtain eventual ownership of the property, a special treatment may be required. Under certain conditions, a lease is considered in substance to be a purchase of the property, and the property must be recorded by the hospital as an asset accompanied by a liability for future lease payments.

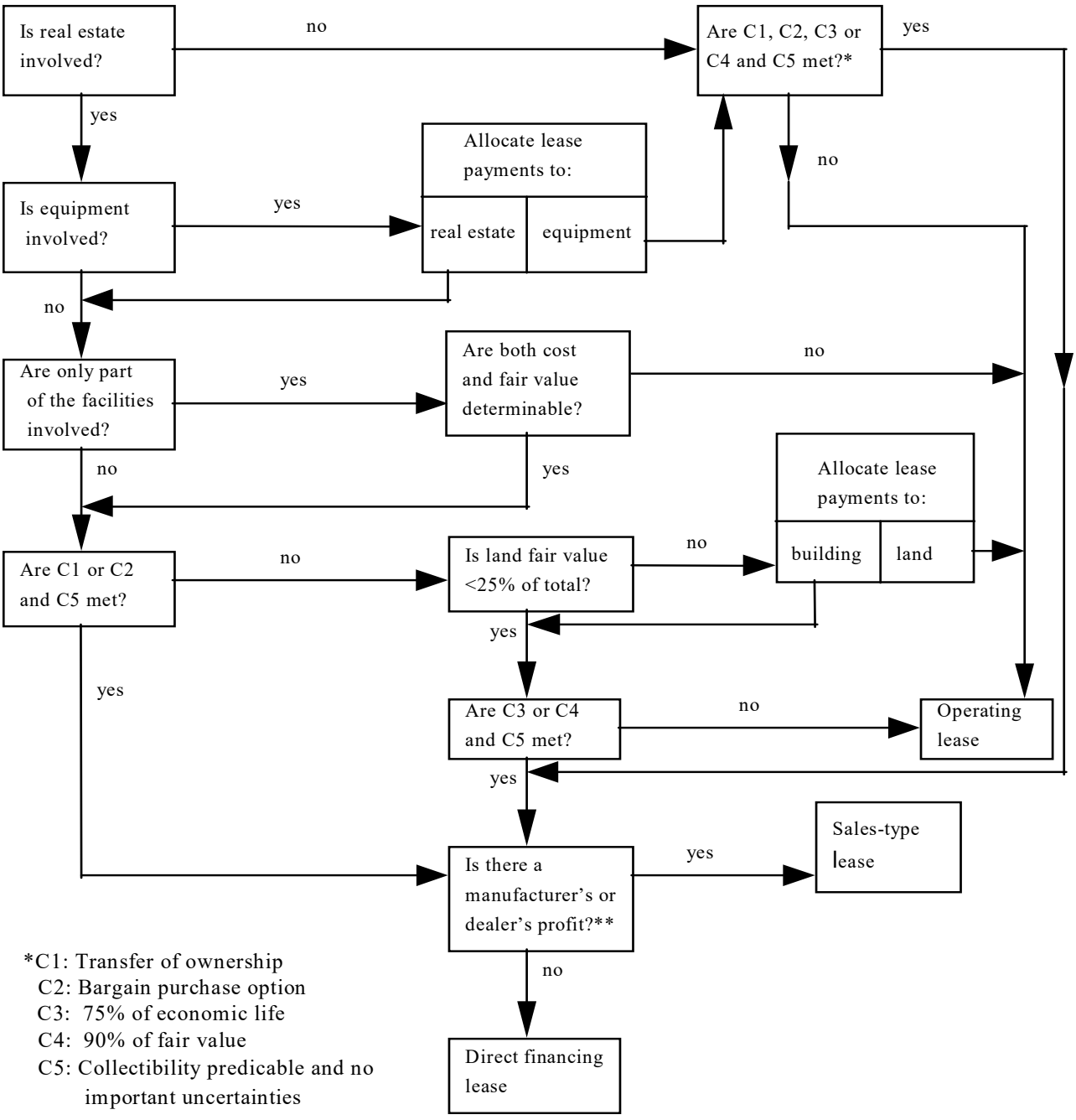
If a lease meets the capitalization criteria in Financial Accounting Standards Board Statement #13, the asset and the related liability must be initially recorded at an amount which represents the present value of the future series of lease payments. The procedure for determining the present value of this payment stream involves estimating a rate of interest and using this rate to reduce each payment to its value as of the day the lease was entered. In effect this method treats this lease as if you borrowed the money to buy the asset; that is, payments do not constitute a rent expense, for the asset is being depreciated, but are treated partially as a reduction in the original liability and partially as interest expense on the remaining portion of the liability.

Any improvements or additions that a hospital makes to a leased asset which fall within the limits of the hospital's capitalization policy, regardless of whether the asset itself has been capitalized, should be capitalized and depreciated.

The following flowcharts summarize the current requirements for lease accounting.

ACCOUNTING PRINCIPLES AND CONCEPTS

Phase 1 - Lessor:

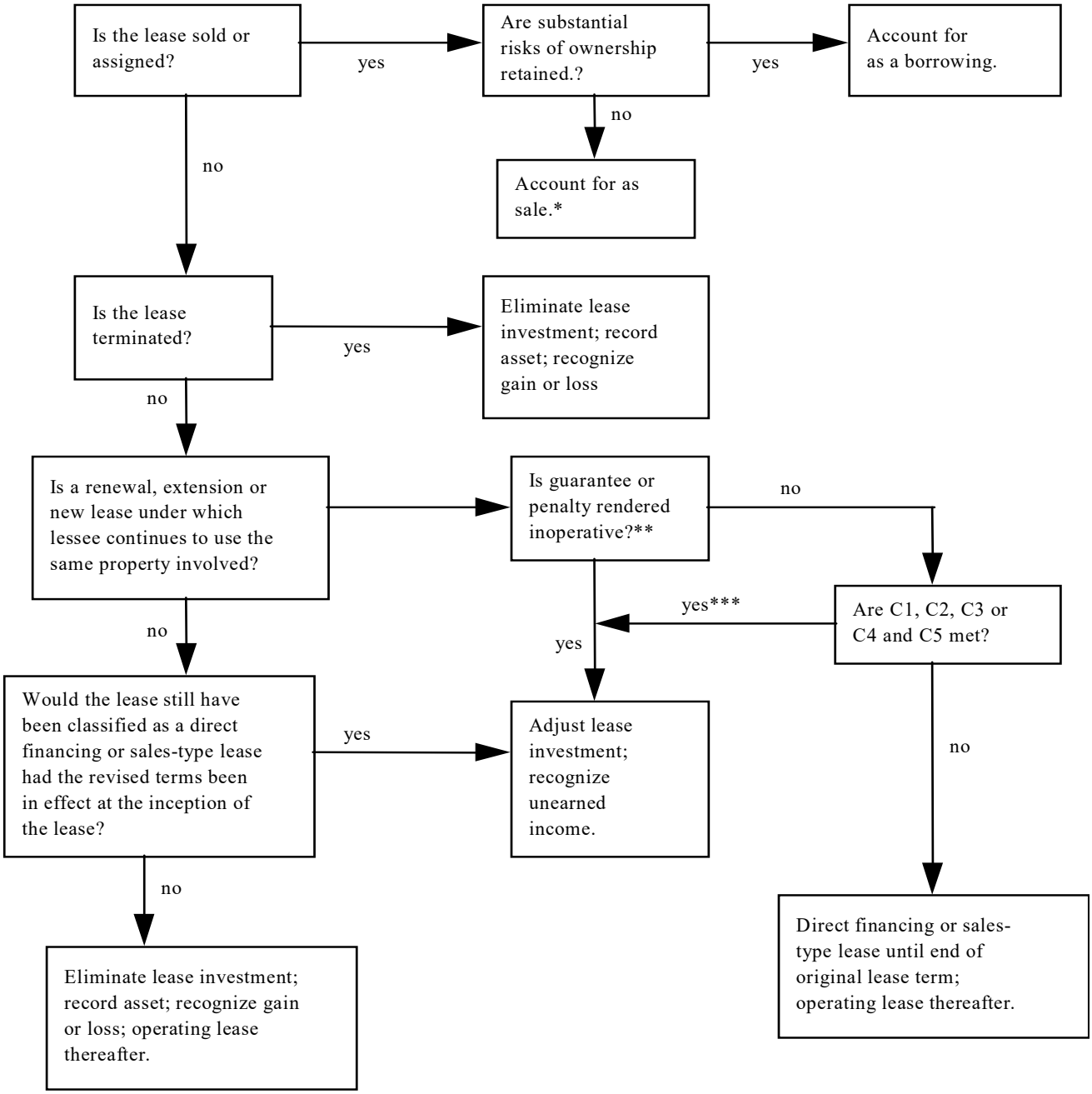


*C1: Transfer of ownership
C2: Bargain purchase option
C3: 75% of economic life
C4: 90% of fair value
C5: Collectibility predicable and no important uncertainties

** Sales-leaseback transactions may not be classified as sales-type leases.

ACCOUNTING PRINCIPLES AND CONCEPTS

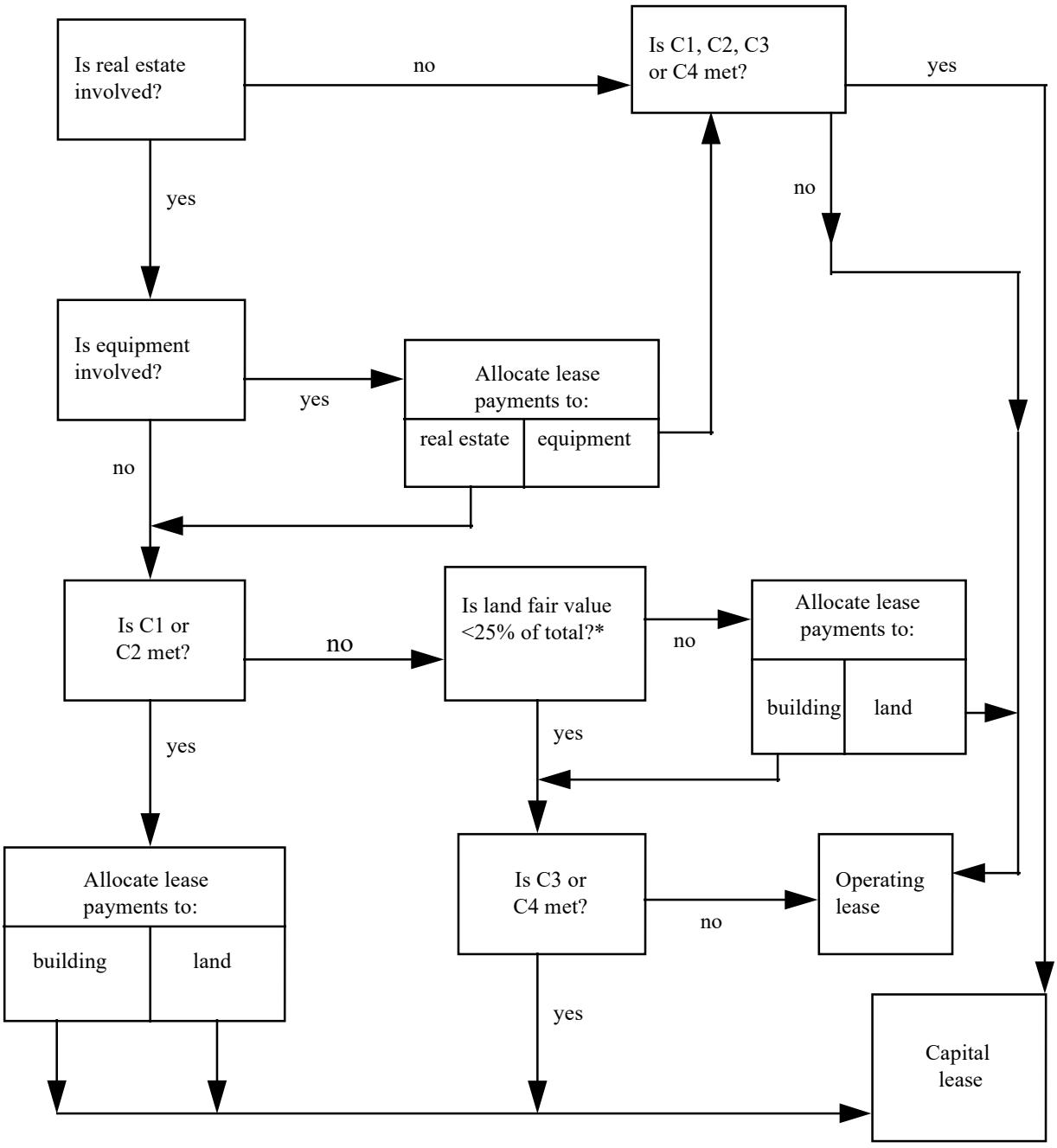
Phase 2 Lessor-direct financing/sales-type lease revisions:



