WASHINGTON STATE DEPARTMENT OF HEALTH

Accounting and Reporting Manual for Hospitals Chapter 1000

DOH 689-188 January 2025

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

Table of Contents

Accounting and Reporting Manual for Hospitals Chapter 1000 1
Preface 1001 5
Economic Relief Due to the Covid-19 Pandemic 1002 5
Prescribed Accounting Principles 1010 6
Matching of Revenue and Expenses 1100 7
Accrual Accounting 1101 7
Accounting Period 1102 8
Interdepartmental Services 1103 8
Central Services and Supplies 1103.1 8
Pharmacy 1103.2 8
Plant Maintenance 1103.3 9
Revenue and Expense Recognition 1104 9
Step 1: Identify the Contract with a Customer 10
Step 2: Identify the Performance Obligations in the Contract 10
Step 3: Determine the Transaction Price 10
Step 4: Allocate the Transaction Price to the Performance Obligations in the Contract 12
Step 5: Recognize Revenue When (or As) the Entity Satisfies a Performance Obligation 12
Illustrative Examples 13
Inpatient Health Care Services 13
Inclusive Rate Hospitals 1105 15
Chemical Dependency Aftercare 1106 15
Timing Differences 1110 16
Accounting For Property, Plant, And Equipment 1120 16
Classification Of Fixed Asset Expenditures 1121 16
Capitalization Of Fixed Assets 1122 17
Depreciation Policies 1123 17
Historical Cost 1124 18
Minor Equipment 1125 19
Property Not Used In Hospital Operations 1126 19
Property Leased From Related Organizations 1127 19

Separate Fund Accounting 1130 20
Unrestricted Funds 1130.1 21
Endowment Fund 1130.2 21
Plant Replacement and Expansion Fund 1130.3 22
Specific Purpose Fund 1130.4 22
Pooled Investments 1130.5 22
Bond Sinking Fund 1130.6 22
Long Term Security Investments 1140 22
Joint Ventures and Investments in Other Entities 1141 23
Accounting For Pledges 1150 23
Accounting For Hospital Research and Education Costs 1160 24
Grant Accountability 1161 24
Overhead Allocation 1162 24
Affiliated School Contracts 1163 25
Education 1170 25
Inservice Education 1171 25
Patient Education 1173 25
Community Health Education 1174 26
Physician Remuneration 1180 26
Financial Arrangements 1181 26
Work Arrangements 1182 27
Physician Billing Services 1183 27
Accounting For Medicare Reimbursement 1200 28
Outlier Payments 1201 28
Year End Closing 1202 28
Ambulatory Surgical Procedures 1203 28
Accounting For Leases 1210 29
Accounting for Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), and Other Contracts 1220 30
Inpatient Services 1221 31
Outpatient Services 1222 32
Hospital Sponsored Health Maintenance Organizations 1230 33

Accounting For Administrative Services Provided By County Agencies 1240 33
Productive And Non-Productive Hours and Pay 1260 33
Swing Beds 1270 33
Inpatient and Outpatient Revenue 1280 34
Short Stay/Observation Patients 1281 34
Admissions From Emergency Room 1282 34
Patients Transfers to Excluded Units 1290 35
Asserted And Unasserted Malpractice Claims 1300 35
Accounting For Self-Insurance 1310 37
Bad Debt and Charity Care 1400 37
Charity Care Policies 1410 37
Accounting For Home Office Costs 1500 38
Public Hospital Districts 1600 38
Small Hospitals 1700 39

Preface 1001

The goal of this Manual is to establish a foundation for uniform accounting and reporting for hospitals within Washington state. It is necessary to follow the basic accounting principles and concepts throughout the Manual. This section outlines the most significant principles and concepts.

Economic Relief Due to the COVID-19 Pandemic 1002

The COVID-19 pandemic is adversely affecting the global economy and causing significant business disruptions. Therefore, the US Government passed several laws to prevent economic downturn in various ways.

The Coronavirus Aid, Relief and Economic Security (CARES) Act, passed at the end of March 2020, was an over $2 trillion relief package. This act provided prompt economic assistance for American workers and families, small businesses, not-for-profit entities, and state and local governments. The CARES Act alleviated some of the financial strain on hospitals, physicians, and other health care entities. Through a series of new policies, The CARES Act temporarily boosted Medicare and Medicaid payments, allowed for added flexibility in treatment, modalities, and expanded the availability of advance or accelerated payments from Medicare. In addition, the CARES Act also included Paycheck Protection Plan (PPP) loans, an employee retention tax credit, Social Security tax payment and pension funding deferrals.

The CARES Act established a Provider Relief Fund for economic support of health care entities. The fund supported entities connected to health care related expenses or lost revenues attributable to COVID-19 and treatment of uninsured COVID-19 patients. Initially, the government allocated $50 billion of the Provider Relief Fund for general distribution across a wide range of U.S. health system entities. Following this, the government allocated amounts for additional general and targeted distributions to health care entities with specific characteristics. An unspecified amount was allocated to pay health care entities for treating uninsured COVID-19 patients.

The Consolidated Appropriations Act, signed into law on December 27, 2020, continued many of the programs in the CARES Act. The Consolidated Appropriations Act added new phases, allocations, and guidance to address issues related to the continuation of the COVID-19 pandemic.

The American Rescue Plan, signed into law on March 11, 2021, provides additional economic assistance for American workers, families, small businesses, and industries. The American Rescue Plan continues many of the programs started by the CARES Act and Consolidated Appropriations Act by adding new phases, allocations, and guidance to address issues related to

the continuation of the COVID-19 pandemic. The American Rescue Plan also creates a variety of new programs to address continuing pandemic-related crises, and fund recovery efforts as the United States begins to emerge from the pandemic.

The federal stimulus legislation continues to evolve, creating difficulties in keeping up with the most current regulations and their impact on financial reporting, especially on revenue recognition. The Small Business Administration, Department of the Treasury, IRS, Department of Health and Human Services, and Health Resources and Services Administration all have resources available.

GASB Technical Bulletin 2020-1 - Accounting and Financial Reporting Issues Related to the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and Coronavirus Diseases clarifies the application of certain GASB Statements to resources received from certain programs by the CARES Act. It clarifies the certain inflows of CARES Act resources and the additional unplanned outflows of resources incurred in response to COVID-19 which is available on the FASB and GASB websites.

Prescribed Accounting Principles 1010

The accounting principles and concepts in this Manual are based on the "Audit and Accounting Guide for Health Care Entities", September 1, 2021, of the American Institute of Certified Public Accountants (AICPA).

Although not included in this Manual, the accounting principles and concepts recommended in the Opinions of the Accounting Principles Board of the AICPA should serve as resources for specific questions on accounting policies and concepts. Official statements by the Financial Accounting Standards Board (FASB) should also reflect the hospital's accounting policies and concepts, as appropriate.

