

Office of Statewide Health Planning and Development
ACCOUNTING AND REPORTING MANUAL FOR CALIFORNIA HOSPITALS

INTERPRETATIONS

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INTERPRETATIONS

PREFACE **6001**

This chapter contains rulings and interpretations made by the Office subsequent to the issuance of this Manual. These rulings and interpretations carry the same authority as other parts of this Manual.

CASES **6100**

As each ruling or interpretation is made, it will be assigned a case number. The case will then be distributed to all hospitals. The following are cases which have been answered to date:

INTERPRETATIONS

TOBACCO TAX FUNDS RECEIVED BY NON-COUNTY HOSPITALS

6101

Query:

How are Tobacco Tax funds calculated and distributed to hospitals, and how should non-county hospitals account and report Tobacco Tax funds that are received from the county? Does it make a difference if the amount of such funds is based on a percentage of uncompensated care costs within the county or is negotiated between the non-county hospital and the county?

Answer:

Every April 15, the Office's quarterly report database for the previous calendar year is "frozen" and necessary data items are extracted to compute each hospital's uncompensated care costs. The following allocations are then made:

Each county's percentage of statewide uncompensated care costs is calculated to determine their portion of the Tobacco Tax funds appropriated from the Hospital Services account. Each county then splits their allocation between county and non-county hospitals based on their respective percentage of county uncompensated care costs. The amount allocated to non-county hospitals is then split - 50% is distributed to non-county hospitals based on their proportion of the county's uncompensated care costs ("formula dollars"), and the other 50% is distributed to non-county hospitals based on negotiations between the county and the non-county hospital ("discretionary funds").

The accounting and reporting requirements for "formula dollars" and "discretionary funds" received by non-county hospitals are the same under most circumstances. Both "formula dollars" and "discretionary funds" are generally used to offset the cost of providing care to indigent patients who are unable to pay for rendered services and who are **not** the responsibility of the county. As a result, the amounts are to be accounted for as a debit to Cash (Account 1000), or a receivable account, and a credit to Restricted Donations and Subsidies for Indigent Care (Account 5880). The patient's accounts receivable is to be written-off to Charity - Other (Account 5870), and related revenue and utilization statistics are to be recorded in the Other Indigent payor category.

In some instances, a non-county hospital may negotiate with the county to receive "discretionary funds" in exchange for providing medical services to patients who are the responsibility of the county. In such cases, the accounting entry would be a debit to Cash (Account 1000), or a receivable account, and a credit to Contractual Adjustments - County Indigent Programs - Traditional (Account 5841). Related revenue and utilization statistics are to be recorded in the County Indigent Programs payor category.

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PEDIATRIC REHABILITATION ACUTE CARE

6102

Query:

When a pediatric patient transfers from Acute Care to Rehabilitation Care, or vice versa, should we count this transfer as a hospital discharge or a service discharge? Section 4121 of the Manual specifies that a hospital discharge is to be counted when a patient transfers from Acute Care to Rehabilitation Care. However, the Office's System of Accounts shows Pediatric - Rehabilitation Acute (Accounts 3295/6295) as a sub-account of Pediatric Acute (Accounts 3290/6290).

Answer:

As a general rule, a transfer within a functional revenue/cost center is neither a hospital discharge or a service discharge. An exception, however, is made when a pediatric patient transfers from Acute Care to Rehabilitation Care, or vice versa. As specified in Section 4121 of the Manual, you must count this transfer to another type of care as a hospital discharge. Another hospital discharge is to be counted when the pediatric patient is formally discharged from the hospital, or is transferred back. Related revenue, expenses, and utilization statistics must remain in the Pediatric Acute revenue/cost center.