* The gain or loss is deferred and systematically recognized if the transfer is with recourse.
** These are guarantees and penalties that are included in the minimum lease payments.
*** May only be classified as a direct financing lease.

ACCOUNTING PRINCIPLES AND CONCEPTS

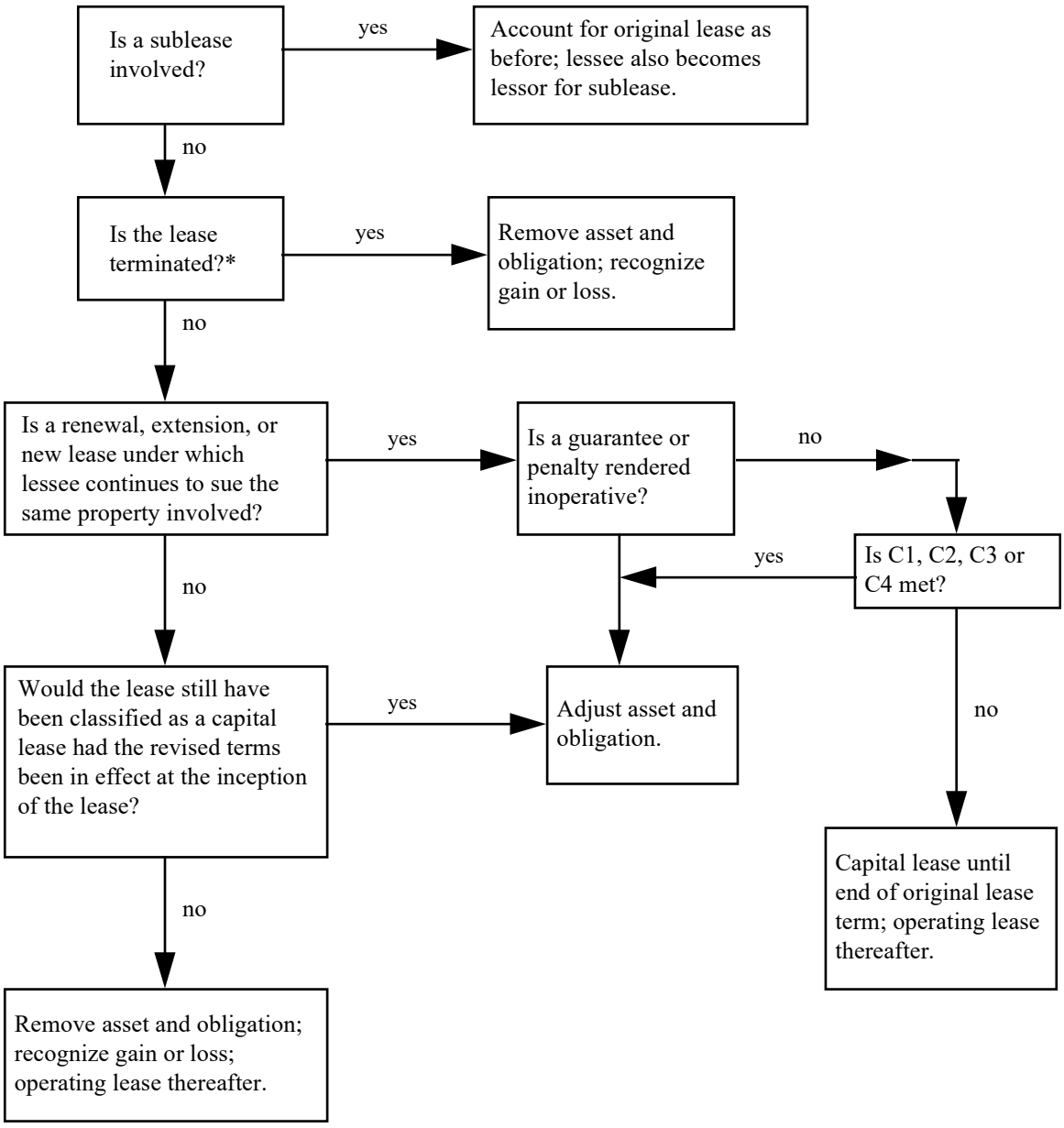
Phase 1 - Lessee:



Use the yes path when only part of a building whose fair value is not determinable is leased. Only C3 is then applicable.

ACCOUNTING PRINCIPLES AND CONCEPTS

Phase 2 Lessee - Capital Lease Revisions



* The lease is considered terminated when the lessee is relieved of the primary obligation by a transfer to a third party.

ACCOUNTING PRINCIPLES AND CONCEPTS

ACCOUNTING FOR HEALTH MAINTENANCE ORGANIZATIONS (HMO), PREFERRED PROVIDER ORGANIZATIONS (PPO), AND OTHER CONTRACTS 1220

Hospitals are contracting with HMO's, PPO's, and directly with employers and unions to provide a full array of patient care services. These services may include inpatient acute care, skilled nursing care, home health care, other outpatient care, and durable medical equipment. Instead of receiving payment on a fee for service basis the hospitals are generally being paid under one of three methodologies to be discussed further on in this section.

To provide a common understanding, the terms used in the 1220 series are defined below:

Admitting Hospital - The hospital which admits a member for 24-hour inpatient care. This may be the contracting hospital or another hospital from which purchased inpatient services are obtained by the contracting hospital.

Capitation Fee (Hospital) - A fixed amount (usually per member) that is paid periodically (usually monthly) to the contracting hospital as compensation for providing comprehensive health care services (usually excluding physician-covered services) for the period. The fee is set by contract between the HMO and the contracting hospital.

Contracting Hospital - The hospital which has contracted with an HMO to provide inpatient services and/or hospital outpatient services for HMO members on a risk-based capitation fee basis.

Copayment - A payment required to be made by a member to the contracting hospital when specific health care services are rendered. Typical copayments include fixed charges for each prescription or certain elective hospital procedures.

Health Maintenance Organization (HMO) - A generic set of medical care organizations organized to deliver and finance health care services. An HMO provides comprehensive health care services to enrolled members for a fixed, prepaid fee (premium).

Member - An individual who is enrolled as a subscriber, or an eligible dependent of a subscriber, in an HMO.

Purchased Inpatient Services - Those services purchased by the contracting hospital from another hospital when a member is admitted to the other hospital with the approval of the contracting hospital. It does not include ancillary services purchased from another hospital or organization for inpatients of the contracting hospital.

Purchased Services - Those services, other than Purchased Inpatient Services, purchased by the contracting hospital from another hospital or organization (vendor).

ACCOUNTING PRINCIPLES AND CONCEPTS

Reinsurance (also known as: Stop-loss insurance) - A contract in which an insurance company agrees to indemnify the contracting hospital for certain health care costs exceeding a predetermined amount (limit) incurred by the contracting hospital in providing care to members. The limit usually covers an annual period and is applied against accumulated charges, a percentage of charges, or patient days for all episodes of care rather than being applied to each episode of care.

Subscriber - The person responsible for payment of premiums or whose employment is the basis for eligibility for membership in the HMO.

Contracting hospitals normally contract to provide all covered inpatient services and specified outpatient services required by HMO members even if all services cannot be directly provided by the hospital. If certain services cannot be provided on-site, the contracting hospital must purchase such services from other hospitals.

The most common contracts fit into the following three categories:

1. Per Diem - This is a contract with an agency to accept a fixed amount per patient day. The most common example of this is the Medi-Cal contract that hospitals enter into with the State of California. In accounting for these transactions the hospital would make the following entries:

   Assume a patient is treated that belongs to XYZ HMO. XYZ has a contract with the hospital to provide care at a rate of $500 per day. The patient is in the hospital for 3 days and generates charges at the hospitals normal rate totaling $4,000.

   To record the receivable

Dr.	Patient Receivables - Other Third Parties - Managed Care (Account 1035.00)	$4,000	
Cr.	Various revenue accounts		$4,000

   To recognize the contractual adjustment

Dr.	Contractual Adjustments - Other Third Parties - Managed Care (Account 5852)	$2,500	
Cr.	Patient Receivables - Other Third Parties - Managed Care (Account 1035.00)		$2,500

   Calculated as $4,000 less $1,500 (Total per diem = 3 days times $500 per day)

When payment is received

Dr.	General Checking Accounts (Account 1001.00)	$1,500	
Cr.	Patient Receivables - Other Third Parties - Managed Care (Account 1035.00)		$1,500

Note that the receivable may be written down at the point of billing or at the time payment is received. It is important to be sure and reserve in the Allowance for Contractual Adjustments - Other Third Parties - Managed Care (Account 1048.00) for amounts in accounts receivable that have yet to be written down to the contracted amount.

2. Risk Sharing Contract - In this type of contract, the hospital agrees to absorb a portion of the cost of treating the particular HMO's patients if the expense incurred during the year exceeds the previously agreed upon budgetary limits. At the same time, the hospital will share in the profit if the expense is under the previously agreed upon budgetary limits. This creates incentive for the hospital to treat each patient as efficiently as possible. Patients treated under these types of arrangements are accounted for in the same manner as noted above. The only difference is that at year end there will be a liability to or a receivable from the HMO for the difference between actual cost and budgeted cost. On the balance sheet the entry will be recorded in either Other Receivables - Third-Party Cost Report Settlement-Other (Account 1053.00) or in Reimbursement Settlement Due - Other Third-Party Payors (Account 2063.00). The other side of the entry creating this receivable/liability must be recorded in Capitation Premium Revenue - Other Third Parties (Account 5990).