The AICPA Audit and Accounting Guide referenced above defines “gross service revenues” as total charges at established rates for services rendered to a patient less charity allowances (charity care at established rates). The guide defines “Net service revenue” as gross service revenue less provisions for contractual adjustments with third party payors, courtesy and policy discounts, or other adjustments and deductions, excluding charity care. It is necessary to hold the concept of gross service revenue and track contractual adjustments to properly monitor the impact of discounts demanded by or negotiated with various payer groups.

The AICPA Audit and Accounting Guide states "Activities associated with the provision of health care services constitute the ongoing, major, or central operations of providers of health care services. Revenues and expenses arise from those activities. Gains and losses, on the other hand, result from a provider's peripheral or incidental transactions and from other events stemming from the environment that may be largely beyond the control of the provider and its management." The guide further states "Gains and losses can be further classified as either operating or nonoperating depending on their relation to a provider's major ongoing or central operations." In this Manual, transactions which meet the AICPA criteria for gains or losses are classified as nonoperating.

Matching of Revenue and Expenses 1100

Determining the net income of an accounting period requires:

- measurements of revenue,
- accounting for provisions of contractual adjustments with third-party payors,
- courtesy and policy discounts, and
- other adjustments and deductions excluding charity care, and expenses associated with the period.

You must record hospital revenue in the period you earn it. This means during the time 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 on 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 contractual adjustments with third-party payors, courtesy and policy discounts and other adjustments and deductions excluding charity care must match against the gross revenues of the accounting period is sometimes overlooked. During the accounting period, you debit patients' accounts receivable and credit revenue accounts. This happens at the hospital's full established rates (gross service revenue) for all services rendered to patients. Some of these accounts receivable will remain unpaid at the end of the accounting period. Most of these accounts will be collected in cash from the patients or from their third-party payers, but the remainder eventually will be written off as deductions from revenue.

It is important that these revenue deductions, including contractual adjustments and courtesy and policy discounts, be given accounting recognition in the same period that the related revenues were recorded. Although certain revenue deductions cannot be precisely determined.

Revenues and expenses must match both the hospital as a whole and each cost center. That is, the costs of the functions and activities included in each cost center description are included in that cost center. Revenue relative to such functions and activities must be included in the matching revenue account. For example, you can include revenues for functions (activities) in the Pharmacy (Cost Center 7170) in the Pharmacy revenue (Account 4170).

Accrual Accounting 1101

All accounting and statistical data requires a full accrual basis of accounting and reporting. This ensures the necessary completeness, accuracy, and meaningfulness in accounting data.

Accounting Period 1102

The basic accounting period for this Manual is one year. This corresponds to the hospital's fiscal year and may consist of twelve-monthly periods, thirteen four-week periods, or any other yearly accounting period used by the hospital.

Interdepartmental Services 1103

Interdepartmental services is the utility provided by one hospital department to another prior to, and extraneous to, the scope of the cost allocation. The term "interdepartmental services" refers to the process of assigning costs directly to appropriate departments or 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. This happens for both the hospital and each cost center of the hospital.

Transfers of supplies and pharmaceuticals are made at invoice cost. Invoice cost 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, if it is consistent with that of the preceding reporting period.

It is recommended that such transfers are made monthly. However, if you do not make monthly transfers, then a reclassification is required. This happens at the end of the fiscal year and prior to cost allocation to reflect all transfers during the reporting period for reporting purposes.

Central Services and Supplies 1103.1

Medical and surgical supplies issued by the central services department for a separate central services charge made to patients, must be accounted for as a cost of the "Central Services" cost center (7050). The related revenue must be reflected in "Central Services" revenue (4050).

If a facility is recording the costs and related revenue for such supplies in other departments (i.e., surgical services, labor and delivery, emergency room), then sub-accounts should be maintained. Accordingly, reclassifications can be made prior to cost allocation.

Medical and surgical supplies and materials issued by central services for a separate charge not made to a patient should be accounted for on a reasonable basis. This should be recorded as an interdepartmental transfer to the cost center using the supplies and materials.

Pharmacy 1103.2

Pharmaceutical supplies and materials issued by the pharmacy for a separate pharmacy charge made to a patient must be accounted for as a cost of supplies and materials to the “Pharmacy” cost center. The related revenue must be reflected in “Pharmacy” revenue.

If a facility is now charging the costs of such pharmaceutical supplies and materials and recording the related revenue in other departments, then sub-accounts should be maintained. Accordingly, both costs and revenues can be reclassified to the pharmacy prior to cost allocation.

Pharmaceutical supplies and materials issued by the pharmacy for a separate charge not made to a patient must be accounted for. This should be recorded as an interdepartmental transfer 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 monthly or reclassified at the end of the accounting period. These costs include all direct expenses assigned to plant maintenance.

A hospital may wish to establish a work order system to account for such non-routine work in the plant maintenance department. An established hospital policy defining a dollar value of "significant" is necessary to the work order system. Costs would be transferred based on the number of labor hours required to complete the work order. A predetermined burden rate would then be calculated by dividing the total direct costs by the total labor hours. These may be budgeted totals or last year's totals adjusted for volume changes.

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. When you receive revenue for activities of a non-revenue producing cost center, it must be accounted for as Other Operating Revenue.

With respect to third-party payor arrangements, governmental regulations or contractual terms will specify requirements the healthcare entity must meet to be entitled to revenue under the contract or provider agreement. Regulations or contracts will also address payment terms and the degree of risk that is to be assumed by the healthcare entity. Therefore, a thorough understanding of the terms of the healthcare entity’s arrangements with significant third-party payors is important for appropriate revenue recognition.

FASB ASC 606-10-05, paragraphs 3-4, states in part: “the core principle is that an entity recognizes revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services.

To achieve that core principle, an entity should apply the following steps:

- **Step 1:** Identify the contract(s) with a customer
- **Step 2:** Identify the performance obligations in the contract

- **Step 3:** Determine the transaction price
- **Step 4:** Allocate the transaction price to the performance obligations in the contract
- **Step 5:** Recognize revenue when (or as) the entity satisfies a performance obligation

Step 1: Identify the Contract with a Customer

A contract is an agreement between two or more parties that creates enforceable rights and obligations. An entity should apply the requirements to each contract that meets the following criteria:

1. Approval and commitment of the parties
2. Identification of the rights of the parties
3. Identification of the payment terms
4. The contract has commercial substance
5. It is probable that the entity will collect the consideration which it is entitled to, in exchange for the goods or services that will be transferred to the customer.

In some cases, an entity should combine contracts and account for them as one contract. In addition, there is guidance on the accounting for contract modifications.

