1 Review of Financial Management and Cost Accounting Principles

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Purpose of This Chapter

This chapter will provide an overview of the health-care industry and hospital financial accounting and reporting issues. The reader will gain insight to the industry and to the accounting and reporting issues facing hospitals today. This chapter will provide the framework for more detailed discussions in subsequent chapters.

The "Business" of Health Care

Make no mistake, health care is business—big business. At over 15 percent of the gross national product (GNP), health-care spending continues to rise sharply. This creates tremendous pressure on hospital leaders to manage their organizations—whether organized as community-based/not-for-profit, for-profit, or academic medical centers—more effectively than many other businesses. Operating efficiently and generating a return on investment is crucial for all hospitals, regardless of ownership, to provide replacement equipment and new technology to keep up with the demands of consumers. For some hospitals, another important aspect of efficient operations is making interest payments on bonds and other indebtedness or making dividend payments to shareholders. For other hospitals, especially rural facilities, efficient operations simply equates to survival.

Mission and Community Focus

Hospitals are guided by a mission and a focus on the community. This characteristic distinguishes hospitals from most other businesses. Today's health-care managers, including pharmacy directors, must balance between making solid business decisions and providing services or programs for the community. With limited resources, health-care leaders often must choose carefully how resources are used and which needs the hospital can reasonably meet.

Another area that distinguishes hospitals from most other businesses is the number of stakeholders involved. How many other businesses provide services to customers (patients) as ordered by independent practitioners (physicians not typically employed by the hospital) and paid for by a third party? Many of the supplies used by hospitals are dictated by the preferences of physicians who have no responsibility for the cost of those supplies. Other stakeholders include the employed caregivers, the lenders, the owners, the vendors, and

the community. These various relationships create a complex operational environment not found in other businesses.

Efficient hospital operations, defined by an excess of revenues over expenses, are often equated to margin. Some argue that generating margin is somehow inherently wrong in health care. However, margin (or return on investment) is needed to replace aging equipment and facilities and to provide new technology for tomorrow's health-care needs. These uses of margin support the mission of the hospital. It has been said that "without margin, there is no mission."

Governance

Most hospitals are organized either as community-based or not-for-profit facilities, for-profit facilities, or academic medical centers.

Community-based/not-for-profit facilities are generally organized as tax-exempt under the Internal Revenue Service regulations (501 (c)(3)). Their primary purpose is to provide community benefit through various programs and services. Access to capital is mainly through donations (which are usually tax deductible to the donor), bonds and other debt instruments, and efficient operations.

For-profit facilities are generally organized as taxable entities. In addition to their mission as an organization, their primary focus is on generating a return for the shareholder or owner(s). Access to capital is mainly through the sale of stock, debt instruments, and efficient operations.

Both not-for-profit and for-profit entities have similar pressures in providing for the needs of the community. Both entities are required to see patients in the emergency room regardless of their ability to pay. Other than public perception, one of the largest distinguishing factors between the two is access to capital and the payment of taxes.

Academic medical centers are similar to the community/not-for-profit facilities, except that a major part of their mission is teaching new health-care professionals and funding research. These additional activities carry a higher cost structure, which is often offset in some measure by other funding sources, such as grants, state legislative funding, and so forth.

All hospitals, regardless of organization, are governed by a board of trustees. There are many different names for this board, including board of directors. Generally, this board oversees all hospital operations. Board composition commonly consists of members of the hospital's senior management team and representatives from the medical staff and the community.

Senior leadership may include the chief executive officer or president, the chief financial officer or vice president of finance, the chief nursing officer, and other administrative officers. Titles will vary depending upon the facility's style and organization. These leaders are accountable to the board for the strategic and tactical decisions made for the operation of the facility.

Department leaders, such as the pharmacy director, are responsible for the day-to-day operational decisions made in the facility. Department leaders often provide input to strategic plans and work with senior leadership to develop implementation plans for the future.

Environmental Factors

Hospital operations are subject to regulatory oversight by numerous agencies and accreditation bodies. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the state pharmacy board, the Centers for Medicare and Medicaid Services (CMS), and the state health department are examples of a few of the many regulatory organizations that seek to reshape the way health care will be delivered in the future. Consumer, payer, and employer groups have also been formed in recent years to address the issue of rising health-care costs and how to improve health-care outcomes. All of these organizations will affect the Pharmacy Director's role in managing the hospital of the future.

The rising cost of caring for the indigent, uninsured, and underinsured is threatening the financial life of many of America's hospitals. The number of Americans living below 200 percent of the Federal Poverty Level (as published by the federal government each spring) continues to increase. Although some citizens seek health care in free clinics, many use hospital emergency rooms. This comes at a high cost and, for most, is an inappropriate setting for health care.

Because of the increasing cost of health insurance premiums, many employees have found coverage to be either unaffordable or unavailable. Many Americans have decided to risk uninsurance to channel financial resources into other areas of their lives. Others have become temporarily uninsured between jobs. In order to reduce health insurance premiums, some employers have offered health plans with high deductibles, which is the amount that beneficiaries must pay before their health insurance will begin to pay, or high copayments, which is the total amount that the beneficiary must pay. Although these plans reduce monthly premium costs, they may become financially stressful when services are needed.

Providing care for indigent, uninsured, and underinsured Americans is challenging the resources of the health-care system. All hospitals are wrestling with this issue. Charity care write-offs and debt expense are among the top financial problems for hospitals. It will take a collaboration of hospitals, safety net providers, communities, payers, and government to solve the issue. Pharmacy directors can play a significant role in creating pharmacy solutions for indigent patients. Many pharmaceutical manufacturers offer programs that provide drugs for patients who cannot afford their medications. Assisting the hospital and the patient with access to these programs is a valuable role of today's pharmacy director.

Overview of the Fiscal Services Department

Fiscal Services is the collective name for a number of different departments often led by the chief financial officer. In some facilities, fiscal services simply refers to the accounting department. Table 1.1 lists the various departments often associated with the chief financial officer, their responsibilities, and who is typically in charge of the department. Titles and specific positions vary among hospitals.