3. Capitation Contract - Under this arrangement, the hospital agrees to treat the members of the health plan for a fixed rate per member per month. The hospital is at risk and is liable for any expenses incurred beyond the monthly capitation payments. Under certain circumstances, an HMO may remit payments in advance to hospitals for services not yet identified. Situations such as this should be accounted for similarly to the accounting for capitated contracts. Hospitals may purchase what is termed reinsurance which will indemnify the hospital for any patient whose charges exceed a flat amount.

INPATIENT SERVICES **1221**

For inpatient services that are provided by the contracting hospital within its own facilities, the accounting of the revenue and expenses for capitation patients is no different than that for any other patient. Revenue (recorded at full-established rates) and all direct expenses, as defined in this Manual, must be accounted in the functional centers related to the services provided. However, for inpatient services (other than just ancillary services) which must be obtained from another hospital where the member is admitted to the other hospital, the accounting for the related revenue and expenses must be accommodated in a different manner.

ACCOUNTING PRINCIPLES AND CONCEPTS

The following are four situations in which inpatient services are provided to members:

1. A member is admitted to the contracting hospital and all daily and ancillary services are directly provided by that hospital. The gross revenue, expenses, and units of service are recorded in the functional centers related to the services provided.

2. A member is admitted to the contracting hospital and most, but not all, ancillary services are directly provided by that hospital. For example, although the patient remains an inpatient of the contracting hospital, the contracting hospital must purchase computed tomographic scanner services from another hospital or organization. In this case, the gross revenue, expenses, and units of service related to all purchased ancillary services must be recorded by the contracting hospital in the functional centers related to the services provided even though purchased from another hospital.

3. A member is not admitted to the contracting hospital but is admitted to another hospital (or to a skilled nursing or intermediate care facility which is not operating under the license of the contracting hospital) with the approval of the contracting hospital. Since the contracting hospital is responsible for all of the cost of the services provided by the admitting hospital, the admitting hospital will bill the contracting hospital for the care provided. Because the member was not admitted to the contracting hospital, it is inappropriate to record the expenses and related units of service [patient (census) days, surgery minutes, etc.] in the functional cost centers of the contracting hospital. It is also inappropriate to gross up the revenue of the contracting hospital related to the services provided by the admitting hospital. However, since the contracting hospital is responsible for the cost of the services provided and has received capitation fees to provide all inpatient services, such cost must be recorded as patient service expense.

4. A member is first admitted to the contracting hospital but during the same episode of care is transferred and admitted to another hospital, or vice versa. In this case, the services provided by the contracting hospital would be accounted as described in 1 or 2 above and the inpatient services provided by the other hospital would be accounted as described in 3 above.

Because the capitation fees are not related to specific patients, all earned capitation fees must be recorded as a credit to the appropriate capitation premium revenue account. To identify capitation premium revenue related to specific risk-based capitation plans separately from other capitation premium revenue, use subaccounts within the capitation premium revenue accounts.

ACCOUNTING PRINCIPLES AND CONCEPTS

The expenses related to purchased inpatient services must be recorded in Account 7900, Purchased Inpatient Services.

The standard unit of measure related to purchased inpatient services is purchased inpatient days.

Example of Capitation Accounting Journal Entries 1221.1

The following is an example of capitation accounting, including assumptions, and the corresponding journal entries related to the capitation risk-based contract and to providing hospital inpatient services to HMO members.

1. There are 3,750 members and the hospital receives $40 per member per month from the HMO (exclusive of risk pool withholds), or $150,000.

Dr.	General Checking Accounts (Account 1001)	$150,000	
Cr.	Deferred Income - Capitation Fee (Account 2103.X1)		$150,000

To record monthly capitation fees received from HMO.

NOTE: Use of the Deferred Income account is optional if the amounts received are earned within the same accounting period.

2. The hospital has reinsurance covering 100% of the cost in excess of $35,000. The annual cost of the reinsurance is $16,000.

NOTE: Cost recoveries are to be identified with specific patients and are to be offset to Inpatient Receivables - HMO/PPO and Other Contracts (Account 1024.00) for members treated by the contracting hospital and recorded as Contractual Adjustments - Other (Account 5840) for members admitted as inpatients to other hospitals.

Dr.	Insurance - Other (Account 8840)	$16,000	
Cr.	General Checking Accounts (Account 1001)		$16,000

To record reinsurance purchased to cover excess health care costs.

ACCOUNTING PRINCIPLES AND CONCEPTS

3. In-house patient care charges for members totaled $178,500, including one in-house patient who had a bill for $38,000. Reinsurance recovery was billed for $3,000 ($38,000 - $35,000).

Dr.	Other Receivables (Account 1069)	$3,000	
Dr.	Patient Receivables - Other Third Parties - Managed Care (Account 1035)	$178,500	
Cr.	Reinsurance Recoveries (Account 5781)		$3,000
Cr.	Various Patient Revenue Centers		$178,500

To record in-house inpatient care services rendered to HMO members and the reinsurance recovery of $3,000 claimed for inpatient services.

4. The hospital purchases computed tomography scanner services for $1,200 from another hospital.

Dr.	Computed Tomographic Scanner (Account 7680.61)	$1,200	
Cr.	Accounts Payable (Account 2020)		$1,200

To record CT Scanner services purchased from another hospital for in-house HMO member patients.

5. The hospital records the patient revenue related to the purchased CT scanner services. A 25 percent mark-up on purchased ancillary services is used in this example.

Dr.	Inpatient Receivables - HMO/PPO and Other Contracts (Account 1025.00)	$1,500	
Cr.	Computed Tomographic Scanner (Account 4680)		$1,500

To record Gross Patient Revenue related to CT Scanner services ($1,200 plus 25% mark-up of $300, or $1,500).

NOTE: A mark-up has been added to the cost of the purchased ancillary services prior to recording the gross revenue. This may seem unnecessary for capitated patients since the amount the hospital will collect has already been determined. However, gross revenue related to ancillary services must be recorded consistently for all patients. If the hospital purchases ancillary services for both capitated and non-capitated patients, the basis for recording gross revenue must be the same. For example, if the hospital purchases CT scanner services for a private pay patient and marks up the cost of the service by "X" percent to determine the charge (gross revenue), then CT scanner services purchased for capitation patients must also be marked-up. Only in this way will gross revenue be comparable among all patients.

ACCOUNTING PRINCIPLES AND CONCEPTS

6. The hospital does not provide open-heart surgery services. One HMO member was admitted to another hospital for such surgery. The cost was $40,000. [This will result in a $5,000 reinsurance recovery ($40,000 - $35,000).]

Dr.	Purchased Inpatient Services (Account 7900)	$40,000	
Cr.	Accounts Payable (Account 2020)		$40,000

To record inpatient services purchased from another hospital.

Dr.	Other Receivables (Account 1069)	$5,000	
Cr.	Reinsurance Recoveries (Account 5781)		$5,000

To record reinsurance recovery claimed for purchased inpatient services.

7. HMO patients have a copayment requirement of $4 per prescription item. During the month 125 prescription items were issued to inpatients and all were paid. (125 x $4 = $500)

Dr.	General Checking Account (Account 1001)	$500	
Cr.	Patient Receivables - Other Third Parties - Managed Care (Account 1035.00)		$500

To record patient copayments collected.

8. Reinsurance payments received.

Dr.	General Checking Account (Account 1001)	$8,000	
Cr.	Other Receivables (Account 1069)		$8,000

To record reinsurance recoveries received from the insurance company ($3,000 for hospital patients and $5,000 for purchased inpatient services).

ACCOUNTING PRINCIPLES AND CONCEPTS

9. Contractual Adjustments were $179,500 for hospital inpatient services. [Gross Patient Revenue of $178,500 for inhouse services plus $1,500 for purchased CT scanner services less copayments of $500 (Entry 7).]

Dr.	Contractual Adjustments - Other Third Parties - Managed Care (Account 5852)	$179,500	
Cr.	Patient Receivables - Other Third Parties - Managed Care (Account 1035)		$179,500

To close in-house capitation patient Accounts Receivable balances to Contractual Adjustments.

10. Capitation fees (when earned) are transferred from the Deferred Income - Capitation Fees account to the Capitation Premium Revenue account.

Dr.	Deferred Income - Capitation Fees (Account 2103.X1)	$150,000	
Cr.	Capitation Premium Revenue - Other Third Parties (Account 5990)		$150,000

To transfer capitation fees earned to Capitation Premium Revenue.

11. Risk pool distribution to the hospital was $16,000 and is credited to Capitation Premium Revenue - Other Third Parties since it does not relate to specific patients. (Normally the risk pool is distributed at the end of the capitation contract period, however, for illustration purposes it is shown here at the end of the first month.)

Dr.	General Checking Account (Account 1001)	$16,000	
Cr.	Capitation Premium Revenue - Other Third Parties (Account 5990)		$16,000

To record risk pool distribution.

The following entries are included only to develop the illustrative income statement shown below.

ACCOUNTING PRINCIPLES AND CONCEPTS

12. Expenses of the contracting hospital related to patient care and non-revenue producing activities were $100,000 and $40,000, respectively.

Dr.	Various Revenue Producing Cost Centers	$100,000	
Dr.	Various Non-Revenue Producing Cost Centers	$40,000	
Cr.	General Checking Account (Account 1001)		$140,000

To record expenses related to patient care and non-revenue producing activities.

13. Non-operating revenue and expenses were $40,000 and $10,000, respectively.

Dr.	General Checking Account (Account 1001)	$40,000	
Cr.	Other Non-Operating Revenue (Account 9400)		$40,000

To record Non-Operating Revenue.

Dr.	Other Non-Operating Expenses (Account 9800)	$10,000	
Cr.	General Checking Account (Account 1001)		$10,000

To record Non-Operating Expenses.