Step 2: Identify the Performance Obligations in the Contract

A performance obligation is a promise in a contract with a customer to transfer a good or service to the customer. If an entity promises in a contract to transfer more than one good or service to the customer, then the entity should account for each promised good or service as a performance obligation. This is appliable only if it is (1) distinct or (2) a series of distinct goods or services that are substantially the same and have the same pattern of transfer.

A good or service is distinct if the following criteria is met:

1. **Capable of being distinct** — The customer can benefit from the good or service either on its own or together with other resources that are readily available to the customer.
2. **Distinct within the context of the contract** — The promise to transfer the good or service is separately identifiable from other promises in the contract.
3. A good or service that is not distinct should be combined with other promised goods or services until the entity identifies a bundle of goods or services that is distinct.

Step 3: Determine the Transaction Price

The transaction price is the amount of consideration (e.g. payment) an entity expects to be entitled to, in exchange for transferring promised goods or services to a customer. This excludes

amounts collected on behalf of third parties. To determine the transaction price, an entity should consider the effects of:

1. **Variable consideration** — If the amount of consideration in a contract is variable, then an entity should determine the amount to include in the transaction price. The price is determined by estimating either the expected value (that is, probability-weighted amount) or the most likely amount. The entity is entitled to the amount of consideration depending on which method they expect to better predict the amount of consideration.

2. **Constraining estimates of variable consideration** — An entity should include in the transaction price some or all of an estimate of variable consideration. But, only to the extent it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the variable consideration is subsequently resolved.

3. **The existence of a significant financing component** — An entity should adjust the promised amount of consideration for the time value of money effects. This should be adjusted if the timing of the payments, agreed upon by the parties to the contract (either explicitly or implicitly), provides the customer or the entity with a significant benefit of financing for the transfer of goods or services.

   In assessing whether a financing component exists and is significant to a contract, an entity should consider various factors. As a practical expedient, an entity does not need to assess whether a contract has a significant financing component. Assessment is not needed if the entity expects, at contract inception, the time between payment by the customer and the transfer of the promised goods or services to the customer will be one year or less.

4. **Noncash consideration** — If a customer promises consideration in a form other than cash, an entity should measure the noncash consideration (or promise of noncash consideration) at fair value. If an entity cannot reasonably estimate the fair value of the noncash consideration, it should measure the consideration indirectly by reference to the standalone selling price of the goods or services promised in exchange for the consideration. If the noncash consideration is variable, an entity should consider the guidance on constraining estimates of variable consideration.

5. **Consideration payable to the customer** — An entity can pay consideration to a customer (or to other parties that purchase the entity's goods or services from the customer) in the form of cash or items (e.g. credit, a coupon, or a voucher) that the customer can apply against amounts owed to the entity. The entity should account for the payment (or expectation of payment) as a reduction of the transaction price or as a payment for a distinct good and/or service.

   If the consideration payable to a customer is a variable amount and accounted for as a reduction in the transaction price, an entity should consider the guidance on constraining estimates of variable consideration.

Step 4: Allocate the Transaction Price to the Performance Obligations in the Contract

For a contract that has more than one performance obligation, an entity should allocate the transaction price to each performance obligation. The transaction amount should depict the amount of consideration to which the entity expects to be entitled to, in exchange for satisfying each performance obligation.

To allocate an appropriate amount of consideration to each performance obligation, an entity must determine the standalone selling price at contract inception of the distinct goods or services. Underlying each performance obligation, an entity would typically allocate the transaction price on a relative standalone selling price basis.

If a standalone selling price is not observable, an entity must estimate it. Sometimes, the transaction price includes a discount or variable consideration that relates to one of the performance obligations in a contract. The requirements specify when an entity should allocate the discount or variable consideration to one (or some) performance obligation(s) rather than to all performance obligations in the contract.

An entity should allocate to the performance obligations in the contract. This allocation includes any subsequent changes in the transaction price on the same basis as at contract inception. Amounts allocated to a satisfied performance obligation should be recognized as revenue, or as a reduction of revenue, in the period in which the transaction price changes.

Step 5: Recognize Revenue When (or As) the Entity Satisfies a Performance Obligation

An entity should recognize revenue when (or as) it satisfies a performance obligation by transferring a promised good or service to a customer. A good or service is transferred when (or as) the customer obtains control of that good or service.

For each performance obligation, an entity should determine whether they satisfy the performance obligation by transferring control of a good or service over time. If an entity does not satisfy a performance obligation over time, the performance obligation is satisfied at a point in time. An entity transfers control of a good or service over time and, therefore, satisfies a performance obligation and recognizes revenue over time if one of the following criteria is met:

1. The customer simultaneously receives and consumes the benefits provided by the entity's performance as the entity performs.
2. The entity's performance creates or enhances an asset (for example, work in process) that the customer controls as the asset is created or enhanced.
3. The entity's performance does not create an asset with an alternative use to the entity, and the entity has an enforceable right to payment for performance completed to date.

If a performance obligation is not satisfied over time, an entity satisfies the performance obligation at a point in time. To determine the point in time at which a customer obtains control of

a promised asset and an entity satisfies a performance obligation, the entity would consider indicators of the transfer of control. these include, but are not limited to, the following:

1. The entity has a present right to payment for the asset.
2. The customer has legal title to the asset.
3. The entity has transferred control of the asset. The notion of transferred control of an asset is easier to apply when considering a good as opposed to a service. FASB ASC 606 states that the rights to the results of services are assets, even if they are often consumed immediately upon receipt. By considering when the customer gains control over the results of a service, the notion of control can also be applied to services. Often, the evidence that a customer has gained control of a service will be that it has realized or consumed the benefits of that service, as described in FASB ASC 606-10-25-25.
4. The customer has the significant risks and rewards of ownership of the asset.
5. The customer has accepted the asset.

For each performance obligation that an entity satisfies over time, an entity shall recognize revenue over time. This occurs by consistently applying a method of measuring the progress toward complete satisfaction of that performance obligation. Appropriate methods of measuring progress include output and input methods. As circumstances change over time, an entity should update its measure of progress to depict the entity's performance completed to date.

Illustrative Examples

The following examples related to various healthcare services are meant to be illustrative, and the actual identification of performance obligations should be based on the facts and circumstances of an entity's specific situation.

Inpatient Health Care Services

Acute Care Hospital (ACH) provided an inpatient surgical procedure to a patient who required four days of care in the hospital. This procedure required ACH to provide and coordinate many goods or services to the patient (i.e. a patient room, meals, nursing care, physician services, therapy services, drugs, supplies, and so forth) within the four days of care. In this example, ACH is acting as the principal for the inpatient services provided.