The chief financial officer (CFO) or vice president often reports to the chief executive officer or president and is responsible for the financial operation of the hospital. The CFO must ensure the integrity of the financial reporting, financial systems, and financial health of the organization. In addition, the CFO ensures compliance with a number of different

Table 1.1. Typical Departments within Fiscal Services

Department	Responsibilities	Typical Person In Charge
Accounting	Handles all general ledger accounting, monthly reporting, and subsidiary ledger accounting for the hospital; typically responsible for maintaining fixed asset records, reconciling all general ledger accounts monthly, and assisting department leaders with understanding monthly reports	Controller
Business Office	Handles all aspects of billing and collections for patient accounts	Business Office Director or Patient Accounts Director
Payroll	Handles all payroll functions for the hospital	Payroll Manager or Supervisor
Accounts Payable	Handles all payments to vendors for the hospital	Accounts Payable Manager or Supervisor
Purchasing and Materials Management	Handles all procurement and materials warehousing and distribution for the hospital	Materials Manager and Purchasing Manager or Supervisor
Decision Support	Analyzes financial and clinical data across the hospital and supports strategic decision making	Director of Decision Support or Financial Analyst
Development	Organizes and conducts fund raising for community-based/not-for-profit hospitals	Director of Development
Treasury	In larger organizations or health-care systems, a separate treasury function will manage investments and cash accounts	Treasurer or Director of Treasury
Cost Reporting	Prepares annual cost reports for Medicare and other governmental payers as required and keeps the organization current on changing regulations	Director of Reimbursement or Cost Reporting Supervisor
Managed Care	Negotiates and maintains managed care contracts	Director of Managed Care

financial regulations, especially in the area of billing and cost reporting. In the past, the CFO was viewed as a "behind the scenes" administrator whose role was somewhat transparent to department leaders and managers. However, CFOs are part of the strategic decision-making in most of today's hospitals. CFOs must have an appreciation for the full complexities of hospital operations to fully align the financial objectives with the strategic objectives of the organization. Pharmacy directors will be well served by forging a relationship with the CFO and understanding the financial implications of their daily operational decisions.

Another key financial player is the controller. The controller handles the day-to-day accounting and reporting issues for the hospital. The controller is often the go-to

person hospital staff turn to with questions about how to accomplish specific financial and accounting tasks.

The Accounting Cycle

The accounting cycle can best be explained by quickly reviewing the revenue cycle, the expense cycle, "capital" items, the budget, and the monthly close and reporting process.

The Revenue Cycle

Revenues are generated when services are provided to patients. See the Income Statement section for a more detailed description of revenues and net revenue. All hospitals have a system in place to "capture charges" for the services provided. In most cases, this system is automated. However, in some hospitals or departments, the system may be manual. Whether automated or manual, charges are entered into the patient accounting system (billing system). Bills are generated after the patient is discharged. There is typically a short lag between the discharge and when the bill is produced (often referred to as "dropped") to ensure that all charges were adequately captured and billed in accordance with regulations or payer requirements. Hospitals generally bill the patient's insurance carrier on behalf of the patient and keep the patient informed as to the status of the claim. Once the insurance carrier (or governmental payer such as Medicare) adjudicates the claim, the hospital will write off discounts as appropriate and bill the patient for any patient portion due (copayment or deductible) as identified by the carrier.

The revenue cycle is affected by the clinical department's successful capture of charges for the services provided, the complexities of the negotiated contracts with the carrier, and the timeliness of the payments received from the carrier and the patient. Quick turnaround of accounts receivable (amounts billed to carriers and patients but uncollected at month-end) is crucial to provide ongoing cash flow to the organization.

The patient accounting system is generally automated and linked with the general ledger accounting system. In some cases, the interface between the two may be manual.

The Expense Cycle

Expenses are the result of commitments for costs incurred in the provision of patient services or the operation of the hospital. Successful hospitals have a defined process to bind the organization to financial commitments. A typical process starts with a purchase request or requisition to be completed by the department leader. This document includes information on the proposed purchase, including vendor, amount, a description of item to be purchased, the general ledger account code, the budgeted amount, and the business justification for the purchase. The purchase requisition is generally submitted to senior leadership or administration for review and approval. Upon approval, the purchase requisition is sent to the hospital's purchasing department, where a formal purchase order is completed and the purchase order is communicated to the vendor. In some organizations, the department leader handles communication with the vendor after approval is obtained from administration. Once the items are appropriately received by the hospital and an invoice is received, the accounts payable department will match the invoice with the original purchase order and requisition. If the

amounts match, the invoice will be paid. If not, the documents are often returned to the originating department to resolve the discrepancy. Accounts payable will typically not pay a vendor's invoice until all discrepancies are adequately resolved.

Like the patient accounting system, the purchasing and accounts payable systems are most often automated and linked with the general ledger accounting system. In some cases, the interface between the systems may be manual.

"Capital" Items

Certain high-dollar items with a useful life of greater than one year are generally referred to as "capital" items. They derive this name because they are reported on the balance sheet as an asset rather than on the income statement as an expense. These items generally require additional review and consideration. Quite often, the analysis required to support the expenditure includes a return on investment calculation. The approval process is often similar to that described under "The Expense Cycle" above. Departmental leadership should consult with the CFO to understand the specific requirements for capital purchases.

The Budget

The budget is the annual roadmap for the organization to obtain its strategic objectives. In most organizations, development of the budget is a lengthy, complicated process that involves close analysis of historical trends and future projections. Typical budget planning can begin six or eight months prior to the end of the hospital's fiscal year. Some hospitals prepare the budget primarily through the work of the CFO, the controller, and decision support analysts. Others rely heavily on department leaders to complete detailed budgets for their departments. The pharmacy director should consult with the CFO to understand the specific responsibilities for budget development.

The completed budget is subjected to an extensive review process. Approvals are obtained from senior leadership, the board of trustees, and any other governing entity (such as the corporate office, in the case of a health system). Once approved, the budget becomes the measuring stick against which monthly performance is compared.

In most hospitals, department leaders are responsible for analyzing and explaining performance variances with the budget. Action plans are often required for ongoing performance that is projected to vary significantly from the budget. This requires a thorough understanding of the departmental operations or responsibility reports and the general accounting processes influencing those reports.

The Monthly "Close"

The controller and staff "close" the general ledger at the end of every month. The ledger may be held open for a designated number of days in the following month to ensure that the accounts are reviewed, complete, and accurate. Some organizations strive to close the ledger within 5–10 days. Others allow additional time for account reconciliation. Once the general ledger is closed, the financial statements and departmental reports can be prepared and distributed for management to review.