ACCOUNTING PRINCIPLES AND CONCEPTS

General Checking Account (1001)

	Dr.		Cr.	
(1)	150,000		16,000	(2)
(7)	500		140,000	(12)
(8)	8,000		10,000	(13b)
(11)	16,000			
(13a)	40,000			
	48,500			

Patient Receivables - Other Third Parties - Managed Care (1035)

	Dr.		Cr.	
(3)	178,500		500	(7)
(5)	1,500		179,500	(9)
			0	

Other Receivables (1069)

	Dr.		Cr.	
(3)	3,000			
(6b)	5,000		8,000	(8)
	0			

Accounts Payable (2020)

	Dr.		Cr.	
			1,200	(4)
			40,000	(6a)
			41,200	

Deferred Income - Capitation Fees (2103.X1)

	Dr.		Cr.	
(10)	150,000		150,000	(1)
			0	

Various Patient Revenue Centers (XXXX)

	Dr.		Cr.	
			178,500	(3)

Computed Tomographic Scanner Revenue (4680)

	Dr.		Cr.	
			1,500	(5)

Reinsurance Recoveries (5781)

	Dr.		Cr.	
			3,000	(3)
			5,000	(6b)
			8,000	

Contractual Adjustments - Other Third Parties - Managed Care (5852)

	Dr.		Cr.	
(9)	179,500			

Capitation Premium Revenue - Other Third Parties (5990)

	Dr.		Cr.	
			150,000	(10)
			16,000	(11)
			166,000	

ACCOUNTING PRINCIPLES AND CONCEPTS

Computed Tomographic Scanner Purchased Services - Medical (7680.61)

	Dr.	Cr.
(4)	1,200	

Purchased Inpatient Services (7900)

	Dr.	Cr.
(6a)	40,000	

Various Revenue Producing Cost Centers

	Dr.	Cr.
(12)	100,000	

Various Non-Revenue Producing Cost Centers

	Dr.	Cr.
(12)	40,000	

Insurance - Other (8840)

	Dr.	Cr.
(2)	16,000	

Other Non-Operating Revenue (9400)

	Dr.	Cr.
		40,000 (13a)

Other Non-Operating Expense (9800)

	Dr.	Cr.
(13b)	10,000	

The following is an illustrative Statement of Income based on the above account balances:

STATEMENT OF INCOME
(ILLUSTRATIVE)

Gross patient revenue	$ 180,000
Less deductions from revenue	179,500
Add capitation premium revenue	166,000
Net patient revenue	$166,500
Other operating revenue	8,000
Total operating revenue	$174,500
Operating expenses:	
CT scanner	$ 1,200
Various revenue producing cost centers	100,000
Insurance - other	16,000
Various non-revenue producing centers	40,000
Other patient care services expenses	40,000
Total operating expenses	$197,200
Net from operations	- 22,700
Non-operating revenue	40,000
Non-operating expenses	10,000
Net income	$ 7,300

ACCOUNTING PRINCIPLES AND CONCEPTS

OUTPATIENT SERVICES 1222

For outpatient services that are provided by a hospital within its own facilities to a registered outpatient, the accounting of the revenue and expenses for capitation patients is no different than that for any other patient. Revenue (recorded at full-established rates) and all direct expenses, as defined in this Manual, must be accounted in the functional centers related to the services provided. However, for outpatient services which must be obtained from another hospital, where the member registers as an outpatient of the other hospital, the accounting for the related revenue and expenses must be accommodated in a different manner.

The following are three situations in which outpatient services are provided to members:

1. A member is registered as an outpatient in the hospital and all ambulatory and ancillary services are directly provided by that hospital. The gross revenue, expenses, and units of service are recorded in the functional centers related to the services provided.

2. A member is registered as an outpatient in the hospital and most, but not all, ancillary services are directly provided by that hospital. For example, the hospital must purchase computed tomographic scanner services from another hospital or organization. Since the patient is a registered outpatient of the purchasing hospital, the gross revenue, expenses, and units of service related to computed tomographic scanner services must be recorded by the purchasing hospital in the computed tomographic scanner services revenue/cost center even though purchased from another hospital.

3. A member does <u>not</u> register as an outpatient of the purchasing hospital but registers as an outpatient at another hospital (or health care facility) with the approval of the purchasing hospital. Since the purchasing hospital is responsible for all of the cost of the services provided by the other hospital, the other hospital will bill the purchasing hospital for the care provided. Because the member was not registered at the purchasing hospital, it is inappropriate to record the expenses and related units of service in the functional cost centers of the purchasing hospital. It is also inappropriate to record any patient revenue by the purchasing hospital related to the services provided by the other hospital. However, since the purchasing hospital is responsible for the cost of the services provided and has received capitation fees to provide all outpatient services, such cost must be recorded as patient service expense in the Purchased Outpatient Services (Account 7950) cost center.

If outpatient services are included in the hospital's agreement with the HMO, the capitation fees would cover both inpatient and outpatient services as specified in the agreement. Such fees would be accounted through capitation premium revenue as indicated in the discussion and example of Inpatient Services above.

ACCOUNTING PRINCIPLES AND CONCEPTS

OTHER COMMENTS 1223

If the hospital has a need to identify expenses with specific risk-based contracts, the hospital is free to expand upon the required account code structure in this Manual. For example, if a capitated patient who is formally admitted as an inpatient to the hospital needs computed tomographic scans that must be purchased from another hospital, the required coding would be 7680.61 (7680 for the Computed Tomographic Scan cost center and .61 for Purchased Services - Medical.) To identify the expense with a specific contract - for example, Complete Care Plan - the expanded coding could be 7680.611, or 7680.6101 with the 1 or 01 identifying the Complete Care Plan contract. For purchased inpatient services related to Complete Care Plan for a patient admitted to another hospital, the coding would be 7900.611 or 7900.6101. The specific code for the underlined portion of course depends on the expanded coding scheme developed by the hospital.

The hospital which has to purchase inpatient services from another hospital may want to keep track of the cost of those services for each hospital from which they purchased them, or based on the kinds of services purchased. In the first case, the 7900 series could be expanded to indicate that 7901 is Compliance Medical Center, 7902 Pleasantville Convalescent Hospital, etc. Or in the second case, 7901 could mean Medical/Surgical Intensive Care, 7902 - Coronary Care, etc. The numbering scheme within Account 7900 is up to the hospital.

HOSPITAL-SPONSORED HEALTH MAINTENANCE ORGANIZATIONS 1230

If a hospital is sponsoring its own Health Maintenance Organization (HMO) and related Individual Practice Associations (IPA's), it is recommended that the cost of administering the program and the related business transactions be accounted for separately from the hospital's general ledger. The hospital must not report the revenues and expenses incurred by the HMO (membership premiums, medical expenses, etc.) on the annual disclosure report.

If the hospital cannot maintain two sets of accounting records for the two entities, the HMO operations should be reclassified out of the hospital's general ledger prior to completing the annual disclosure report.

ACCOUNTING FOR ADMINISTRATIVE SERVICES PROVIDED BY OTHER COUNTY AGENCIES 1240

The cost of administrative services provided to the hospital by other county agencies or departments must be recorded and reported by the hospital as a purchased service. The cost of such services must be charged to the appropriate functions. For example, if purchasing and general accounting services are purchased from a county agency or department, the cost of each service must be charged to the appropriate functional cost center.

ACCOUNTING FOR MEDICAL SERVICES PURCHASED FROM ANOTHER FACILITY 1250

The accounting for the purchase of medical services by one hospital from another is the same regardless of financial classification. Expenses for inpatient services purchased from another facility, where the patient is not admitted to the purchasing hospital, must be recorded in the Purchased Inpatient Services cost center

ACCOUNTING PRINCIPLES AND CONCEPTS

(Account 7900) by the purchasing hospital. No inpatient revenue is recorded, however, related purchased inpatient days and discharges must be recorded. All expenses for outpatient services purchased from another facility, where the patient is not registered as an outpatient of the purchasing hospital, must be recorded in the Purchased Outpatient Services cost center (Account 7950) by the purchasing hospital. No outpatient revenue or units of service are recorded.

When patients are formally admitted as inpatients or registered as outpatients of the hospital, and the hospital must purchase ancillary or ambulatory services from another facility, related revenues and expenses must be recorded in the appropriate revenue/cost center by the purchasing hospital. For example, assume Hospital C must purchase CT Scanner services for a Medi-Cal inpatient from Hospital D. In this case, Hospital D would provide the CT Scanner services on an outpatient basis to the Hospital C patient. Hospital D would record its direct expenses in the CT Scanner cost center and record outpatient revenue at the full established rates using the "Other Third Parties - Traditional" payor category. The difference between full established rates and what Hospital C pays would be recorded in Contractual Adjustments - Other Third Parties - Traditional (Account 5851). Hospital D would record the appropriate number of units of service.

Hospital C would pay Hospital D and record the payment in the CT Scanner cost center as medical purchased services. Hospital C would also record CT Scanner inpatient Medi-Cal gross revenue and appropriate Medi-Cal Contractual Adjustments. Hospital C records the same number of units of service counted by Hospital D.

Although this double counts revenues and expenses, only in this way do both hospitals have an accurate accounting of the transactions and comparable revenue and expense per unit figures.

ACCOUNTING FOR COUNTY INDIGENT PROGRAMS AND FUNDS 1260

Effective January 1, 1983, the State transferred responsibility for medically indigent adults to counties and provided a funding mechanism. These persons were, in essence, rolled into the existing county responsibility for indigent health care under Section 17000 of the Welfare and Institutions (W & I) Code.

In September 1989, the California Healthcare for Indigent Program (CHIP) was legislatively created to implement Proposition 99, which imposed a tobacco products tax to provide funding for the health care of the medically indigent and for other purposes. Funding for counties under the Medically Indigent Services Program (MISP) and AB-8 program was eliminated by legislation enacted in 1991. That legislation transferred the responsibility and funding for social services, public health and health from the State to the counties. The program is called "realignment" (See Section 1280 for a discussion on how county hospitals are to account for realignment funds). Under both the CHIP and realignment programs, funding from the State is dependent on each county fulfilling a Maintenance of Effort requirement.

Although the MISP program was eliminated by the "realignment" legislation, the California Medical Services Program (CMSP) still exists. Under CMSP, which was created for counties with a population of less than 3,000,000, the State administers the program for those counties electing to have the State do so. As administrator of the CMSP, the State is responsible for determining patient eligibility and paying hospitals for services provided to patients under this program.

ACCOUNTING PRINCIPLES AND CONCEPTS

Because of the number of funding sources being used by counties to fund indigent health care, the County Indigent Programs (CIP) payor category, established in this Manual, must be used to consolidate and track the revenue related to all indigent health care for which counties are responsible.

The following applies to all hospitals:

Hospitals providing care to indigent patients for which the county is responsible, whether that is a county hospital or another hospital under arrangements with the county, must account for the CIP patients' charges and related contractual adjustments in the County Indigent Programs payor category. The accounting requirements for CIP patients are the same as for any other sponsored patient. Gross patient revenue based on the hospital's full established rates and the units of service provided are to be recorded for the appropriate revenue centers. A patient receivable account (Patient Receivables - County Indigent Programs - Traditional, Account 1024 and Patient Receivables - County Indigent Programs - Managed Care, Account 1034) must be established equal to the gross patient revenue amount. The difference between the amount of the receivable and the amount to be received from the patient (if any) and the responsible county must be charged to the Contractual Adjustments - County Indigent Programs - Traditional account (Account 5841) or Contractual Adjustments - County Indigent Programs - Managed Care account (Account 5842) and credited to the patient's receivable account.

(NOTE: The first edition of this Manual required county hospitals to record all unpaid charges to an appropriate charity account. However, this is no longer appropriate since indigent patients must be specifically identified to either the County Indigent Programs payor category or Other Indigent payor category.)

The following applies to County Hospitals Only:

Under W & I Code Section 17000, counties are required to provide health care to all residents who qualify as indigents under the standards established by each county. In order to distinguish between patients who qualify as indigents and those who don't, all patients must be classified by county hospitals at the time of admission, or as soon as is possible, as being indigent and/or paying patients.