This example presumes that ACH concluded there is not a lease of the patient room to the patient. In this example, ACH concluded that the bundle of goods and services provided during this inpatient stay should be accounted for as a single performance obligation. In reaching this conclusion, ACH considered the following factors:

A. The patient could have benefitted from some of the individual goods or services (e.g. room, meals, drugs) provided as part of the inpatient care and surgery (that is, some of the individual goods or services are capable of being distinct). However, the nature of ACH's promise to the patient was to transfer a combined service (the inpatient surgical

procedure and related goods and services). Additionally, the patient's expectation is that he or she will receive the full scale of the combined care during the inpatient stay.

B. The overall provision of care may include identifying goods or services provided, including:

    - Amount of necessary nursing care and physician services
    - Drugs to administer
    - Time the patient will need to stay in the facility and be provided a room, meals, and supplies

    In coordinating the patient's care during the inpatient stay, ACH provided a significant service of integrating the goods or services promised in the contract into the combined service.

C. All of the goods or services provided during the inpatient stay are highly dependent on, or highly interrelated with, other goods or services promised in the contract. For example, a patient is not in a position to decide whether or not to purchase an imaging procedure that is required to determine a course of treatment or to guide a surgical procedure, without significantly affecting that course of treatment or surgical procedure. Similarly, a patient is not in a position to decide whether or not to purchase a general anesthetic when general anesthesia is required for a surgical procedure.

D. In this example, the individual promised goods or services are not substantially the same and do not represent a series of distinct goods and services. In this case, the goods and services are not substantially the same during the inpatient stay. This is because different and additional goods and services were provided in connection with the surgical procedure at the beginning of the stay, but fewer and different goods and services were provided post-surgery as the patient recovered.

    The goods and services provided on Day 1 are substantially different from the goods and services provided on Day 4 in terms of the actual services provided, the level of direct physician activity, and the amount of drugs or other supplies. The goods and services provided on Day 1 were substantially different than the goods and services provided on Day 4 and were not provided in the same pattern. Therefore, ACH determined that the goods and services provided during the other three days of the stay do not constitute a series of distinct goods and services.

According to FASB ASC 606-10-25-27, ACH determined that the inpatient procedure should be accounted for over time (versus point in time) because the patient simultaneously received and consumed the benefits provided by ACH as ACH performed. In this example, the patient is covered by insurance and the payment for the inpatient services is based on diagnostic-related group codes. ACH is entitled to a payment from the insurer, and a related deductible or coinsurance payment from the patient, for all goods and services related to the inpatient stay.The inpatient stayis calculated without regard to the amount of resources that ACH provides to the patient.

ACH considered all of the factors in step 3 of FASB ASC 606 and determined that these payments represent the transaction price. ACH determines the revenue at the reporting date by multiplying the transaction price by a measure of the progress toward the complete satisfaction of the performance obligation to be incurred over the complete in-patient stay.

To measure the progress in satisfying the performance obligation at the reporting date, ACH considered various input and output methods.ACH determined its undiscounted charges represented the best proxy of its progress on satisfying the performance obligation. ACH concluded that it establishes its charges to reflect the level of effort it incurs to provide goods or services to its patients.

As a result, in this case, ACH measured progress toward complete satisfaction of the performance obligation by using undiscounted charges incurred as of the reporting date relative to the total expected undiscounted charges to be incurred over the inpatient stay.

Inclusive Rate Hospitals 1105

Although most hospital services are billed on an itemized basis, inclusive rates may be appropriate in some circumstances. The most common usage of inclusive rate billing is for chemical dependency treatment programs. An inclusive rate system could also be utilized for a DRG-based billing system. While the possible bases for charging under inclusive rate systems are varied, the critical feature of any such system is that the patient's charge is independent of service utilization.

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 report costs and related statistics by cost center.

Revenue from an inclusive rate must be reclassified to the revenue centers providing the service. Reclassification should be made on the same basis used to establish the inclusive rate.

Chemical Dependency Aftercare 1106

It is common for chemical dependency treatment programs to charge one fee that includes a certain number of inpatient treatment days along with follow-up visits after the patient is released. The patient may or may not utilize all of the subsequent visits that are included in the overall fee.

Accrual accounting mandates that the portion of the revenue related to future outpatient treatments be deferred. A portion of the revenue will be recognized each time the patient receives follow-up treatment. Deferred revenue must be recorded in:

- Deferred Income - Other (Account 2093) for income that will be recognized within **one year,** or
- Deferred Income - Other (Account 2271) for income that will be recognized **one year or more** from the date of inpatient service.

You must recognize the amount in the deferred revenue account as outpatient revenue over the estimated term of the follow-up visits.

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 for tax purposes and to governmental units or outside agencies making payments based upon those reported operations.

You must reflect timing differences on accounting records of the hospital. The two primary types of timing differences relate to income tax allocations and third-party reimbursement contracts.

Timing differences related to income tax come from loss carry-backs, accelerated depreciation, and other techniques. These other techniques move revenue or allowable expense to a different tax year than the year in which it would normally accrue under generally accepted accounting principles.

Timing differences related to third-party reimbursement contracts come from accelerations and lags in payments.

Accounting For Property, Plant, And Equipment 1120

Classification Of Fixed Asset Expenditures 1121

All property, plant, and equipment and related liabilities must be reported as a part of unrestricted funds since segregation in a separate fund would imply the existence of restrictions on asset use. All assets restricted by third parties, including donors, for acquisition or construction of property, plant, and equipment must be segregated and included in plant replacement and expansion funds until expended. During that time the asset cost shall be transferred to unrestricted funds. Cost of construction in progress should be reported in unrestricted funds 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 as of the date of donation.

To obtain accounting control over hospital equipment, a subsidiary equipment ledger should 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 information about quantity, type, and cost of equipment is available.

Capitalization Of Fixed Assets 1122

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

- Normal repair, 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 $500 or more and has a minimum useful life of three years.

Depreciation Policies 1123

Depreciation expense on movable and minor and equipment must be charged to the using cost center. If an item is not directly identifiable to one cost center, you can record the related depreciation expense in the "Depreciation" cost centers (8810-8819).

Depreciation on the plant, including fixed equipment, is not assigned directly to the cost centers occupying the building. Such depreciation must be an indirect cost which is accounted and reported in Account 8810 (Depreciation).

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

The method of depreciation used for accounting purposes at the time of acquisition may be used in reporting depreciation on all assets acquired prior to October 1, 1974. If the accounting method is not the straight-line method, the differences between the recorded depreciation and depreciation calculated on a straight-line basis must be disclosed in the reporting package.

Depreciation expense does not increase to reflect general price-level changes even if such an entry appears in the hospital's audited financial statements. This type of change would be inconsistent with the requirements stated above.