INTERPRETATIONS

SB 1255 MEDI-CAL DISPROPORTIONATE SHARE PROGRAM

6103

Query:

Our hospital is eligible to participate in the SB 1255 Disproportionate Share Program and has successfully negotiated with the California Medical Assistance Commission (CMAC) to receive SB 1255 payments. We agreed to receive a specified rate per paid Medi-Cal patient day for a specified time period, up to a total dollar amount. We will receive lump-sum periodic payments from the Department of Health Services instead of being paid through the Medi-Cal fiscal intermediary. How are these SB 1255 payments to be accounted and reported?

Answer:

Since SB 1255 payments are considered supplemental payments for services provided to Medi-Cal patients, they are to be included in net Medi-Cal inpatient revenue by crediting Medi-Cal Contractual Adjustments. Record the gross amount received as a debit to Cash (Account 1000), or a receivable account, and a credit to Contractual Adjustments - Medi-Cal - Traditional (Account 5821). If a portion of the SB 1255 payments are transferred back to a related public entity, record the transaction as a debit to Fund Balance (Account 2310) and a credit to Cash (Account 1000). Report such transfers as a reduction to the Fund Balance on Report Page 7, Statement of Changes in Equity.

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. See Section 1270 of the Manual for information regarding the SB 855 Disproportionate Share Program.

INTERPRETATIONS

INTEGRATED PATIENT CARE SERVICES

6104

Query:

Our hospital has undergone a hospital-wide restructuring with respect to the way health care services are delivered to patients. Specifically, the restructuring involves the integration of previously separate functional services into multi-disciplinary patient care centers. For example, a patient care center may include functions related to Daily Hospital Services, Clinical Laboratory Services, Physical Therapy, Housekeeping, Central Transportation, Admitting, and Medical Records. Separate patient care centers exist for Medical, Surgical, and Maternal patients.

Staff are classified into major working groups and are cross-trained to perform a variety of tasks outside of their traditional "functional" duties and responsibilities. For example, an employee in the Technical group may be assigned to monitoring vital signs, making beds, changing dressings, collecting lab specimens, transporting patients, and housekeeping. The expenses associated with a patient care center are accumulated in one account, since distinct functions for employees do not exist. What are the Office's accounting and reporting requirements for integrated patient care services?

Answer:

The concept of functional accounting and reporting is the foundation of the Office's accounting and reporting system requirements. It is essential that all hospitals account and report similar functions in a uniform manner, regardless of who provides the service or where the services are located. These requirements assure comparable reporting among all hospitals.

To meet the Office's current requirements, you must still report expenses by functional cost center. Since all expenses for a patient care center are being accumulated in one expense account, you may allocate these expenses to the various functional cost centers. This allocation may be based on a time-study or the model from which the functional services were originally integrated. Be sure that payroll data are reclassified consistently with labor expense data. The worksheet which documents the reclassification from the General Ledger to the Hospital Annual Disclosure Report should be retained in your working files.

In the future, if integrated patient care services become the standard method of health care delivery, the Office will re-evaluate its functional accounting and reporting requirements.

INTERPRETATIONS

**ANCILLARY SERVICES PROVIDED BY HOSPITAL PERSONNEL AT A
FREESTANDING SKILLED NURSING FACILITY**

6105

Query:

Our hospital has an agreement with a freestanding skilled nursing facility to provide hospital respiratory therapy staff to work at the skilled nursing facility. The freestanding skilled nursing facility pays our hospital for the direct expenses associated with our respiratory therapy staff to work at the skilled nursing facility. How should our hospital record and report this activity?

Answer:

Since the payment to the hospital relates only to hospital staff providing ancillary services at the skilled nursing facility, the payment received by the hospital should be recorded as Other Operating Revenue (Account 5780), not patient service revenue. This revenue is to be directly offset against the direct expenses of the ancillary cost center where the hospital staff is assigned to.

In the example above, the hospital will record expenses for salaries and wages of hospital staff providing ancillary services at a freestanding skilled nursing facility in the Respiratory Therapy cost center (Account 7720). The payment received from the skilled nursing facility is to be recorded as Other Operating Revenue and directly offset to the Respiratory Therapy cost center. No standard units of measure would be counted related to staff services provided to skilled nursing facility patients.