The State distributes CHIP and realignment funds rateably in advance to counties. These funds are either maintained by the County Auditor-Controller or transferred to the county hospital(s). If the funds are transferred to the county hospital's responsibility, they are to be recorded by the hospital as Deferred Income - Other (Account 2093), a sub-account of the Other Liabilities Account. This method of accounting is required since the funds have not yet been earned, but in all probability will be recognized as revenue within 12 months.

If all or part of the patient's account is to be paid from CHIP and/or realignment funds, an amount equal to the payment is then debited to Deferred Income - Other (Account 2093) and credited to the patient's receivable account. If the CHIP and/or realignment funds have been exhausted, no transfer from the Deferred Income - Other account is required. The difference between the patient's gross charges and the amount to be paid by the patient and from CHIP and/or realignment funds must be charged to Contractual Adjustments - County Indigent Programs - Traditional (Account 5841).

ACCOUNTING PRINCIPLES AND CONCEPTS

In some counties, the county hospital(s) does not receive the CHIP and/or realignment funds in advance, but the funds are retained by the County Auditor-Controller, or other county agency. To receive payment, the hospital renders a bill to the Auditor-Controller. This would preclude the use of the Deferred Revenue account in the example above.

There may be times when the county hospital is unable to provide the services required by the indigent patient and another provider must be authorized to render the services. If the county purchases inpatient services from another institutional provider, it is not appropriate for the indigent patient services rendered by an authorized provider to be recorded as a daily hospital service of the county hospital since to do so would distort the revenue and expenses of, and services rendered by, the county hospital. For example, if the patient (census) days of care provided by an authorized hospital were included with the county hospital's statistics, the county hospital's occupancy rate would be distorted. When the authorized hospital's bill is received by the county hospital, the amount must be charged to Purchased Inpatient Services (Account 7900) and an appropriate payable account credited.

ACCOUNTING FOR MEDI-CAL DISPROPORTIONATE SHARE AND OTHER SUPPLEMENTAL PAYMENTS 1270

Medi-Cal programs provide supplemental payments to hospitals that have high utilization rates of Medi-Cal and low-income patients. This section describes accounting for the following Medi-Cal disproportionate share and other supplemental payment programs:

1) Inpatient Disproportionate Share (SB 855)
2) Emergency Services Supplemental Payments (SB 1255)
3) Construction and Renovation Reimbursement (SB 1732)
4) Graduate Medical Education Supplemental Payments (SB 391)
5) Outpatient Supplemental Payments (SB 1179)

MEDI-CAL INPATIENT DISPROPORTIONATE SHARE (SB 855) 1271

Legislation enacted effective July 30, 1991 (SB 855, Chapter 279) and clarifying legislation enacted effective October 14, 1991 (SB 146, Chapter 1046), provides that additional payments are to be made by the State to disproportionate share hospitals that provide acute care inpatient services to Medi-Cal beneficiaries. Funding for the additional payments is provided by intergovernmental transfers from public entities (counties, hospital districts, and the University of California) to the State. Amounts transferred are matched with Federal Medicaid funds. The disproportionate share funds are paid to disproportionate share hospitals as a supplemental amount for each Medi-Cal day of care paid for by the Medi-Cal Fiscal Intermediary.

Approval of the disproportionate share payment program by the Health Care Financing Administration was effective retroactive to August 17, 1991.

ACCOUNTING PRINCIPLES AND CONCEPTS

The intergovernmental transfer payments are to be made to the State Controller's Office (SCO) by public entities (counties, hospital districts, and the University of California system) and may not be made directly by the hospital, and therefore are not recorded in its books and records. This is consistent with Section 14163 (e) of the Welfare and Institutions Code which provides that the intergovernmental transfers to fund the disproportionate share program are to be made to the SCO by the public entity that is the licensee of each identified eligible hospital.

After July 1st of each year, the Department of Health Services notifies eligible hospitals of the estimated disproportionate share amounts to be disbursed. Normally, disproportionate share payment amounts related to the SB 855 program will be received concurrently with the hospital's regular Medi-Cal payments in eight installment payments on the last day of the month in the months of October through May from the Medi-Cal intermediary. However, due to delays in the availability of the disproportionate share funds, disproportionate share payments may be delayed. When such delays occur, it is appropriate to accrue the delayed payments. Disproportionate share payments must not be based on when services are rendered to Medi-Cal inpatients. To avoid over accruals of disproportionate share funds, hospitals should be aware that disproportionate share payments may not exceed 80 percent of its prior calendar year Medi-Cal paid days.

Supplemental disproportionate share payment amounts are to be recorded and reported in full as a credit to Disproportionate Share Payments for Medi-Cal Patient Days (Account 5830). This is consistent with Section 14105.98 (d) (1) of the Welfare and Institutions Code which specifies that the disproportionate share payment amounts "shall be distributed as a supplement to . . . payments on all billings for Medi-Cal acute inpatient hospital services that are paid through the Medi-Cal claims payment systems.

The public entity may require the hospital to remit certain portions of the disproportionate share payments to the public entity. In this instance, these amounts are to be recorded on the hospital's books as a reduction to the Unrestricted Fund Balance. This transfer must not be recorded as a debit to Disproportionate Share Payments for Medi-Cal Patient Days (Account 5830) or Contractual Adjustments - Medi-Cal (Account 5820), or recorded as an operating or non-operating expense. This is consistent with the requirements of the State Controller's Office and reflects the fact that SB-855 does not require the remittance of received payments to the public entities.

The following entries indicate how the supplemental amounts are to be recorded by eligible hospitals.

Assumptions: The hospital's Medi-Cal contract rate is $1,500 per patient day and the additional disproportionate share payment rate is $300 per paid Medi-Cal patient day. The Medi-Cal patients receiving services are Medi-Cal - Traditional patients.

1. To record patient care services rendered to Medi-Cal - Traditional inpatients:

Dr. Patient Receivables - Medi-Cal - Traditional (Account 1023)	$60,000	
Cr. Revenue (Various Accounts)		$60,000

ACCOUNTING PRINCIPLES AND CONCEPTS

2. To record contractual adjustments related to the 30 patient days of services recorded in 1. above, based on contract rate [$60,000 - $45,000 ($1,500 x 30 days)]:

Dr. Contractual Adjustments - Medi-Cal - Traditional (Account 5821)	$15,000	
Cr. Patient Receivables - Medi-Cal - Traditional (Account 1023)		$15,000

3. To record receipt of $22,500 for 15 days of Medi-Cal Traditional inpatient services ($1,500 x 15 days) and $4,500 in additional disproportionate share payments (1/8th installment payment):

Dr. Cash (Account 1000)	$27,000	
Cr. Patient Receivables - Medi-Cal - Traditional (Account 1023)		$22,500
Cr. Disproportionate Share Payments for Medi-Cal Patient Days (Account 5830.05)		$ 4,500

4. (Same as entry no. 3, except disproportionate share payments to the hospitals have been delayed.) To record receipt of $22,500 for 15 days of Medi-Cal - Traditional inpatient services ($1,500 x 15 days) and to recognize of $4,500 in additional disproportionate share payments (1/8th installment payment):

Dr. Cash (Account 1000)	$22,500	
Dr. Other Receivables (Account 1060)	$4,500	
Cr. Patient Receivables - Medi-Cal - Traditional (Account 1023)		$22,500
Cr. Disproportionate Share Payments for Medi-Cal Patient Days (Account 5830.05)		$4,500

5. To record receipt of disproportionate share payments:

Dr. Cash (Account 1000)	$4,500	
Cr. Other Receivables (Account 1060)		$4,500

6. If the public entity requires the hospital to transfer portions of the disproportionate share payments to the public entity, the following entry would be made:

Dr. Unrestricted Fund Balance (Account 2310)	$10,000	
Cr. Cash (Account 1000)		$10,000

7. If the public entity receives lump-sum retroactive disproportionate share payments for services rendered in previous payment years, the following entry would be made:

Dr. Cash (Account 1000)	$100,000	
Cr. Other Non-Operating Revenue (Account 9400)		$100,000

MEDI-CAL EMERGENCY SERVICES SUPPLEMENTAL PAYMENTS (SB 1255) 1272

Legislation enacted in 1989 (SB 1255, Chapter 996) provides supplemental Medi-Cal payments to qualifying hospitals that provide emergency services to Medi-Cal beneficiaries (Medi-Cal - Traditional patients) based on negotiations between hospitals and the California Medical Assistance Commission (CMAC).

To qualify for Medi-Cal Emergency Services Supplemental Payments (SB 1255), the hospital must be a Medi-Cal Inpatient Disproportionate Share (SB 855) hospital, the hospital must be a Medi-Cal contracting hospital, the hospital must be licensed to provide basic emergency services on site and demonstrate a need for extra funding to cover emergency services health care costs. CMAC negotiates the award levels and the Department of Health Services (DHS) administers and distributes the funds. SB 1255 supplemental payments are lump-sum amounts (not patient specific) based on dates of service.

Funding for Medi-Cal Emergency Services Supplemental Payments (SB 1255) comes from voluntary intergovernmental transfers from public entities (counties, hospital districts, and the University of California system) and matching Federal Medicaid funds.

Since SB 1255 supplemental payments are negotiated supplemental Medi-Cal payments, the payments are to be recorded as a credit to Contractual Adjustments - Medi-Cal - Traditional (Account 5821). Do **not** record and report SB 1255 payments in Disproportionate Share Payments for Medi-Cal Patient Days (Account 5830). This account is to be used only for recording and reporting SB 855 disproportionate share payments.

ACCOUNTING PRINCIPLES AND CONCEPTS

The following entries indicate how SB 1255 supplemental payments are to be recorded by eligible hospitals.

Assumptions: The hospital has successfully negotiated a lump-sum payment with CMAC for $20,000 related to services provided to Medi-Cal - Traditional patients and has received the payment from DHS.

1. To record the SB 1255 supplemental payment received from DHS:

Dr. Cash (Account 1000)	$20,000	
Cr. Contractual Adjustments - Medi-Cal - Traditional (Account 5821)		$20,000

Since SB 1255 supplemental payments are based on dates of service, hospitals can accrue the payments. The following entries are an example of accruing a SB 1255 supplemental payment.

2. (Same assumptions as the previous example, only the hospital has not received the SB 1255 supplemental payment received from DHS).

Dr. Other Receivables (Account 1060)	$20,000	
Cr. Contractual Adjustments - Medi-Cal - Traditional (Account 5821)		$20,000

3. To record the receipt of the SB 1255 supplemental payment:

Dr. Cash (Account 1000)	$20,000	
Cr. Other Receivables (Account 1060)		$20,000

If the public entity requires the hospital to remit certain portions of the SB 1255 supplemental payments to the public entity, these amounts are to be recorded on the hospital's books as a reduction to the Unrestricted Fund Balance (Account 2310). This transfer must not be recorded as a debit to Disproportionate Share Payments for Medi-Cal Patient Days (Account 5830) or Contractual Adjustments - Medi-Cal - Traditional (Account 5821), or recorded as an operating or non-operating expense.