The monthly close process can be a stressful time for the controller and staff. There is often a very short window to close the ledger and to consider numerous accounts and

issues. Department leaders can assist the close process by ensuring that invoices are processed promptly, and that critical information about trends and operational changes is communicated to the controller in a timely manner.

Basics of Accounting

This section will provide a general overview of the basics of accounting, including the basic accounting methods, the general ledger chart of accounts, and the types of accounts used.

Accounting Methods

There are three basic accounting methods used by health-care organizations: cash basis, accrual basis, and fund accounting.

Cash-basis accounting recognizes income and expense only when cash is received or disbursed. It is a simple method of accounting that ignores liabilities for purchases made but not yet received, and assets earned but not yet collected. Financial reports generated by cash-basis accounting can be grossly misleading and inaccurate. Cash-basis accounting is typically limited to individuals or small community organizations.

The accrual basis of accounting is used for most businesses. This method seeks to "accrue" revenues and expenses to the proper period in which they are earned. This is a large part of the monthly close process for the controller and staff. For the monthly financial statements to be accurate, the controller and staff must ensure that all transactions for the month are properly recorded, regardless of whether cash has been received or paid. Most of the examples and discussion in the remainder of this chapter focus on the accrual basis of accounting.

Fund accounting is typically used by governmental entities and academic medical centers. Fund accounting establishes specific funds for a variety of uses. Two examples include an equipment replacement fund and the general fund. The equipment replacement fund would be used to replace specific equipment in the future. The general fund serves as the operating fund for the entity. Many of the funds extend beyond the normal one-year cycle. This makes budgeting and maintenance of the funds a bit more complex.

General Ledger Chart of Accounts

The general ledger uses a set of accounts organized according to their type. The term *chart of accounts* simply refers to the listing of all available general ledger account numbers. The number of digits varies by hospital, but a typical number is six. The following table demonstrates a typical configuration for organizing the chart of accounts:

Account Range	General Account Category
1xx.xxx	Assets
2xx.xxx	Liabilities
3xx.xxx	Equity or Fund Balance
4xx.xxx	Revenues
5xx.xxx	Deductions from Revenues
6xx.xxx and 7xx.xxx, if needed	Expenses

General ledger accounts are further organized within the category listed above. For example, 100.000 may be used for the general cash account, whereas 120.000 may be used as a patient receivables account. Some hospitals maintain detailed general ledgers using a separate account for tracking specific details. Other hospitals organize the general ledger in a broader manner and use subsidiary ledgers to provide detail.

Each revenue-producing department is assigned a revenue center code beginning with the first digit of the revenue account range identified in the chart of accounts (in the example above, 4). For example, the emergency department may be assigned 460, and the pharmacy department may be assigned 480. Therefore, all revenues recorded in the general ledger for those departments will be reflected in the account series starting with 460 and 480, respectively. The last three digits are often assigned to the type of revenue (inpatient, outpatient, etc.), the payer (Medicare, Blue Cross, self pay, etc.), or a combination of both.

All departments are assigned a unique cost-center code for tracking expenses. For example, the emergency department may be assigned 660, and the pharmacy department may be assigned 680. The last three digits, referred to as the subaccount or subcode, are often standardized by type of expense. For example, 200 may be supplies, and 300 may be repairs and maintenance. The subaccount may be further refined to provide additional detail. For example, 210 may be chargeable supplies, 225 may be implant devices, and 266 may be minor office equipment.

Along with the general ledger chart of accounts, most controllers have a list of expense subaccounts and their definitions to be used by all departments. Department leaders should understand the organization of the chart of accounts and the appropriate use of the subaccounts because they are often responsible for coding purchase requisitions and invoices as well as performance results within their department.

Financial Reporting

Financial reporting for health-care organizations is regulated by a number of different entities. The American Institute of Certified Public Accountants publishes an Audit and Accounting Guide for Health Care Organizations that summarizes the reporting requirements. This section introduces the basic financial statements and their application to operational management.

The Balance Sheet

The first financial statement typically reported is the balance sheet. The balance sheet lists assets owned by the organization on the left side of the report, and the liabilities owed and the equity of the organization on the right side of the report. Equity, or fund balance, represents the difference between the assets and the liabilities. It is called "net assets" because it reflects the amount of ownership in the organization after payment of liabilities. The financial statement derives its name from the fact that the total of the left side of the report must "balance" or equal the total of the right. In other words, assets must equal liabilities and equity.

The balance sheet represents a given date in time. It is often referred to as a "snap-shot" of the entity's assets and liabilities as of that specific date. It is a valuable statement that

assists management in understanding the overall health of the organization. Managing an effective organization is dependent on understanding how quickly accounts receivable can be converted to cash and how much cash is available to pay upcoming liabilities. For this reason, the balance sheet is mostly used by senior leadership and the board rather than by department leaders.

Table 1.2 is an example of a typical balance sheet. Quite often, the balance sheet compares both current year and prior year totals. Table 1.3 lists definitions for typical line items reported on the balance sheet.

The Income or Operating Statement

The income statement, also referred to as the operating statement or the statement of revenues and expenses, reports the financial performance of the organization for a designated period of time. The designated period may be the end of the month and the year-to-date period ended that month. The income statement details the revenues earned and the related expenses incurred in the operation of the organization.

The income statement is used by hospital leadership to manage the operation. The individual departmental reports are modeled after the income statement and reflect the revenues and expenses for the specific department. The income statement is generally presented with the prior year information and the current year budget. This assists management in analyzing trends.

Table 1.4 is an example of an income statement for a typical for-profit hospital. Table 1.5 is an example of a statement of revenues and expenses for a typical not-for-profit hospital. Table 1.6 is a listing of definitions for the typical line items reported on the income statement.

The following provides a brief overview of the concept of net revenue, reimbursement methodologies, and the excess of revenues over expenses or EBIDTA—earnings before interest, depreciation, taxes, and amortization.

Net Revenue

Hospital organizations typically do not collect 100 percent of the amounts charged for services. Because of negotiated discounts with insurance payers and mandated contractual adjustments from government payers, hospitals only collect a percentage of the amounts charged for services.

Hospitals charge specified rates for the services and supplies provided to patients. These charges include room and board, also referred to as "routine charges," and ancillary services, such as imaging, operating room charges, and lab. The charges result in "gross revenue" on the income statement.

The negotiated discounts and mandated contractual adjustments are recorded in accounts labeled as "Deductions from Revenue" on the income statement. Another important deduction from revenue is the write-off for charity care.