The estimated useful life of a depreciable asset is its normal operating or service life in terms of its utility to the hospital. Some factors to consider in determining useful life include normal wear and tear, obsolescence due to normal economic and technological advances, climatic or local conditions, and the hospital's policy for repair and replacement.

In selecting a proper useful life for computing depreciation, hospitals should utilize the most recent asset life guidelines published by the American Hospital Association. However, with the rapidly changing technology in hospitals, these recommendations may not be all inclusive or

reflect current technology or intended utilization. In which case, the expertise of the manufacturer or other reliable sources may be considered.

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 on the portion of time the asset was in use during the year. That is, if an asset was received and in use in the hospital for eight months in the year of acquisition, two-thirds of a full year's depreciation expense would be recognized in that first year.
- 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 until that building was actually put into use.

Depreciable assets may be disposed of through sale, scrapping, trade-in, donation, exchange, demolition, abandonment, or involuntary conversions such as condemnation, fire, theft or other casualty. If disposal of a depreciable asset results in a gain or loss, then adjustment to the depreciation records is not appropriate. A gain or loss on the disposal of a depreciable asset is a non-operating gain or loss and should not impact depreciation expenses included in operating expenses.

Historical Cost 1124

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

- Billed price of the asset
- Freight and delivery charges
- Sales taxes
- Installation costs, including costs of foundations and bases, alterations, and renovations
- Costs of "tuning up" and trial runs
- Reconditioning costs, in the case of used assets
- Costs of title investigations, legal fees, and brokerage commissions
- Financial feasibility studies, architectural fees, and consulting fees
- Activities essential to the acquisition, improvement, expansion, or replacement of plant and equipment.
- Interest during construction when the related debt is an obligation of the hospital to an unrelated party.

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 through a professional appraisal.

Minor Equipment 1125

Minor equipment has the following characteristics:

A. location generally not fixed;
B. subject to requisition or use by various departments of the hospital;
C. relatively small size and unit cost;
D. subject to storeroom control;
E. fairly numerous quantities in use;
F. a useful life of usually three years or less.

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

1. 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.
2. The original investment in this equipment and all subsequent purchases may be capitalized and written off over three years.
3. 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 Washington State Department of Health (Department).

Property Not Used in Hospital Operations 1126

Land held for future expansion, old hospital buildings, and land awaiting disposal must be included in Other Assets (Accounts 1440-1449). Do not include these items as Board Designated - Other Assets unless the governing board of the hospital has taken formal action to set these items apart.

Property Leased From Related Organizations 1127

When land, buildings and improvements used by the hospital are leased from a related organization, the hospital must record the amount of the 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 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 this section.

For balance sheet reporting, donor-restricted funds must be reported separately in the appropriate restricted fund classifications. For income statement purposes, expenses relating to donor-restricted activities must be reported in unrestricted funds. All donations relative to such current year donor- restricted activities must be reported as "Other Operating Revenue." 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.

The statement of financial position (balance sheet) should focus on the entity as a whole and report separate amounts for each of the classes of net assets:

A. Net assets without donor restrictions
B. Net assets with donor restrictions

In addition to the two classes of net assets above, further disaggregation of total net assets may also be reported. For example, the entity may wish to disaggregate net assets with donor restrictions between those expected to be maintained in perpetuity and those expected to be spent over time for a particular purpose. Information about the amounts and purposes of board designations of net assets without donor restrictions should be provided in notes to or on the face of the financial statements.

Hospitals receiving no restricted gifts, bequests, or grants do not need to use separate fund accounting.

This Manual provides for the separation of restricted funds into three categories:

1. Endowment fund
2. Plant replacement and expansion fund
3. Specific purpose fund

The accounts within each restricted fund are self-balancing, as each fund constitutes a subordinate accounting entity.

Funds for specific operating purposes consist of donor-restricted resources and should be accounted for in a restricted fund or as deferred revenue in unrestricted funds. These resources should be reported as "Other Operating Revenue" in the financial statements during the period in which expenditures are made for the purpose intended by the donor.

All expenses relating to restricted fund activities must be recorded in unrestricted funds (whether the actual expenditures of cash are made from unrestricted funds 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 the grant or gift whose terms require separate accounting.

Sufficient account numbers are allowed so 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 5210-5219)
- Transfers from Restricted Funds for Education Expenses (Accounts 5280-5299)
- Transfers from Restricted Funds for Other Operating Expenses (Accounts 5790-5799)

Unrestricted Funds 1130.1

The unrestricted fund is used to account for the resources and day-to-day activities not required by grant, 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 board appropriates resources in this manner, it should be recognized that the board also 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 1100-1199) have been set aside for board-designated assets.

The term "restricted" should 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 change the purpose for which the assets have been designated at any time subsequent to the original designation.

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.

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

Endowment Fund 1130.2

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 "Nonoperating Gains" (Account 9090).

Plant Replacement and Expansion Fund 1130.3

Resources restricted by donors for additions to property, plant, and equipment are considered as contributions to the permanent capital of the hospital. Accordingly, these resources should be included in the restricted fund balance.

A transfer of resources from restricted fund balance to unrestricted fund balance should be shown in the financial statements for the period in which expenditures are made for the purpose intended by the donor.

Specific Purpose Fund 1130.4

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

Pooled Investments 1130.5

Investments of various funds may be pooled, unless prohibited 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 using memorandum records.

Assets included in pooled investments must be reflected in an appropriately titled "Other" current asset account (i.e. "Assets Included in Investment Pools"). Gains and losses from investment pools in unrestricted funds must be recorded in Account 9060, "Gains or Losses from Unrestricted Investments." Gains and losses from such investments in the restricted funds must be recorded directly in the fund balance account.

Bond Sinking Fund 1130.6

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

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 these partnerships depends primarily on two issues; **percentage of ownership** and **influence**.

The three possible methods of accounting for these investments are consolidation, the equity method, or the cost method. An investment or joint venture 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% of the venture and does not have significant influence over the financial and operating policies of the investee.

Descriptions of the three methods of accounting for joint ventures or other investments in other entities are described below:

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. This method would require the elimination of inter-company balances and transactions and the recognition of any minority interest.

Equity: Under the equity method the hospital's investment is initially recorded at cost. Then, the hospital adjusts the carrying amount to recognize its share of earnings or losses on the investment after the date of acquisition. Any dividend received from the investment reduces the carrying amount of the investment.

Cost Method: Under the cost method, the hospital's investment is recorded at acquisition 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 the cost of the investment.

Accounting For Pledges 1150

All pledges, except a provision for amounts estimated to be uncollectable, must be included in the hospital's accounting and reporting records. If unrestricted, revenue from pledges (net of provision for uncollectables) must be included in Account 9040 (Unrestricted Contributions).