4. If the public entity requires the hospital to transfer portions of the supplemental payments to the public entity, the following entry would be made:

Dr. Unrestricted Fund Balance (Account 2310)	$10,000	
Cr. Cash (Account 1000)		$10,000

ACCOUNTING PRINCIPLES AND CONCEPTS

MEDI-CAL CONSTRUCTION AND RENOVATION REIMBURSEMENT (SB 1732) 1273

Legislation enacted in 1988 (SB 1732, Chapter 1635) provides supplemental Medi-Cal reimbursement to qualifying hospitals for a portion of their debt service on revenue bonds that were issued to finance construction, renovation, or replacement of hospital facilities including buildings and fixed equipment.

Funding for Medi-Cal Construction and Renovation Reimbursement (SB 1732) comes from the State General Fund and matching Federal Medicaid funds. The Department of Health Services (DHS) determines the payment amounts, and administers and distributes the funds.

To qualify for SB 1732 reimbursement funds, the hospital must be a Medi-Cal Inpatient Disproportionate Share (SB 855) hospital and be a Medi-Cal contracting hospital. Also, eligible projects include only new capital projects funded by new debt where the final plans were submitted to the Office of the State Architect and the Office of Statewide Health Planning and Development after September 1, 1988, and before June 30, 1994.

Reimbursement related to SB 1732 reflects the hospital's annual debt multiplied by a ratio of the hospital's paid Medi-Cal patient days to total patient days. Reimbursement is calculated annually and is ongoing through the life of the bond as long as the hospital qualifies as a Medi-Cal Inpatient Disproportionate Share (SB 855) hospital, the hospital is a Medi-Cal contracting hospital, and the constructed or renovated portion of the hospital is accessible to Medi-Cal beneficiaries (including Medi-Cal - Traditional patients and Medi-Cal Managed Care patients).

Since SB 1732 reimbursements are supplemental Medi-Cal payments, the reimbursements are to be recorded as a credit to Contractual Adjustments - Medi-Cal - Traditional (Account 5821) or Contractual Adjustments - Medi-Cal - Managed Care (Account 5822). Do **not** record and report SB 1732 reimbursements in Disproportionate Share Payments for Medi-Cal Patient Days (Account 5830) or as other operating or non-operating revenue. The following entries indicate how reimbursements related to SB 1732 are to be recorded by eligible hospitals.

To record the SB 1732 reimbursement from DHS assuming services are provided to Medi-Cal - Traditional patients:

Dr.	Cash (Account 1000)	$50,000	
Cr.	Contractual Adjustments - Medi-Cal - Traditional (Account 5821)		$50,000

ACCOUNTING PRINCIPLES AND CONCEPTS

MEDI-CAL GRADUATE MEDICAL EDUCATION SUPPLEMENTAL PAYMENTS (SB 391) 1274

Legislation enacted in 1997 (SB 391, Chapter 294) provides supplemental Medi-Cal payments to university teaching hospitals, major (nonuniversity) teaching hospitals, and children's hospitals to recognize medical education costs incurred for services rendered to Medi-Cal beneficiaries (Medi-Cal - Traditional patients) based on negotiations between hospitals and the California Medical Assistance Commission (CMAC).

Funding for the Medi-Cal Graduate Medical Education program (SB 391) comes from voluntary intergovernmental transfers from public entities (counties, hospital districts, and the University of California system), voluntary contributions from private individuals or entities, and Federal funds. CMAC negotiates the award levels and the Department of Health Services (DHS) administers and distributes the funds.

To qualify for SB 391 supplemental payments, a hospital must meet the following three criteria:

1) The hospital must be a Medi-Cal contracting hospital; and

2) The hospital must be a member of the following State defined hospital Peer Groups:

   University Teaching Hospital
   Major (non-university) Teaching Hospital
   Large Teaching Emphasis Hospital
   Small/Medium Teaching Emphasis Hospital
   Children's Hospital; and

3) The hospital must be an affiliate of the University of California Schools of Medicine, or be a member of one of the above Peer Groups with a Medi-Cal utilization rate of 25 percent or more.

Since SB 391 payments are supplemental Medi-Cal payments, the payments are to be recorded as a credit to Contractual Adjustments - Medi-Cal - Traditional (Account 5821). Do **not** record SB 391 in Disproportionate Share Payments for Medi-Cal Patient Days (Account 5830) or as other operating or non-operating revenue. The following entries indicate how SB 391 payments are to be recorded by eligible hospitals.

1. To record the SB 391 payment from DHS assuming services are provided to Medi-Cal - Traditional patients:

Dr.	Cash (Account 1000)	$50,000	
Cr.	Contractual Adjustments - Medi-Cal - Traditional (Account 5821)		$50,000

ACCOUNTING PRINCIPLES AND CONCEPTS

If the public entity requires the hospital to remit certain portions of the SB 391 payments to the public entity, these amounts are to be recorded on the hospital's books as a reduction to the Unrestricted Fund Balance (Account 2310). This transfer must not be recorded as a debit to Contractual Adjustments - Medi-Cal - Traditional (Account 5821), or recorded as an operating or non-operating expense.

2. If the public entity requires the hospital to transfer portions of the SB 391 payments to the public entity, the following entry would be made:

Dr. Unrestricted Fund Balance (Account 2310)	$10,000	
Cr. Cash (Account 1000)		$10,000

MEDI-CAL OUTPATIENT SUPPLEMENTAL PAYMENTS (SB 1179) 1275

Legislation enacted in 1993 (SB 1179, Chapter 385) provides supplemental Medi-Cal payments to qualifying hospitals that provide outpatient services to a disproportionate share of low-income patients.

Funding for Outpatient Supplemental Payments (SB 1179) comes from the State General Fund and matching Federal Medicaid funds. This program is administered by the Department of Health Services (DHS) which distributes the funds.

DHS annually calculates an outpatient disproportionate share factor for each hospital in California that receives Medi-Cal payments for outpatient services. Hospitals with an outpatient disproportionate share factor exceeding the mean factor for all hospitals qualify to receive SB 1179 supplemental payments. The supplemental payment for each qualifying hospital is in proportion to the hospital's outpatient disproportionate share factor.

Since SB 1179 payments are supplemental Medi-Cal payments, the payments are to be recorded as a credit to Contractual Adjustments - Medi-Cal - Traditional (Account 5821). Do **not** record SB 1179 in Disproportionate Share Payments for Medi-Cal Patient Days (Account 5830) or as other operating or non-operating revenue. The following entries indicate how SB 1179 payments are to be recorded by eligible hospitals.

To record the SB 1179 payment from DHS assuming services are provided to Medi-Cal - Traditional patients:

Dr. Cash (Account 1000)	$5,000	
Cr. Contractual Adjustments - Medi-Cal - Traditional (Account 5821)		$5,000

ACCOUNTING PRINCIPLES AND CONCEPTS

ACCOUNTING FOR REALIGNMENT FUNDS (County Hospitals Only) 1280

Three bills, AB-1288 (Chapter 89), AB-948 (Chapter 91), and AB-1491 (Chapter 611), were enacted in 1991 to transfer the responsibility and funding for social, health, and mental health services from the State to the counties. The transfer was called "realignment." In addition, the above legislation eliminated State funding for the Medically Indigent Services Program (MISP) and the AB-8 Program.

Funding for the realignment program comes from an increase in sales tax and in vehicle license fees. The increase in sales tax is split by the State Controller, as specified in the legislation, among Social, Mental Health, and Health services. The funds in the three accounts are transferred by the State Controller to the counties. The funds transferred must retain their program designation and be deposited by the County Auditor-Controller in separate accounts within the Local Health and Welfare Trust Fund. The increase in the vehicle license fees is transferred by the State Controller to the County General Fund. An amount equal to twice the amount of the increased vehicle license fees must be transferred by the county to the Health Account in the Local Health and Welfare Trust Fund.

The funds in the Health Account of the Local Health and Welfare Trust Fund can be used for both Health and public health programs. In most cases, the funds designated by the county for the county hospital programs will be used (1) to provide indigent health care services, (2) to cover the shortage between patient and other operating revenue and operating expenses, and (3) to cover other expenses. Funds in the Mental Health Account of the Local Health and Welfare Trust Fund may also be designated by the county to the county hospital.

The following describes the typical accounting treatment for health care services rendered to an indigent patient by a county hospital using realignment funds. For services rendered to indigent patients, gross patient revenue, based on the full established rates, is recorded in the County Indigent Programs payor category for various revenue centers. A patient receivable account is established equal to the gross revenue amount. The county hospital renders a bill to the County Auditor-Controller for the services provided by the hospital for specific patients. The Auditor-Controller pays all or part of the bill from the Local Health and Welfare Trust Fund and transfers the payment amount to the hospital. The amount of the payment is credited to the patient's accounts receivable balance and debited to the cash account by the hospital. The difference between the amount of the patient receivable and the amount paid, i.e., the unpaid amount of the receivable, is recorded as Contractual Adjustments - County Indigent Programs - Traditional (Account 5841), and credited to the patient's receivable account.

In some counties, the county allocates a certain amount of the realignment funds to the county hospital for indigent patient care but the funds are not identified for the care of specific patients. Since the funds are not identified with specific patients, the realignment funds received by the county hospital are to be recorded as a credit to Contractual Adjustment - County Indigent Programs - Traditional (Account 5841). In order to account for the realignment funds received within the period in which the funds are used, a deferred income account may need to be established within the balance sheet liability accounts.

ACCOUNTING PRINCIPLES AND CONCEPTS

Realignment funds that are not identified for patient care but are to be used by the hospital to meet revenue short-falls are to be accounted as Non-Operating Revenue in Account 9210 County Appropriations - Realignment Funds (Non-Patient Care). These amounts are to be included in the amount reported on line 840 of the Quarterly Financial and Utilization Report and on line 575 of Page 8 of the Hospital Annual Disclosure Report.

ASSERTED AND UNASSERTED MALPRACTICE CLAIMS 1300

Due to the increasing number of malpractice claims being filed and the increase in the awards to the plaintiffs, malpractice costs have increased dramatically in recent years. This increase has resulted in a number of methods of insurance to protect the hospital against future loss. The insurance alternatives include retrospectively rated policies, captive insurance, multi-provider captive insurance, and claims-made insurance. The methods for accounting for asserted and unasserted claims have also increased. The purpose of this paragraph is to provide guidance to standardize the accounting for malpractice claims, asserted and unasserted. Listed below are pertinent definitions of terminology to be used in the following discussion in Section 1300 and 1310.

Asserted claim. A claim made against a health care provider by or on behalf of a patient alleging improper professional service.

Claims-made policy. A policy that covers only malpractice claims covered by the policy reported to the insurance carrier during the policy term.

Multi-provider captive. An insurance company owned by two or more health care providers that underwrites malpractice insurance for its owners.

Occurrence-basis policy. A policy that covers claims resulting from incidents that occur during the policy terms, regardless of when the claims are reported to the insurance carrier.

Reported incident. An occurrence identified by a health care provider, usually under some form of claim-management-reporting system, as one in which improper professional service may be alleged, thereby resulting in a malpractice claim.

Retrospectively rated policy. An insurance policy with a premium that is adjustable based on the experience of the insured health care provider or group of health care providers during the policy term.

Self-insurance. Risk of loss assumed by a health care provider. No external insurance coverage.

Tail coverage. Insurance designed to cover malpractice claims incurred before, but reported after, cancellation or expiration of a claims-made policy.