Gross revenue less the associated deductions equals net revenue. Net revenue is the amount of revenue earned and expected to be collected. In retail terms, net revenue most closely reflects "cash sales." Because net revenue is the real measure of the revenue earned by the hospital, the financial reporting guidelines for published financial statements

Table 1.2. Typical Balance Sheets As of December 31, 2006 and 2005

Assets	12/31/06	12/31/05
Current Assets		
Cash and Cash Equivalents	103,930	203,851
Accounts Receivable:		
Patient Receivables	20,292,328	17,049,650
Less: Allowance for Deductions From Revenue	(6,277,112)	(5,328,811)
Less: Allowance for Bad Debt	(6,767,871)	(4,699,947)
Net Patient Receivables	7,247,345	7,020,892
Net Final Settlements—Governmental Programs	458,797	559,333
Net Accounts Receivable	7,706,142	7,580,225
Inventories	1,131,869	906,737
Prepaid Expenses	237,421	197,028
Other Receivables	210,041	69,794
Total Current Assets	9,389,403	8,957,635
Property, Plant & Equipment		
Land and Land Improvements	495,889	495,889
Buildings and Building Improvements	24,546,453	22,447,943
Equipment	14,179,321	12,863,605
Construction in Progress	78,509	1,641,170
Gross Property, Plant & Equipment	39,300,172	37,448,607
Less: Accumulated Depreciation	(20,350,104)	(18,800,937)
Net Property, Plant & Equipment	18,950,068	18,647,670
Other Assets		
Intangible Assets, Net	504,566	504,566
Investment in Subsidiaries	1,018,125	0
Total Other Assets	1,522,691	504,566
Total Assets	29,862,162	28,109,871

Table 1.2. Typical Balance Sheets As of December 31, 2006 and 2005 (*Continued*)

Liabilities And Equity	12/31/06	12/31/05
Current Liabilities		
Accounts Payable	1,727,020	1,531,920
Accrued Expenses	2,257,618	1,804,463
Accrued Payroll	611,500	1,223,527
Total Current Liabilities	4,596,138	4,559,910
Long-Term Debt		
Notes Payable	4,500,000	5,650,000
Total Long-Term Debt	4,500,000	5,650,000
Other Liabilities		
Misc. Long-Term Obligations	82,610	12,365
Total Other Liabilities	82,610	12,365
Total Liabilities	9,178,748	10,222,275
Equity		
Capital In Excess of Par Value	514,395	514,395
Retained Earnings—Start of Year	18,138,801	15,420,606
Net Income—Current Year	2,030,218	1,952,595
Total Equity	20,683,414	17,887,596
Total Liabilities and Equity	29,862,162	28,109,871

Table 1.3. Balance Sheet Definitions

Assets	
Cash and Cash Equivalents	This represents the cash on hand and short term cash investments as of the balance sheet date.
Accounts Receivable	
Patient Receivables	This represents the accounts receivable from patients or payers on behalf of patients (Medicare, Medicaid, Blue Cross, Cigna, etc.). For several payers, the receivable is reduced to the net amount expected to be collected and is shown on this line at the net amount. For other payers, the gross receivable is shown on this line and an allowance for deductions from revenue is accrued.
Allowance for Deductions From Revenue	This represents the difference between negotiated or regulated rates expected to be received and the gross charges in accounts receivable. An allowance is calculated and accrued for all payers whose accounts are not discounted and reported net in the line above. Often referred to as Allowance for Discounts and Contractual Adjustments.
Allowance for Bad Debt	This represents the estimated amount of bad debt included in patient receivables. Often referred to as Allowance for Uncollectible Accounts.
Net Patient Receivables	This represents the net amount expected to be collected from patients or payers on behalf of patients.
Net Final Settlements—Gov. Programs	This represents receivables (or payables) anticipated from filed Medicare and Medicaid cost reports. These amounts are not finalized until the cost report is final settled by the intermediary.
Inventories	This represents supplies on hand as of the balance sheet date. Supplies includes medical and surgical supplies, lab, and diagnostic imaging.
Prepaid Expenses	This represents invoices paid which benefit future periods and are therefore expensed over those future periods.
Other Receivables	This represents miscellaneous receivables not from patients and patient services.
Current Assets	This represents assets which are highly liquid. Generally, current assets are assets that are expected to be converted to cash in less than one year.
Property, Plant & Equipment	
Land and Land Improvements	This represents the historical cost of land and any improvements (such as sidewalks and landscaping). Depreciation is not calculated on land.
Buildings and Building Improvements	This represents the historical cost of the buildings and building improvements.
Equipment	This represents the historical cost of major moveable equipment (typically large, stationary equipment that is capable of being moved, such as lab analyzers, imaging equipment, and autos), fixed equipment (typically large equipment attached to the

Table 1.3. Balance Sheet Definitions (*Continued*)

	buildings, such as boilers, HVAC, and back-up electrical generators), and certain minor equipment (typically office furnishings and equipment greater than an established dollar threshhold . . . amounts below that threshhold are typically expensed to supplies).
Construction in Progress	This represents the costs of construction projects currently in progress that have not yet been placed in service.
Accumulated Depreciation	This represents the depreciation expense recorded over time associated with the property, plant & equipment assets noted above. Depreciation is not calculated on land and on construction in progress.
Net Property, Plant & Equipment	Often referred to as "net book value", this represents the depreciated cost of the property, plant & equipment assets.
Other Assets	
Investments	This represents the cost of long-term investments. Often, specific investment categories will be reported on the Balance Sheet.
Intangible Assets, Net	This represents specific intangible assets associated with the organization. Goodwill from a purchase of the facility is one example.
Liabilities	
Accounts Payable	This represents invoices and check requests which have been approved and are awaiting payment. These invoices have been processed through the accounts payable system.
Accrued Expenses	This represents known expenses for the period which have not been processed through the accounts payable system. These expenses may be awaiting receipt of the final invoice, be in transit to the accounts payable department, etc.
Accrued Payroll	This represents an accrual for the end of period payroll expense (payroll earned by employees but not yet paid).
Current Liabilities	This represents those liabilities that are expected to be paid within one year.
Notes Payable	This represents long-term debt evidenced by a signed note.
Misc. Long-Term Obligations	This represents other long-term debt or commitments by the facility.
Equity	
Capital in Excess of Par Value	This represents the initial capital recorded upon the purchase or startup of the organization (only applicable to a for-profit facility).
Retained Earnings	This represents the accumulated earnings (losses) of the organization since its inception.
Net Income—Current Year	This represents the current year's net income.