If pledges are restricted, they must be reflected in the appropriate restricted fund, except a provision for amounts estimated to be uncollectable.

Accounting For Hospital Research and Education Costs 1160

All costs incurred in research activities and formal education activities (as opposed to inservice education - a separate inservice education section follows) must be reported in unrestricted fund cost centers 8200-8299 (Research and Education Expenses).

Grant Accountability 1161

Separate cost centers should be maintained for all research and educational activities that require separate accounting by law, grant contract, or donation restriction. Transfers from restricted funds to match the expenditures for these activities must also be segregated into separate cost centers in the series 5210- 5219 (Research) or 5280-5299 (Education). Thus, accountability is maintained for all restricted research and education activities.

Overhead Allocation 1162

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 indirect costs incurred, plus an overhead factor of 10 percent of such direct costs. On 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 on December 31:

Unrestricted fund:

December 31. Dr. Research Projects (Account 8200)	$150
Cr. Cash (Account 1011)	$150
Dr. Due from Specific Purpose Fund (Account 1072)	$165
Cr. Transfers from Restricted Funds for Research Expenses (Account 5210)	$165

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

Specific purpose fund:

December 31. Dr. Fund Balance (Account 2571)	$165
Cr. Due to Unrestricted Fund (Account 2510)	$165

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

If indirect overhead must, by grant contract, be recorded in unrestricted funds where direct costs of the grant activity are recorded, natural expense classification .99 (other miscellaneous expenses) must be used.

A separate account entitled "Overhead Applied" should be established in unrestricted funds and credited with the amount of such overhead applications. For reports to the Department, the balance in the "Overhead Applied" account must be offset against the restricted activity account. Thus, costs remaining in the restricted activity account are direct costs only.

Affiliated School Contracts 1163

Education expenses incurred relative to affiliated school contracts must be reflected in the Education Expenses cost center (8200) in unrestricted funds. Salaries, wages, and stipends paid to students on approved programs (including residents) must be reflected in this cost center. Fees paid to physicians involved primarily in approved education programs must also be recorded in the education expenses account, in the appropriate cost center.

Education 1170

Inservice Education 1171

Inservice education activities are defined as educational activities conducted within the hospital for hospital personnel. The cost of time spent by hospital personnel as students in such classes and activities must remain in the cost center that their normal salary and wage costs are charged (i.e., the cost center in which they work). However, the cost (defined as salary, wages, and payroll-related fringe benefits) of time spent in such classes and activities by those instructing and administering the programs must be included in the "Inservice Education" cost center (8740).

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" 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.

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

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.

Patient Education 1173

Patient education includes tasks which relate to teaching patients how to take care of themselves after they leave the hospital setting. The cost associated with the provision of this service is recorded in the cost center that provides the service. 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 1174

Community health education includes the sponsoring of courses such as childbirth preparation, stress management, 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 (Account 5770) and the expenses must be recorded in the Community Health Education cost center (Account 8760).

Physician Remuneration 1180

Due to the many 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 1181

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

1. **Joint Arrangement** -- The hospital bills patients for the physician's contractual services, including this amount as hospital revenue. All departmental expenses are paid by the hospital. The hospital remits a fee, which is included in hospital expense, to the physician.

2. **Contractual Department** -- Under this arrangement, the physician may pay any or all expenses of the department. The hospital bills patients for the departmental services and remits a fee to the physician. This fee is typically designed to cover the expenses incurred by the physician plus their professional fee. Payments to the physician are recorded as Professional Fees (sub-classification of expense .20) regardless of the expenses incurred by the physician.

3. **Rental Department** -- The physician bills the patients for certain Part A and Part B components (as defined by Medicare) and incurs all substantial direct expenses. The physician remits a fee to cover certain expenses. This fee is recorded as "Other Operating Revenue" (Account 5780) and is offset against the departmental expenses in the re-classification process.

4. **Independent/Separate Department** -- The functions of the department are provided by an independent group of physicians. Neither revenue nor expenses are incurred by the hospital. The hospital refers patients 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 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 to the physician must be recorded as Other Operating Revenue (Account 5780).

6. **Salaried** -- The physicians are employees of the hospital and paid a salary unrelated to revenues generated.

Work Arrangements 1182

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

1. Professional Component – providing direct patient care.
2. Hospital Administration – administering overall hospital activities.
3. Department Supervision – supervising activities of the department.
4. Utilization Review – performance of utilization review activities.
5. Research – working on research projects.
6. Education – 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 30% of their time in research and education activities, 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:

- 30% Research and Education Expenses (8200-8299)
- 20% Hospital Administration (8610)
- 50% Remains in the cost center

Physician Billing Services 1183

Many hospitals are providing billing services for physicians under an agency arrangement. Any fees charged to the physicians must be recorded as Other Operating Revenue (Account 5780).

Accounting For Medicare Reimbursement 1200

With the implementation of the Prospective Payment System (PPS), hospitals are paid based on a predetermined, fixed amount. The payment amount for a particular service is based on the classification system of that service (e.g. diagnosis-related groups for inpatient hospital services).

Medicare reimburses hospitals using a variety of methodologies depending on the services provided. The PPS was developed to reimburse hospitals for inpatient acute and psychiatric services based on Diagnostic Related Groups (DRG's). Outpatient services are reimbursed based on the Hospital Outpatient Prospective Payment System (OPPS). Skilled nursing facility units are reimbursed based on Resource Utilization Groups (RUGS).

Deductions from revenue arise as a result of a hospital's agreement to accept an amount less than gross charges as payment in full from Medicare. Total reimbursement includes the payment from Medicare and payments from the patient (deductibles and coinsurance). Contractual adjustments are the difference between gross charges and total reimbursement. Any patient liability not collected is a bad debt expense unless the hospital waives the patient's responsibility for deductibles and coinsurance. In that case, the amount would then be classified as an Administrative Adjustment (Account 5970).

Outlier Payments 1201

Under PPS, Medicare provides additional reimbursement for outliers. Outliers are DRG cases with unusually long lengths of stay or unusually high costs. If the hospital is able to identify outliers, it should establish an asset account, “Outlier Payments Due,” and debit the additional outlier payments due to this account. The corresponding credit would be to “Contractual Adjustments - Medicare.” When the outlier payment is received the hospital will debit “Cash” and credit “Outlier Payments Due.”

Year End Closing 1202

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. You can do this based on patient days, (using the hospital's patient day experience or HCFA mean length of stay) or on patient charges.