Trust fund. A fund established by a health care provider to pay malpractice claims and related expenses as they arise. (In the case of a government, the trust fund often is established as an "internal service fund.")

ACCOUNTING PRINCIPLES AND CONCEPTS

Unasserted claim. A medical malpractice claim that has not been, but may in the future be, asserted by or on behalf of a patient related to a reported or unreported incident.

Unreported incident. An occurrence in which improper professional service may have been administered by the health care provider that may result in a malpractice claim. The occurrence, however, has not yet been identified by the health care provider under a formal or informal claims-reporting system.

Wholly owned captive. An insurance company subsidiary of a health care provider that provides malpractice insurance primarily to its parent.

As noted above there are two major forms of claims, asserted and unasserted. There are also two categories within each of these types of claims namely reported and unreported incidents. A reported incident is an occurrence which the hospital is aware of that may potentially result in a claim against the hospital. An unreported incident is one that the hospital is not aware of.

The basic conclusion that the AICPA's Statement Of Position 87-1 arrives at in regard to these incidents is that the cost of malpractice claims, including the cost of litigations, should be accrued in the period that the incident creating the cause for claim occurred. If it is probable that a loss has been incurred and the loss can be estimated, then it should be accrued. If a range of the loss can be determined, then the most likely amount within that range should be accrued. If that cannot be determined, then the minimum amount in the range should be accrued.

Estimated losses from asserted claims should be accrued either on a group or individual basis as should unasserted claims. The accrual should be based on all information relevant to the situation, which may include industry experience, and the historical experience of the hospital of service. An accrual should also be made for the estimated cost of unreported incidents. The estimate of cost associated with unreported incidents may also be based on the above sources as well as existing reported incidents and asserted claims. The hospital should note that as the amount of services provided increases, so does the likelihood of unasserted claims and unreported incidents.

If a hospital cannot reasonably estimate the liability relating to a particular category of malpractice claims, the loss contingency should be disclosed in accordance with Financial Accounting Standards Board (FASB) Statement No. 5.

More and more hospitals are purchasing claims-made policies. If the policy is not continually renewed the hospital is uninsured for malpractice claims when the policy expires. The hospital can purchase tail coverage to protect itself against such an event. The cost of tail coverage should be expensed in the period it is purchased. The hospital should accrue for liabilities that are expected to occur during periods that the claims-made policy and/or tail coverage do not cover.

ACCOUNTING PRINCIPLES AND CONCEPTS

The following entries indicate how to account for some of the various transactions involved with asserted, unasserted claims and tail coverage:

1. The hospital estimates at December 31, 199X that it has $1,000 in asserted and unasserted claims. The losses are probable and the hospital has a reasonable basis for estimating the amount.

Dr. Other Unassigned Expenses (Account 8890)	$1,000	
Cr. Other Accrued Expenses Payable (Account 2049)		$1,000

To accrue estimated expenses related to asserted and unasserted claims at December 31, 199X.

2. The hospital purchases 2-year tail coverage for $1,500 for a claims-made insurance policy covering the period January 1, 199X to December 31, 199X, a one-year period. The cost of the tail coverage for the claims-made policy period of January 1, 199X to December 31, 199X is recorded as expense in the year it is purchased.

Dr. Insurance - Hospital and Professional Malpractice (Account 8830)	$1,500	
Cr. General Checking Account (Account 1001)		$1,500

To record tail coverage purchased for the year-end, December 31, 199X.

For further clarification of how to account for asserted and unasserted claims, please refer to Statement of Position 87-1, issued by the American Institute of Certified Public Accountants.

ACCOUNTING FOR SELF-INSURANCE 1310

The absence of insurance, commonly referred to as self-insurance, covering possible property losses or the possibility that injury claims (non-professional) will be made against the facility does not justify the recording of an expense since the probability of such events is uncertain and the amount of the loss cannot be reasonably estimated. However, you may accrue expenses and related liabilities for malpractice (professional liability) and employee medical and dental benefits since the criteria for the accrual of a loss contingency are met. Refer to Section 1300 for discussion of malpractice insurance.

Examples of how to account for the accrual of expenses and related liabilities for self-insurance programs are as follows:

ACCOUNTING PRINCIPLES AND CONCEPTS

1. The hospital becomes self-insured for malpractice coverage. The hospital has an actuary determine amount of liability the hospital has related to malpractice claims. The actuary estimates that $10,000 will need to be accrued for the year ended December 31, 199X. The actuary estimates the amount will be paid within one year. The entry is as follows:

Dr. Insurance - Hospital and Professional Malpractice (Account 8830)	$10,000	
Cr. Other Current Liabilities (Account 2109.xx)		$10,000

2. The next year the hospital pays out the $10,000 accrued in the prior year.

Dr. Other Current Liabilities (Account 2109.xx)	$10,000	
Cr. General Checking Account (Account 1001.00)		$10,000

Similar accounting can be used for self-insurance programs for employee medical and dental benefits except that the expense would be recorded as an employee benefit and recorded in the cost center where the employee works.

ACCOUNTING FOR TRANSITIONAL INPATIENT CARE 1350

Transitional Inpatient Care is a new type of service enacted by legislation (AB 911, Chapter 305, Statutes of 1995) in an effort to provide cost-effective care to Medi-Cal patients. Transitional Inpatient Care is provided to patients on the basis of physicians orders and approved nursing plans in either licensed general acute care beds or licensed skilled nursing beds. This care consists of intensive licensed nursing care to patients who require medical care, rehabilitative care, or both, who have suffered an illness, injury, or exacerbation of a disease, and whose medical condition has clinically stabilized so that daily physician services and the immediate availability of technically complex diagnostic and invasive procedures are not medically necessary. Such care is more intensive than Skilled Nursing care but less intensive than the usual Medical, Surgical and Pediatric Acute care requirements.

If Transitional Inpatient Care services are provided to patients in licensed general acute care beds, the related revenue, expenses, and utilization statistics are to be recorded in the Medical/Surgical Acute (Accounts 3170/6170) cost center. However, if Transitional Inpatient Care services are provided to patients in licensed skilled nursing beds, the related revenue, expenses, and utilization statistics are to be recorded in Skilled Nursing Care (Accounts 3580/6580) cost center. To track Transitional Inpatient Care separately, hospitals may want to use the optional Transitional Inpatient Care sub-accounts: Transitional Inpatient Care (Acute Beds)(Accounts 3178/6178) and Transitional Inpatient Care (SNF Beds)(Accounts 3582/6582).

When a patient transfers between an acute care cost center and Transitional Inpatient Care (SNF Beds) a hospital discharge is counted. However, when a patient

transfers between an acute cost center and Transitional Inpatient Care (Acute Beds), or transfers between skilled nursing care and Transitional Inpatient Care (SNF Beds), no hospital discharge is counted. See Section 4121 of the Manual for the definition of a hospital discharge.

When a patient transfers between Medical/Surgical Acute and Transitional Inpatient Care (Acute Beds), or transfers between Skilled Nursing and Transitional Inpatient Care (SNF Beds), no service discharge is counted. See Section 4122 of the Manual for the definition of a service discharge.

BAD DEBT AND CHARITY CARE 1400

The determination of what is classified as bad debt versus what is considered charity care can be made by establishing whether or not the patient has the ability to pay. The patient's accounts receivable must be written off as bad debt if the patient has the ability but is unwilling to pay off the account. While bad debts are based on several generally accepted methods (estimated provisions), charity care reflects actual amounts written off and is not the expected level of charity to be provided.

The critical factor involved is at what point should ability to pay be determined. According to the Healthcare Financial Management Association (HFMA) Principles and Practice Board Statement Number 2 entitled "Defining Charity Service as Contrasted to Bad Debts" this determination should be made at the point of admission or as soon as possible thereafter.

Hospitals must maintain written documentation regarding their charity care criteria, and for individual patients, hospitals must maintain written documentation regarding all charity care determinations.

Included in the hospital's criteria for establishing ability to pay, procedures should be included for recognizing the impact of events subsequent to the admission that may change the ability to pay. The HFMA statement also notes that once a patient is determined to be eligible for charity care that decision is final unless an error was made in the determination. However, a patient who is determined to have the ability to pay may at some point in the future be changed to charity care due to additional subsequent information.

A patient should generally meet the hospital's requirements for indigency to be eligible for charity care. Suggested criteria for the hospital to consider in determining if a patient is indigent may include, but are not limited to, the following:

- The patient's gross income should be within the established range for determining the poverty level.
- Net worth should be considered along with liquidity and non-liquid assets net of liabilities and claims against those assets.
- Employment status and capacity for future earnings as compared to ability to meet future obligations.
- Other living expenses and financial obligations should be considered in conjunction with the size of the family.

ACCOUNTING PRINCIPLES AND CONCEPTS

All available resources must first be applied, including Medi-Cal, welfare, and other third-party sources. The portion of the patient's bill that is uncollectible due to inability to pay is all that should be written-off as charity care.

The following examples are to assist in clarifying the differences between bad debt and charity care.

Example 1:

A hospital with an emergency room provides emergency care or medically urgent services to a patient without a determination of payment source. Subsequently, the hospital finds that the patient is unable to pay after making a determination of the patient's financial resources. Should the care then be classified as charity care or bad debt?

Response:

> The determination of financial class should be made at the time of admission or as soon as possible. Since the hospital found out that the patient was unable to pay, the patient would be classified as charity care.

Example 2:

A hospital treats a patient who claims to have insurance for the cost of the care. However, later it is determined that the patient's insurance does not provide coverage for the services and the hospital determines that the patient is unable to pay for the care. Should the patient be classified as charity care or bad debt?

Response:

> If the patient claims to have insurance for the cost of care, but subsequently, it is determined that the patient does not have insurance nor the ability to pay, then the care would be classified as charity care.

Example 3:

Must the hospital classify the entire care as charity care or can a portion of the care be classified as charity care?

Response:

> If the patient can pay the charges as determined at time of admission, but because of medical complications the charges have increased dramatically, then the portion of the charges that the patient is unable to pay would be classified as charity care.

Example 4:

A patient who has insurance is treated at the hospital. While the patient is undergoing treatment, the hospital determines that the insurance covers only a portion of the services. The hospital determines that the patient is unable to pay for the non-covered services. Can the unreimbursed amount be considered charity care?

ACCOUNTING PRINCIPLES AND CONCEPTS

Response:

The charges related to services not covered by insurance (deductibles, coinsurance, copayments, or other non-covered charges for Medicare, Medi-Cal, HMO, PPO's, contracts and commercial insurances) would be charged to charity care based on the hospital's determination that the patient is unable to pay for the charges not covered by insurance.

ACCOUNTING FOR HOME OFFICE COSTS 1500

If the hospital is a subsidiary of a corporation, or is related in some other manner, the cost of services provided by the home office must be recorded in the appropriate functional cost center as a purchased service. For example, XYZ corporation provides administrative services and data processing services for General Hospital, its wholly owned subsidiary. General Hospital would record the expense for data processing as a purchased service .69 in the Data Processing cost center. Fees paid to XYZ for management services would be recorded in the Hospital Administration cost center as a purchased service, natural classification (.64). In addition, the cost of services obtained from related parties must be reported on report page 3.