Note: The equity section for a typical not-for-profit Balance Sheet is called Fund Balance, and generally does not have additional categories similar to Capital in Excess of Par Value, etc. like those listed above.

Table 1.4. Typical Income Statements (For a For-Profit Hospital) For the Years Ended December 31, 2006 and 2005

	Actual 12/31/06	Budget YTD 12/31/06	Variance	Actual 12/31/05	Variance
Routine	22,401,329	21,260,601	1,140,728	20,589,364	1,811,965
Ancillary	100,643,253	96,342,124	4,301,129	87,273,058	13,370,195
Total Inpatient Revenue	123,044,582	117,602,725	5,441,857	107,862,422	15,182,160
Outpatient Revenue	73,052,290	73,467,933	(415,643)	62,946,349	10,105,941
Total Patient Revenue	**196,096,872**	**191,070,658**	**5,026,214**	**170,808,771**	**25,288,101**
Other Revenue	1,035,102	1,054,363	(19,261)	1,127,139	(92,037)
Gross Revenue	**197,131,974**	**192,125,021**	**5,006,953**	**171,935,910**	**25,196,064**
Provision for Charity Care	8,589,652	7,985,650	604,002	7,015,685	1,573,967
Other Revenue Deductions	131,251,287	127,236,628	4,014,659	109,783,362	21,467,925
Total Deductions from Revenue	139,840,939	135,222,278	4,618,661	116,799,047	23,041,892
Net Revenue	**57,291,035**	**56,902,743**	**388,292**	**55,136,863**	**2,154,172**
Salaries & Benefits	26,246,788	24,394,341	1,852,447	23,793,777	2,453,011
Contract Labor	220,302	230,652	(10,350)	235,492	(15,190)
Supplies	8,023,455	8,521,581	(498,126)	8,416,809	(393,354)
Professional Fees	3,025,032	3,050,608	(25,576)	3,015,879	9,153
Contract Services	4,105,601	3,652,013	453,588	3,501,605	603,996
Repairs and Maintenance	3,250,602	3,106,405	144,197	3,095,659	154,943
Rents and Utilities	1,252,465	1,249,463	3,002	1,235,652	16,813
Bad Debts	2,869,715	2,659,546	210,169	2,354,628	515,087
Other Operating Expenses	519,272	428,285	90,987	415,982	103,290
Total Operating Expenses	**49,513,232**	**47,292,894**	**2,220,338**	**46,065,483**	**3,447,749**

	Actual 12/31/06	Budget YTD 12/31/06	Variance	Actual 12/31/05	Variance
EBIDTA	**7,777,803**	**9,609,849**	**(1,832,046)**	**9,071,380**	**(1,293,577)**
Capital Costs					
Depreciation & Amortization	2,610,976	2,147,640	463,336	2,622,198	(11,222)
Total Capital Costs	**2,610,976**	**2,147,640**	**463,336**	**2,622,198**	**(11,222)**
Pretax Income	**5,166,827**	**7,462,209**	**(2,295,382)**	**6,449,182**	**(1,282,355)**
Income Taxes	2,066,731	2,984,884	(918,153)	2,579,673	(512,942)
Net Income	**3,100,096**	**4,477,325**	**(1,377,229)**	**3,869,509**	**(769,413)**

Table 1.5. Typical Statement of Revenues and Expenses (For a Not-For-Profit Hospital) For the Years Ended December 31, 2006 and 2005

	Actual 12/31/06	Budget YTD 12/31/06	Variance	Actual 12/31/05	Variance
Routine	22,401,329	21,260,601	1,140,728	20,589,364	1,811,965
Ancillary	100,643,253	96,342,124	4,301,129	87,273,058	13,370,195
Total Inpatient Revenue	123,044,582	117,602,725	5,441,857	107,862,422	15,182,160
Outpatient Revenue	73,052,290	73,467,933	(415,643)	62,946,349	10,105,941
Total Patient Revenue	**196,096,872**	**191,070,658**	**5,026,214**	**170,808,771**	**25,288,101**
Other Revenue	1,035,102	1,054,363	(19,261)	1,127,139	(92,037)
Total Revenue from Operations	**197,131,974**	**192,125,021**	**5,006,953**	**171,935,910**	**25,196,064**
Provision for Charity Care	8,589,652	7,985,650	604,002	7,015,685	1,573,967
Other Revenue Deductions	131,251,287	127,236,628	4,014,659	109,783,362	21,467,925
Total Deductions from Revenue	139,840,939	135,222,278	4,618,661	116,799,047	23,041,892
Net Patient Service Revenue	**57,291,035**	**56,902,743**	**388,292**	**55,136,863**	**2,154,172**
Professional Care of Patients	20,246,788	18,494,341	1,752,447	17,993,777	2,253,011
Dietary Services	2,220,302	2,230,652	(10,350)	2,235,492	(15,190)
General Services	8,023,455	8,521,581	(498,126)	8,416,809	(393,354)
Fiscal and Administrative Services	4,025,032	4,050,608	(25,576)	4,015,879	9,153
Employee Health and Welfare	4,105,601	3,652,013	453,588	3,501,605	603,996
Medical Malpractice Costs	3,250,602	3,106,405	144,197	3,095,659	154,943
Depreciation	2,610,065	2,596,856	13,209	2,578,965	31,100
Interest	3,519,272	4,328,285	(809,013)	3,415,982	103,290
Provision for Bad Debts	2,869,715	2,659,546	210,169	2,354,682	515,033
Total Operating Expenses	**50,870,832**	**49,640,287**	**1,230,545**	**47,608,850**	**3,261,982**
Income from Operations	**6,420,203**	**7,262,456**	**(842,253)**	**7,528,013**	**(1,107,810)**

	Actual 12/31/06	Budget YTD 12/31/06	Variance	Actual 12/31/05	Variance
Nonoperating Gains (Losses)					
Interest Earnings	865,900	845,980	19,920	795,650	70,250
Unrestricted Donations	65,982	75,900	(9,918)	74,300	(8,318)
Rental Income	15,324	15,300	24	14,987	337
Gain (Loss) on Disposal of Assets	5,623	5,685	(62)	4,988	635
Development Expenses	(9,826)	(8,650)	(1,176)	(8,549)	(1,277)
Other Income (Expense)	10,987	9,850	1,137	9,652	1,335
Total Nonoperating Gains (Losses)	**953,990**	**944,065**	**9,925**	**891,028**	**62,962**
Excess of Revenues Over Expenses	**5,466,213**	**6,318,391**	**(852,178)**	**6,636,985**	**(1,170,772)**