Ambulatory Surgical Procedures 1203

The OPPS system has been used since August of 2000. The OPPS sets payment for individual services using a set of relative weights, a conversion factor, and adjustments for geographic differences in input prices. Hospitals can also receive additional payments in the form of outlier adjustments for extraordinarily high-cost services and pass-through payments for some new technology. The unit of payment under the OPPS is the individual service as identified by Healthcare Common Procedure Coding System (HCPCS) codes. CMS classifies services into ambulatory payment classifications (APCs) based on clinical and cost similarity.

In recent years, the agency has revised payment policy to increase the amount of packaging costs within the APCs. This includes the arrival of comprehensive APCs, that package together an expanded number of related items and services contained on the same claim into a single payment for a comprehensive primary service under the OPPS.

Congress has made many changes over time to the OPPS.However, the most significant change was the implementation of site-neutral payment via Congress's enactment of Section 603 of the Bipartisan Budget Act of 2015 (BiBA), as modified by the 21st Century Cures Act. Site-neutral payment policy requires that According to site-neutral payment policy, new off-campus provider-based departments are not paid under the OPPS. Instead, these services are covered and paid under the Physician Fee Schedule at a lower rate than the same services under the OPPS.

Accounting For Leases 1210

Often a hospital will obtain control of the use of land, buildings, or equipment by entering into an agreement to lease them from an outside party. The consideration in the contract should be allocated to separate lease and non-lease components in accordance with the provisions of FASB ASC 841.

At the commencement date of the lease, the lessee should recognize a right of use asset and a lease liability for the lease components. The lease liability should be measured at the present value of the unpaid lease payments. The right-of-use asset should consist of the following: the amount of the initial lease liability, any lease payments made to the lessor at or before the commencement date minus any incentives received, and other direct costs.

The right-to-use asset is amortized from the commencement date to the earlier of the end of the lease term or the end of the useful life of the asset. If the amount paid is merely to obtain the use of the asset for the period of the lease, then it is treated as expense and charged to the using cost center. If the cost cannot be identified as belonging to a specific cost center, the amount of the lease must be charged to Leases and Rentals (Account 8820).

However, when a lease agreement is used as a way for a hospital to obtain eventual ownership of the property, special treatment may be required. Under certain conditions, a lease is considered in substance to be a purchase of the property. Therefore, the property must be recorded by the hospital as an asset accompanied by a liability for future lease payments. For additional information about build-to-suit transactions, see FASB ASC Topic 840.

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

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 paid under a PPS system, per diem, risk sharing, or capitation contract.

To provide a common understanding, the terms used in this section 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 where inpatient services are obtained by the contracting hospital.

Capitation Fee (Hospital) - A fixed amount (usually per member) 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.

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

Co-insurance – A variable payment required to be made by a member to the contracting hospital when specific health care services are rendered.

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 - 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 for inpatients of the contracting hospital.

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

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 premium payment or whose employment is the basis for eligibility for membership in an 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.

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 an 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 Per Diem contracts. 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 and budgeted cost.

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 reinsurance to indemnify the hospital for any patient whose charges exceed a flat amount.

Inpatient Services 1221

For inpatient services provided by the contracting hospital within its own facilities, the accounting of the revenue and expenses for capitation patients is the same for any other patient. Revenue (recorded at full established rates) and all direct expenses must be accounted for in the functional cost centers related to the services provided. However, for inpatient 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.

The following describes four situations in which inpatient services are provided to members and the accounting treatment is used in these situations:

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 the contracting hospital. 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 from another hospital.
3. A member is not admitted to the contracting hospital but is admitted to another hospital (or to an intermediate care or skilled nursing 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 the total, (i.e. 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 not appropriate to record the expenses and related units of service in the functional cost centers of the contracting hospital related to the services provided by the admitting hospital. It is also inappropriate to gross up the revenue of the contracting hospital related to the services provided by the admitting hospital.
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 Contractual Adjustments - Other (Account 5860). To identify contractual adjustments related to specific risk-based capitation plans separately from other contractual adjustments use sub-accounts within Contractual Adjustments - Other (Account 5860).

Outpatient Services 1222

Under risk-based capitation plans, contracting hospitals usually are not responsible for providing most outpatient services. However, in those cases where the hospital is responsible for outpatient services, the accounting for revenue and expenses for capitation patients is no different than any other hospital outpatient.

That is, revenue (recorded at full established rates) and all direct expenses, as defined in this Manual, must be accounted for in the functional centers related to the services provided, even if those outpatient services must be purchased from another hospital or organization. Appropriate standard units of service must be maintained along with the number of outpatient visits.

Hospital Sponsored Health Maintenance Organizations 1230

If a hospital is sponsoring its own Health Maintenance Organization (HMO) and/or related Individual Practice Associations (IPA's), it is recommended that the cost of administering these programs and the related business transactions be accounted for as separate entities, rather than on the hospital's general ledger.

Accounting For Administrative Services Provided By County Agencies 1240

The cost of administrative services provided to the hospital by county agencies or departments must be recorded and reported as a purchased service. The cost of such service must be charged to the appropriate functions. This provision will primarily impact hospitals owned by public hospital districts as well as those directly owned by a county.

Productive And Non-Productive Hours and Pay 1260

All salaries and wages including on-call pay, call-back pay, and overtime pay are included in the natural classification of expenses. Time for hours worked is classified in accounts .01 through .07 and non-work time is reported in account .08.

Paid hours include both productive and non-productive hours. Only actual hours worked should be included in productive hours. Hours worked may be defined as total paid hours minus vacation, holiday, sick leave, bereavement leave, jury duty, meetings, workshops, and other paid time off the job. Time allowed for coffee breaks, lunch breaks, (if compensable), and in-service education is considered work time or productive hours.

Overtime hours are hours to which an overtime rate is applied. The actual hours paid are no different than regular work hours and are included with productive hours. It is the rate which changes.

For standby and on-call situations, the Fair Labor Standards Act differentiates between restricted and unrestricted on-call. All restricted call hours must be counted as productive hours However, when employees are on unrestricted call, only actual time worked should be included in productive hours with the excess going into non-productive time.

Swing Beds 1270

The Social Security Act (the Act) permits certain small, rural hospitals to enter into a swing bed agreement. Under the Act, a hospital can use its beds, as needed, to provide either acute or skilled nursing facility (SNF) care. As defined in the regulations, a swing bed hospital is a hospital or critical access hospital (CAH) participating in Medicare that has CMS approval to provide post-

hospital SNF care and meets certain requirements. Medicare Part A (the hospital insurance program) covers post-hospital extended care services furnished in a swing bed hospital.