The allocation of home office costs for items such as interest and insurance must be classified in the .71 to .90 natural classifications as Other Direct Expenses, not as Purchased Services (.61 to .69).

DIVISIONAL EQUITY AND INCOME TAX CONSIDERATIONS OF A SUBSIDIARY OR DIVISION OF A CORPORATION 1510

A hospital which is a subsidiary or division of a corporation is to record the following balances in its general ledger.

1. Divisional Equity - This is the accumulation of earnings since inception. The divisional equity of a hospital that is a subdivision or division of a corporation must be recorded in Divisional Equity (Account 2740.00) and reported on the retained earnings line of the balance sheet on page 8 of the annual disclosure report.

2. Income Taxes - The hospital or division's share of the corporation tax benefit or liability must be recorded in Other Current Assets (Account 1109.00) or Other Assets (Account 1350) if it is a benefit, or if a liability in Other Current Liabilities (Account 2109.00) or Other Non-Current Liabilities (Account 2270). The income statement recording must be to Provision for Income Taxes (Account 9900).

ACCOUNTING PRINCIPLES AND CONCEPTS

DISTRICT HOSPITALS 1600

In general, the major differences between district hospitals and other non-profit hospitals are that district hospitals may have certain restricted taxing powers, and for long-term borrowing, district hospitals look to district taxpayers to authorize the issuance of bonds.

Tax revenue in district hospitals must be accounted for in the same manner as donations and grants. That is, if they are restricted as to use, they must be included in an appropriate restricted fund. If they are not restricted as to use, they must be reflected in one of the following accounts as appropriate:

9150	Assessment Revenue
9160	County Allocation of Tax Revenue
9170	Special District Augmentation Revenue
9180	Debt Services Tax Revenue

These are all Unrestricted Fund accounts.

All long-term borrowing done by a district hospital, or on behalf of a district hospital by another authority or governmental unit, must be included in all reports to this Office. For example, if bonds were issued by an agency other than a district hospital and the liability and related asset and interest expense were recorded on the books of that agency, it would be necessary for the district hospital to reflect these amounts as if they were included on the books of the hospital for all reporting to this Office. The bond liability must be reflected in Bonds Payable (Account 2250.00) in the Unrestricted Fund.

Any tax revenue relative to the repayment of principal or the payment of interest recorded on the books of the issuing agency must also be reflected in reports to this Office. Tax revenue for repayment of debt principal, interest, and other related expenses is to be recorded in the Specific Purpose Fund, Account 2570. An amount equal to the debt principal paid is to be a fund balance transfer to the Unrestricted Fund when actually paid. An amount equal to the interest and other related expenses is to be transferred from the Specific Purpose Fund to the Unrestricted Fund and is to be recorded as Other Operating Revenue in Account 5780, "Transfers From Restricted Funds For Other Operating Expenses".

The following responses refer to an example, which follows, utilizing "T" accounts to illustrate a representative set of transactions.

1. Tax revenue received for payment of principal, interest, and other bond related expenses must be accounted in the Specific Purpose Fund until the funds are expended. There are no Restricted Fund account numbers specifically designated for such taxes.

2. The bond liability must be reflected as a liability of the Unrestricted Fund. Account 2250.00 - Bonds Payable is to be used.

3. The cash balance representing the excess of tax revenue over disbursements must be reflected in the Specific Purpose Fund. The accounts would be Checking Accounts (Account 1511.00) and Specific Purpose Fund Balance (Account 2571.00).

ACCOUNTING PRINCIPLES AND CONCEPTS

Paying agent fees would be reflected as an expense of the Unrestricted Fund, in an "Other Unassigned Costs" account (Accounts 8890-8999), using the "Other Unassigned Costs" natural classification of expense category (.84).

Assuming these costs were included in costs to be funded by tax revenues, a like amount of revenue would be transferred from the Specific Purpose Fund to the Unrestricted Fund. See journal entries (1), (2), (6) and (7) in the example.

JOURNAL ENTRIES

(B) - Beginning balances in the accounts noted - assume:

- Bonds were issued for construction of new hospital building and building has been completed.
- Tax revenues were accrued in the Specific Purpose Fund at the time the Bonds were sold in the amount of the Bond principal.

1. Accrual of interest expense and paying agent fees for current year.
2. Establishment of interfund receivable (Unrestricted Fund) and payable (Specific Purpose Fund) relative to interest expense and paying agent fee expense.
3. Establishment of interfund receivable (Unrestricted Fund) and payable (Specific Purpose Fund) for payment of current portion of Bond principal.
4. Accrual in the Specific Purpose Fund of Taxes receivable equal to interest and paying agent fees payable accrual noted in (1).
5. Receipt of tax revenues for year ended (recorded in the Specific Purpose Fund).
6. Transfer of funds from Specific Purpose Fund to Unrestricted Fund to cover payment of interest, paying agent fees, and bond principal.
7. Payment of interest, paying agent fees, and bond principal.

ACCOUNTING PRINCIPLES AND CONCEPTS

UNRESTRICTED FUND

General Checking Accounts
(1001.00)

Dr.	Cr.
(6)XX	XX(7)

Hospital Buildings
(1221.00)

Dr.	Cr.
(B)XX	

Due From Specific Purpose Funds
(1072.00)

Dr.	Cr.
(2)XX	
(3)XX	
	XX(6)

Interest Payable
(2041.00)

Dr.	Cr.
(7)XX	XX(1)

Paying Agent Fees Payable
(2049.00)

Dr.	Cr.
(7)XX	XX(1)

Bonds Payable
(2250.00)

Dr.	Cr.
(7)XX	XX(B)

Fund Balance - Capital Outlay
(2320.00)

Dr.	Cr.
	XX(3)

Transfers from Restricted Funds
For Other Operating Expenses
(5790.00)

Dr.	Cr.
	XX(2)

Interest - Other
(8870.84)

Dr.	Cr.
(1)XX	

Paying Agent Fees
(8890.84)

Dr.	Cr.
(1)XX	

ACCOUNTING PRINCIPLES AND CONCEPTS

RESTRICTED FUND

Checking Accounts
(1511.00)

Dr.	Cr.
(5)XX	XX(6)

Taxes Receivable
(1539.00)

Dr.	Cr.
(B)XX	XX(5)
(4)XX	

Due to Unrestricted Fund
(2510.00)

Dr.	Cr.
	XX(2)
	XX(3)
(6)XX	

Fund Balance
(2571.00)

Dr.	Cr.
	XX(B)
	XX(4)

Transfers to Unrestricted
Fund for Operating Purposes
(2573.00)

Dr.	Cr.
(2)XX	

Fund Balance - Capital Outlay
(2572.00)

Dr.	Cr.
(3)XX	

ACCOUNTING PRINCIPLES AND CONCEPTS

Taxes required for bond redemption over the term of the bonds may be recognized as a receivable in the Specific Purpose Fund, as this is a type of pledge which the voters made when approving the bond issue. However, only the "earned" portion of bond interest and other bond related expenses are to be recognized in the Unrestricted Fund.

Interest to maturity should not be recorded as a liability. This is contrary to generally accepted accounting principles. The only portion of interest which should be reflected is interest earned during the current period. Any unpaid portion of such interest expense should be reflected as a liability.

SMALL HOSPITALS 1700

Although the reporting requirements of the Manual are the same for all hospitals, several facets of the accounting system were designed in large part to help smaller hospitals.

In principal, it is the desire of the Office to have information which facilitates meaningful comparison of costs in all hospitals. This requires that all hospitals report uniformly. However, the Office also recognizes that due to the varying organizational and operation structures of California hospitals, it is not practical to require all hospitals, especially smaller hospitals, to maintain their accounting records in exactly the same manner. Therefore, a certain degree of flexibility is allowed in the required accounting system and certain types of reclassifications are set forth for the purpose of bringing the hospital's accounting system into compliance with the Manual's reporting requirements. These reclassifications are described in detail in the Cost Finding Chapter of this Manual.

Reclassifications are of special significance to smaller hospitals. The most important of these allows for reclassification to meet the required reporting level (Type 1). This was allowed principally in recognition of the fact that in smaller hospitals many functions may be performed by the same individual or group of individuals and separate recording in the accounting records of the cost of each function may be highly impractical. For example, if one person performed the general accounting, patient accounting, and credit and collection functions (see cost centers 8530, 8550, and 8530, respectively), it may be highly impractical to establish separate cost centers for each function in the accounting records. Instead, the costs may be recorded in one cost center during the year and reclassified in the general ledger at year-end to meet the Manual requirements that the costs of these functions be accounted and reported separately.

Other types of reclassifications relate to patients cared for in clinical divisions other than the applicable one (Type 2 - i.e., Medical/Surgical patients cared for in Intensive Care Units) and functions performed in Cost Centers other than those prescribed in the Manual (Type 3). Again, these types of reclassifications apply more directly to smaller hospitals and serve to aid in adapting the Manual to their special characteristics.

Reclassifications are to be made on a separate worksheet and adjusting journal entries completed prior to completing the disclosure report. The Cost Finding

ACCOUNTING PRINCIPLES AND CONCEPTS

Chapter also describes methods of determining bases for allocation. These methods are included in order to aid the hospital in determining realistic and reasonable allocation bases.

The Manual also allows for informal sampling to be used to obtain statistics, both Standard Units of Measure and Cost Finding Statistics. Again, this is of special importance to smaller hospitals.

Each hospital, especially smaller hospitals, must evaluate their organizational and operational structures as they relate to the requirements of the Manual and determine when and if reclassifications will be necessary. It should be emphasized that reclassifications are to be the exception rather than the rule and are not meant to be substitutes for implementing the uniform accounting system, as prescribed in the Manual.

COUNTY HOSPITALS 1800

County hospitals occasionally provide services (e.g., laundry and linen) to other County agencies. The budget for this service might be included with the hospital's operating budget with no inter-agency transfer of expenses occurring.

The expense associated with providing services to other County agencies for which revenue are not received, nor expense transferred, must not be included in the final patient care cost determination. The total expense of providing the service would be included in the appropriate cost center (e.g., Account 8350 for laundry and linen). The cost of services to other agencies would be separated during cost finding by allocating the patient related expenses to the appropriate cost center and the non-patient related expenses to line 910 on Report Page 20, (Non-Operating Cost Centers) by using the proper statistical basis (dry and clean pounds for the laundry and linen example). The statistics related to services to other agencies would be entered on Report Page 19.

It is important to note that this method would be used only when no revenue is received nor expenses transferred for services to other County agencies.

ACCOUNTING FOR MEDI-CAL REVENUE 1850

In order to assure uniformity in the classification of Medi-Cal revenue, hospitals must classify Medi-Cal gross inpatient revenue billed with specific Medi-Cal UB82-based billing codes to specific Revenue Centers, as determined by the Office and the Department of Health Services. Failure to classify the Medi-Cal revenue as specified may result in recovery of Medi-Cal payments for inpatient services. For consistency, amounts (charges) billed to other payors using comparable UB82 codes shall be classified consistent with the Medi-Cal billing.