Table 1.6. Definitions of Income Statement Items

Gross Revenue	
Inpatient Routine	Patient service gross charges generated from room and board
Inpatient Ancillary	Gross charges for ancillary services provided to inpatients (such as lab, imaging, operating room, and pharmacy services).
Outpatient Ancillary	Gross charges for ancillary services provided to outpatients (such as lab, imaging, operating room, emergency room, and pharmacy services).
Other Revenue	Revenues generated from other sources such as gift shop sales, cafeteria sales, charges for release of health information, and capitation payments.
Deductions from Revenue	
Provision for Charity Care	Discounts provided to indigent patients in accordance with established facility policies. Many policies provide a 100% discount (full write-off) for patients with incomes less than 100% of the published Federal Poverty Level (FPL). Typically, for patients with incomes of greater than 100% of the FPL but less than 200% of the FPL, a substantial discount is offered on a sliding scale. Some facilities extend the full 100% discount to patients with incomes up to 200% of the FPL.
Other Revenue Deductions	Represents the discounts negotiated with insurance and managed care payers, and the mandated contractual adjustments from governmental payers. Often, the financial statement includes more detailed line items such as Medicare Contractual Adjustments, Medicaid Contractual Adjustments, HMO/PPO Discounts, etc. In some cases, these details are disclosed in the notes to the financial statements.
Net Revenue	Represents the amount of gross revenue expected to be collected from the appropriate payers.
Operating Expenses	
Salaries and Benefits	Represents the cost of payroll and related fringe benefits.
Contract Labor	Represents the cost of outsourced labor, such as temporary nursing labor.
Supplies	Represents the cost of medical, surgical, and office supplies used by the organization. Often includes the cost of minor equipment (such as office equipment and furnishings).
Professional Fees	Represents the cost of fees to professional medical staff for services rendered under contract. Examples may include emergency room services, medical directorships, clinical reading contracts, etc.
Contract Services	Represents the cost of services outsourced under contract to external organizations. Examples may include an outsourced pharmacy or lab, or a grounds keeping contract.
Repairs and Maintenance	Represents the cost of repairs and maintenance on equipment and buildings, including maintenance agreements.

Table 1.6. Definitions of Income Statement Items (*Continued*)

Rents and Utilities	Represents the cost of leases for equipment and buildings, and the cost of building utilities (such as gas, water, and electric).
Bad Debts	Represents the write-off of uncollectible accounts for patients who are unwilling to pay their balance. Hospitals are required to have a collection process and to ensure that every patient account follows that process to completion.
Other Operating Expenses	Represents a variety of miscellaneous operating expenses such as legal and professional fees, marketing, advertising, community support, etc.
EBIDTA	Represents Earnings Before Interest, Depreciation, Taxes, and Amortization
Capital Costs	
Depreciation & Amortization	Represents the cost of capitalized or fixed assets spread over the expected useful life of those assets.
Income Taxes	Represents an estimate of the income taxes due on the pretax income shown. Includes both federal and state taxes.

The expense descriptions listed above are grouped to reflect general categories or departments of expense on the Statement of Revenues and Expenses for Not-For-Profit Hospitals.

recommend that net revenue be the starting point on the income statement, and that gross revenue and the associated deductions only be disclosed in the notes of the financial statements.

Reimbursement Methodologies

The payment for services provided by hospitals is often referred to as "reimbursement." Over the years, hospitals have been reimbursed under a number of different methodologies. Each methodology shifts the risk of high-cost services to different stakeholders. Table 1.7 is a listing of the various payment methodologies and who bears the risk. These methodologies will be explored further in subsequent chapters. The pharmacy director should understand the different methodologies and the operational strategies that he or she should undertake based on their impact on net revenue.

Excess of Revenues over Expenses or EBIDTA

Net revenue less operating expenses equals earnings before interest, depreciation, taxes, and amortization (EBIDTA for for-profit reporting) or the excess of revenues over expenses (for not-for-profit reporting). This line item on the financial statement roughly equates to "cash income," but only to the extent that the depreciation expense is reported separately. It is an important measure of the success of the organization.

Table 1.7. Various Hospital Reimbursement Methodologies

Methodology	Description	Typically Used By	Risk for High Cost Services
Fee for Service	Patient is charged for services rendered and remits payment at 100% of charges	This methodology was used primarily before the advent of Medicare and health insurance as an employee benefit	The payer (which was typically the patient) held the risk for service utilization
Discounted Fee for Service	Patient is charged for services rendered at full rates, but the bill is discounted by some negotiated percentage	Indemnity insurance plans, uninsured discount programs, and other smaller payer sources	The payer continues to hold the risk for service usage
Fixed Payment by Clinical Diagnosis	Hospital is reimbursed based upon a fixed or pre-determined payment amount for a specific medical diagnosis	Medicare and other governmental payers	Shifts more of the risk for service usage to the hospital. Typically, there is a provision to provide additional reimbursement for outlier/catastrophic cases
Per Diem Rates	Hospital is reimbursed a fixed, pre-negotiated amount per day for the care of the patient regardless of the services provided to the patient	Managed care and similar insurance payers	Shifts more risk to the hospital for service usage. Typically, the payer requires a daily review of the patient's case and approves the number of days allowed
Per Case Rates	Hospital is reimbursed a fixed, pre-negotiated amount per case for the care of the patient regardless of the diagnosis and the services provided	Managed care and similar insurance payers	Shifts most of the risk for service usage to the hospital. Typically, there is separate negotiated coverage for outlier/catastrophic cases
Capitation	Hospital is paid in advance a negotiated amount per insurance subscriber per month to provide for all of the medical services required by the designated subscribers during that month	Managed care and similar insurance payers	Shifts all of the risk for service usage to the hospital. This payment methodology is not very common in most markets in the United States. It is a common methodology in physician reimbursement

Table 1.8. Typical Key Operating Indicators For the Years Ended December 31, 2006 and 2005