In accordance with the Balanced Budget Act (BBA) of 1997, the SNF-level services of non-CAH swing bed facilities are covered under the SNF prospective payment system (PPS) effective with cost reporting periods beginning on or after July 1, 2002. This applies to short term hospitals, long term hospitals, and rehabilitation hospitals certified as swing bed hospitals. The SNF-level services of CAHs with swing beds are exempt from the SNF PPS, in accordance with the Benefits Improvement and Protection Act of 2000 and the Medicare Modernization Act of 2003 and are instead paid based on 101 percent of reasonable cost. To qualify for SNF-level services, a beneficiary is required to receive acute care as a hospital inpatient covered under Medicare Part A for a medically necessary stay of at least 3 consecutive calendar days.

The SNF PPS covers all costs (ancillary, routine, and capital) related to covered services furnished to beneficiaries under Medicare Part A. Like the PPS for inpatient hospital services, the SNF PPS excludes certain specified services, which are separately billable to Part B and Part D. The SNF PPS relies on information from a resident assessment instrument to classify residents into payment categories based on patient characteristics. Non-CAH swing bed hospitals are required to complete the MDS assessment to meet this requirement. There is no longer a separate Swing Bed MDS assessment manual.

The amount of reimbursement for swing bed services must be entered as both revenue and as direct expense in the swing bed cost center (Account 3210/6210). The same amount must be excluded from both revenue and expenses in the acute care cost center.

Patient days for swing bed patients should also be transferred from acute care to the swing bed cost center. In addition, an estimate of the corresponding FTE's should also be transferred from acute care to the swing bed cost center. This cost center must contain only revenues and expenses related to long term inpatient care. Under no circumstances should ancillary services be recorded in this revenue center.

Inpatient and Outpatient Revenue 1280

Short Stay/Observation Patients 1281

Short stay/Observation patients are patients who are scheduled to be in and out of the hospital within the same day (or night). Short stay patients include, but are not limited to, ambulatory surgery, psychiatric day care or night care, observation rooms (to observe for shock, reactions to medication, etc.), routine dialysis treatments, and other programs where the procedure or treatment is not anticipated to require an overnight stay.

Admissions From Emergency Room 1282

Once a patient is admitted as an inpatient to a licensed hospital, all revenue applicable to that patient stay is considered inpatient revenue. If the patient is admitted from the emergency room, the patient stay would have commenced when the patient entered the emergency room and all

revenue applicable to that patient, including emergency room revenue, would be classified as inpatient revenue.

If a patient is treated in the emergency room and subsequently returns to the hospital as an inpatient at a later date, this would constitute two separate patient stays. Therefore, the emergency room revenue applicable to this patient would be classified as outpatient revenue.

Patients Transfers to Excluded Units 1290

Under the Medicare and Medicaid PPS, certain types of inpatient hospital units are excluded from the diagnosis related group (DRG) payment methodology. Forbilling and reporting to these programs, patients transferred into or out of one of these excluded units are to be counted as a discharge and a new admission.

For reporting to the Department, patients transferred into or out of an excluded unit are counted as a new admission, not as a discharge

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 section is to provide guidance to standardize the accounting for malpractice claims. Listed below are pertinent definitions of terminology to be used in the following discussion:

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 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, where improper professional service may be alleged, 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 term of the policy.

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.

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 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, 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 but still could result in a claim against the hospital.

Following the AICPA Audit and Accounting Guide, 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 both asserted and unasserted claims should be accrued either on a group or individual basis. The accrual should be based on all relevant information, which may include industry experience and the historical experience of the hospital. If industry experience is used, it must be adjusted for a provider's actual experience using an experience modification factor.

The experience modification factor is developed by using a credibility factor that measures the statistical significance of a provider's own data, depending on its stability and volume of industry data. 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.

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 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. This is because the probability of such events is uncertain and the amount of the loss cannot be reasonably estimated. However, the facility 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.

Bad Debt and Charity Care 1400

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

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

Charity Care Policies 1410

Hospitals must maintain written charity care policies which specify that access to medically necessary hospital healthcare must not be denied on the basis of ability to pay. It should also include provisions ensuring that admission policies will not significantly reduce the amount of charity care provided.

The hospital's charity care policy must contain uniform procedures for identification of indigent persons. Initial determination of sponsorship status is to be completed at the time of admission or as soon as possible following initiation of services. Notice that charges may be waived or reduced if charity care criteria are met and readily available to the public. The hospital shall make a reasonable effort to determine the existence of third-party sponsorship for all or part of the charges for services provided to patients.

Oral information must be relied upon for the initial determination of sponsorship status of patients. Final determination of sponsorship status shall be based on W-2 forms, pay stubs,

income tax returns, determinations of eligibility for Medicaid or unemployment compensation, or a written and signed statement from a responsible party.

The hospital's charity care policy shall reflect the prohibited and required hospital practices and policies detailed in chapter 70.170 RCW and chapter 246-453 WAC.

Beginning January 1, 2023, each hospital must report to the Department, on a quarterly basis, the number of submitted and completed charity care applications that the hospital received in the prior quarter according to the hospital’s charity care policy in chapter 70.170 RCW. The Department will develop a standard form for hospitals to use in submitting information.

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. The allocation of home office expenses for items such as interest and insurance must be classified as Other Direct Expense, not as Purchased Services.

Public Hospital Districts 1600

The Office of the State Auditor of the state of Washington, according to authority contained in RCW 43.09.200, requires all hospital districts and county hospitals to maintain their accounting records in conformity with essential legal requirements and regulations applicable to municipal corporations.

The State Hospital Commission and the Office of the State Auditor reviewed their legal requirements and responsibilities toward public hospital districts and agreed that the uniform system of accounts which the State Hospital Commission adopted by regulation on September 30, 1974 shall be applicable to all district hospitals. That agreement remains in effect for all public hospital districts.

In general, the major differences between district hospitals and other not-for-profit hospitals are that district hospitals have certain restricted taxing powers. For long-term borrowing, district hospitals look to district taxpayers to authorize the issuance of bonds. Section 2263 of the Manual specifies the accounting procedures and additional sub-accounts necessary to properly account for the issuance and redemption of bonds.

Bond redemption, interest resources, and construction resources shall be considered as board designated assets are recorded and reported in that section of the unrestricted fund. Tax revenue for operations and for payment of interest must be recorded as other operating revenue. Tax revenue relative to the repayment of principal must be recorded as nonoperating revenue in the designated accounts.

Specific accounts applicable to public hospital districts are identified in Sections 2260-2263 of this Manual.

Small Hospitals 1700

It is the intent of the Department to accumulate information which facilitates meaningful comparisons of costs in all hospitals. This requires that all hospitals report uniformly. However, the Department also recognizes that due to the varying organizational and operational structures of Washington 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 maintaining consistency between hospitals while allowing flexibility for hospital management.

Each hospital, especially smaller hospitals, must evaluate its organizational and operational structures as they relate to the requirements of this Manual and determine when and if reclassifications will be necessary.

DOH 689-188 January 2025
To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.