	Actual YTD 12/31/06	Budget YTD 12/31/06	Budget Variance	Actual YTD 12/31/05	Variance
Admissions	4,074	4,062	12	3,898	176
Adjusted Admissions	6,493	6,600	(107)	6,173	320
Patient Days	27,932	27,255	677	27,605	327
Adjusted Patient Days	44,515	44,281	234	43,715	800
Average Length of Stay (ALOS)	6.86	6.71	0.15	7.08	(0.22)
Average Daily Census (ADC)	76.53	74.67	1.86	75.63	0.90
Outpatient Visits	43,765	51,582	(7,817)	44,181	(416)
Deliveries	600	620	(20)	598	2
ER Visits	12,814	10,410	2,404	10,631	2,183
Inpatient Surgeries	1,690	2,027	(337)	1,722	(32)
Outpatient Surgeries	8,716	9,879	(1,163)	8,769	(53)
Total Case Mix Index	1.29	1.28	0.01	1.27	0.02
Medicare Case Mix Index	1.31	1.34	(0.03)	1.32	(0.01)
Performance Ratio	(1.7)	2.7	(4.4)	(0.2)	0.2
Labor Cost Per Man-hour	23.29	22.55	0.74	21.56	1.73
MHPAPD	20.67	20.07	0.60	20.68	(0.01)
MHPAA	141.73	134.64	7.09	146.45	(4.72)
FTEs—Employed	425	408	17	407	18
FTEs—Contract	16	18	(2)	26	(10)
Total Personnel % NR	45.80%	42.90%	2.90%	43.20%	2.60%
Overtime % Personnel	2.90%	2.90%	0.00%	3.30%	(0.40%)
Adjusted EPOB	3.62	3.51	0.11	3.62	0.00
Supply Expense % NR	14.00%	15.00%	(1.00%)	15.30%	(1.30%)
Net Days in AR—Net	53	54	(1)	51	2
Bad Debt/Charity % NR	11.50%	7.10%	4.40%	6.60%	4.90%
EBIDTA % of Net Revenue	13.60%	16.90%	(3.30%)	16.50%	(2.90%)
Per Adjusted Patient Day:					
Gross Revenue	4,428.42	4,338.75	89.67	3,933.09	495.33
Deductions from Revenue	3,141.42	3,053.72	87.70	2,671.81	469.61
Net Revenue	1,287.00	1,285.03	1.97	1,261.27	25.73
Operating Expenses	1,112.28	1,068.01	44.27	1,053.76	58.52
EBIDTA	174.72	217.02	(42.30)	207.51	(32.79)
Per Adjusted Admission:					
Gross Revenue	30,361.94	29,111.92	1,250.02	27,853.47	2,508.47
Deductions from Revenue	21,538.07	20,489.68	1,048.39	18,921.34	2,616.73
Net Revenue	8,823.87	8,622.24	201.63	8,932.12	(108.25)
Operating Expenses	7,625.95	7,166.10	459.85	7,462.57	163.38
EBIDTA	1,197.92	1,456.14	(258.22)	1,469.56	(271.64)

Table 1.9. Definitions for Key Operating Indicators

Volume Statistics

Admissions	Inpatient statistic representing incremental inpatients admitted to the facility overnight for services.
Patient Days	Inpatient statistic representing the total number of days patients are in-house and occupying a bed during the month.
Average Length of Stay (ALOS)	Inpatient statistic representing the average length of time each patient stays in-house. Calculated as **Patient Days/Admissions**.
Average Daily Census (ADC)	Inpatient statistic representing the average number of patients in-house during a defined time period. Calculated as **Patient Days/Number of Days in Period**.
Deliveries	Inpatient statistic representing the number of births in the period.
Outpatient Visits	Outpatient statistic representing the number of visits from patients on an outpatient basis. This is generally determined from the specific tests/procedures performed on the patient. Generally, this number is larger than outpatient registrations.
ER Visits	Outpatient statistic representing the number of patient visits to the ER.
Adjusted Admissions, Patient Days, & ADC	An overall statistic representing both inpatient and outpatient volumes in terms of admissions and patient days. Adjusted statistics seek to "convert" outpatient volumes to an IP statistic. Calculated as **Admissions/(Inpatient % of Total Revenue)** (substituting patient days or ADC for Admissions as necessary.) (or as **Admissions * the Adjustment Factor**) The adjustment factor is **Total Revenue/Total IP Revenue**. **This is a key statistic used in the comparison of facilities**.
Surgeries—Inpatient and Outpatient	A count of the total surgeries performed, separated between inpatient and outpatient. The statistic is further classified as C-Sections, pain cases, endoscopy cases, lithotripsy, and all other.

Intensity of Services

Total Case Mix Index (CMI)	A measure of the relative complexity of cases treated by the facility. The CMI is determined as a result of medical record coding on patients seen during the time period. Generally, the higher the number, the more complex the patient base.
Medicare Case Mix Index	Same as total case mix index but applied only to the Medicare population. For the Medicare DRG system, generally the higher the Medicare CMI, the higher the DRG reimbursement.

Table 1.9. Definitions for Key Operating Indicators (*Continued*)

Operational Statistics

Performance Ratio	A measure of the overall operational performance of the facility. The % change in NR - the % change in Operating Expenses × 100 should be positive. The actual calculated value is less meaningful than its sign. Calculated as **(% Change in net revenue between 2 periods - % Change in Expenses between the same 2 periods) × 100**
Labor Cost Per Man-hour	Employed (salaries and wages only) costs per man-hour.
Total Man-hours per Adjusted Admission or Adjusted Patient Day (MHAA or MHAPD)	A productivity statistic which compares total man-hours (both employed and contracted) to adjusted volumes (inclusive of both inpatient and outpatient).
FTEs	A measure of employees (both employed and contracted) stated in terms of "full-time equivalents" (part-time employees' hours are converted to full-time equivalents).
Total Personnel % of Net Revenue	A productivity statistic measuring total personnel costs (salaries, wages, contract labor, and benefits) as a % of net revenue.
Overtime % Personnel	The % overtime to total personnel time. Calculated as **OT Hours/Total Paid Hours.**
Supply Expense % Net Revenue Supply Expense per AA	Measurements of supply cost management comparing with net revenue and per adjusted admission.
Net Days in AR—Net	An AR management statistic representing the number of average net revenue days in net accounts receivable. The calculation is based on a three-month rolling average net revenue per day.
Percent of Net Revenue and per Adjusted Patient Day and per Adjusted Admission	Measurements of total financial results (gross revenue, net revenue, operating expenses, and EBIDTA).
Adjusted EPOB	Measures the *E*mployees *P*er *O*ccupied *B*ed as adjusted for outpatient volume. It is calculated as Total FTEs/ Equivalent ADC.

Table 1.10. Payer Mix
For Periods Ended December 31, 2006 and 2005

	YTD 12/31/06	% to Total	YTD 12/31/05	% to Total
Inpatient	**Revenue**			
Medicare	80,640,727	65.5%	69,288,124	64.2%
Medicaid	10,844,996	8.8%	9,013,203	8.4%
Workers' Compensation	446,365	0.4%	2,334,866	2.2%
Commercial	9,274,010	7.5%	4,177,251	3.9%
Champus	204,527	0.2%	369,843	0.3%
HMO/PPO	12,369,215	10.1%	13,977,674	13.0%
Other	697,469	0.6%	428,993	0.4%
Blue Cross	6,406,675	5.2%	6,216,344	5.8%
Self Pay	2,157,665	1.8%	2,126,698	2.0%
Total	123,041,648	100.0%	107,932,996	100.0%
Outpatient	**Revenue**			
Medicare	25,564,673	35.5%	21,723,290	34.8%
Medicaid	3,434,542	4.8%	3,170,689	5.1%
Workers' Compensation	1,577,624	2.2%	1,338,974	2.1%
Commercial	2,632,861	3.7%	2,549,689	4.1%
Champus	670,903	0.9%	629,172	1.0%
HMO/PPO	25,571,206	35.5%	24,001,358	38.4%
Other	81,463	0.1%	2,542	0.0%
Blue Cross	10,867,280	15.1%	7,834,216	12.5%
Self Pay	1,651,484	2.3%	1,258,520	2.0%
Total	72,052,036	100.0%	62,508,450	100.0%
Total	**Revenue**			
Medicare	106,205,400	54.4%	91,011,414	53.4%
Medicaid	14,279,538	7.3%	12,183,892	7.1%
Workers' Compensation	2,023,989	1.0%	3,673,840	2.2%
Commercial	11,906,871	6.1%	6,726,940	3.9%
Champus	875,430	0.4%	999,015	0.6%
HMO/PPO	37,940,421	19.4%	37,979,032	22.3%
Other	778,931	0.4%	431,535	0.3%
Blue Cross	17,273,955	8.9%	14,050,560	8.2%
Self Pay	3,809,149	2.0%	3,385,218	2.0%
Total	195,093,684	100.0%	170,441,445	100.0%

Table 1.10. Payer Mix
For Periods Ended December 31, 2006 and 2005 (*Continued*)

YTD 12/31/06	% to Total	YTD 12/31/05	% to Total	YTD 12/31/06	% to Total	YTD 12/31/05	% to Total
Admissions				**Patient Days**			
2,776	68.1%	2,575	66.1%	19,426	69.5%	18,297	66.3%
391	9.6%	294	7.5%	2,357	8.4%	1,958	7.1%
19	0.5%	32	0.8%	106	0.4%	1,007	3.6%
148	3.6%	137	3.5%	2,358	8.4%	1,255	4.5%
13	0.3%	12	0.3%	(2)	0.0%	76	0.3%
416	10.2%	500	12.8%	2,052	7.3%	2,833	10.3%
17	0.4%	24	0.6%	174	0.6%	116	0.4%
212	5.2%	232	6.0%	1,057	3.8%	1,589	5.8%
82	2.0%	92	2.4%	404	1.4%	474	1.7%
4,074	100.0%	3,898	100.0%	27,932	100.0%	27,605	100.0%
Registrations				**Visits**			
16,827	34.2%	15,934	33.7%	20,670	32.1%	20,333	32.5%
3,801	7.7%	3,139	6.6%	4,183	6.5%	3,609	5.8%
2,233	4.5%	1,244	2.6%	3,488	5.4%	2,174	3.5%
2,000	4.1%	1,782	3.8%	5,278	8.2%	2,162	3.5%
222	0.5%	232	0.5%	238	0.4%	258	0.4%
15,541	31.6%	16,960	35.8%	17,410	27.0%	19,342	31.0%
20	0.0%	5	0.0%	20	0.0%	5	0.0%
5,883	12.0%	5,166	10.9%	7,226	11.2%	6,436	10.3%
2,623	5.3%	2,861	6.0%	5,963	9.2%	8,152	13.0%
49,150	100.0%	47,323	100.0%	64,476	100.0%	62,471	100.0%

Statement of Owner's Equity or Fund Balance

Another standard financial statement is the statement of owner's equity or fund balance. This statement provides a detailed account of the equity balance at the beginning and the end of the reporting period. The net income or loss (excess of revenues over expenses, in the case of a not-for-profit organization) is often the most significant transaction on this financial statement. Net income increases equity on the balance sheet, whereas net losses decrease equity. The statement of owner's equity or fund balance is reviewed by senior leadership and the board. Most organizations do not use this financial statement at the departmental level.

Statement of Cash Flows

The final financial statement is the statement of cash flows. This statement identifies the sources and uses of cash in the organization. The statement of cash flows must tie to the cash balance reported on the balance sheet. Although this statement is useful for senior leadership and the board, it is not typically used by the department leaders.

Statistical Analysis and Key Operating Indicators

Hospitals are driven by statistical analysis. Nearly every clinical department maintains statistical indicators that reflect the quality, efficiency, or effectiveness of the services they provide. Hospital finance is no exception. Table 1.8 is an example of a typical key operating indicators report that measures a facility's financial performance. Table 1.9 is a listing of the definitions, including calculations, for many of the key indicators.

Key financial indicators allow benchmarking comparisons with other facilities of different patient and service mixes. Many of these indicators are available for a specific department, thus allowing for detailed comparisons between departmental operations both inside and outside the organization.

One additional statistical report that is often reviewed by management is the payer mix of the hospital. Payer mix can be based on admissions or cases, patient days, or revenues. Table 1.10 is a typical payer mix report.

Conclusion

Understanding the relationships between accounts and the financial implications of operational decisions is an essential role of the department leader. Managing yearly trends, keeping current operations in line with budget expectations, and understanding future opportunities require clinical department leaders to be savvy financial professionals as well. The remainder of this book will explore many of these basic financial concepts in-depth, providing a greater understanding of the crucial role the pharmacy director plays in hospital finance.