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Uniform Accounting for Hospitals

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There are 6,500 hospitals in the United States—and nearly as many systems of hospital accounting. During the past two years a committee of the American Hospital Association has been at work to establish uniform definitions of hospital terms and a uniform classification of accounts. The committee completed a report in May of this year, which is available to hospital executives, trustees and accountants at the headquarters of the association in Chicago. The present article is intended to outline briefly the scope and purpose of the report of the committee, of which I was chairman.

Hospital care costs money. In this respect, hospitals resemble private industry, and each hospital resembles all others. Sources of revenue vary greatly—likewise the proportionate amounts and sources of capital investment. But control of salaries, supplies and miscellaneous services involves methods not dissimilar to those employed in factories, mail order houses or schools. Consequently, the committee gave first attention to a uniform classification of expenses.

As the basis for classifying operating expenses, the committee recommended the departmental organization of the hospital, with such categories as administration, dietary, housekeeping, medical and surgical service, etc. The classification, as set forth in exhibit "B" resembles other accepted classifications known to hospital administrators. The committee, however, made a special effort to establish mutually exclusive categories of expenses, so that salaries and supplies could be charged to the various accounts uniformly, regardless of the size of the hospital.

The classification of accounts and the manual are intended to serve the medium-sized hospital, with a bed capacity of approximately 100. Larger institutions will need to expand the categories to allow for extensive and complete departmentalization. Small institutions, on the other hand, will probably find it desirable to combine some of the accounts.

The committee was particularly concerned with the integrity of the class of accounts which is designated as "operating expenses"

and has to do with the provision of hospital care to patients. These accounts are not affected by the hospital's financial structure or the laws of the state in which the hospital operates. Hospital operating expenses include salaries, supplies, miscellaneous services and depreciation of fixtures and equipment for hospital care. The term "non-operating" expense is applied to interest expense, depreciation on buildings and taxes.

Administrators and accountants will ask immediately why these important items of cost were excluded from the operating expenses. The answer is that the committee had in mind the comparative use of expense data for different institutions, as well as the use of the accounts for internal administration. No member of the committee would argue that interest, depreciation and taxes are not "expenses" of hospital services. In fact, it has been the neglect of these items in hospital financial policy that has suggested the need for isolating them in the hospital accounts. Otherwise, they may be forgotten by the administrator, through failure to record them, or give rise to incomparable data through non-uniform methods of handling.

Some hospitals have large debts. Others have none. The debts and lack of debts are often the result of good fortune or public policy, rather than business acumen or efficiency. Comparative data should be prepared with a uniform treatment of the item of interest. For one hospital to include an amount of "$1.50 per patient-day" as the interest paid on capital indebtedness may void any attempt to compare its operating efficiency with that of other institutions.

To argue for inclusion of interest expense by those institutions which have no indebtedness would have raised the theoretical argument of "interest as a cost" as well as confused many superintendents and hospital accountants in their bookkeeping procedures. Moreover, there would still be the question in comparative data as to whether an interest "allowance" were too large or too small and whether it had been included or excluded. The committee felt that uniformity could be achieved by omission of interest from the "operating expense" and regularly classifying it as "non-operating expense." In this way it can be identified and included as a separate item when desirable.

The method of dealing with depreciation, that is, classifying it as "non-operating" expense, was also dictated by the need for uniformity in comparative data. Most hospital capital has been

provided on a non-profit basis, that is, through taxation or voluntary contributions. Custom and confused thinking about hospital finance have led hospitals in the past to ignore the economic significance of capital investment. Some institutions have kept records of the estimated allowances for depreciation, but very few have established funds for the replacements of buildings, except when compelled to do so by the requirements of bond holders. Depreciation on buildings has been entirely excluded from the thinking of most hospital administrators and trustees and also from the accounting records of most hospitals.

The suggestion that depreciation on buildings be classified as "non-operating expenses" is not a step backward. It is a step forward. In the past, depreciation on buildings has been almost uniformly omitted from hospital records, with a few exceptions which destroyed the comparability of data from different institutions. The recommended procedure will, it is hoped, encourage hospitals to keep records of building depreciation. Depreciation represents the use of important economic values which are enjoyed currently, even though provided once and for all by taxpayers or contributors. Building depreciation is an item of hospital expense. There can be no argument on this point. But the committee recommended classifying it as "non-operating expense."

Depreciation of fixtures and equipment has ordinarily been treated as "operating expense," to be met through patients' fees or other forms of current income. The word depreciation will seldom be found in hospital accounts; but the fact of depreciation is recognized by the custom of charging the costs of replacements of fixtures and equipment among the operating expenses. The committee recommends that regular allowances be made for the depreciation of fixtures and equipment and that purchases of new fixtures and equipment be capitalized.

A word about taxes:—In all but three states "non-profit" hospitals are exempt from taxation even though earnings exceed taxation. Proprietary hospitals, on the other hand, must pay taxes even though they operate at a loss. In the interests of comparability, it is recommended that taxes be separately classified among the non-operating expenses.

The report includes a classification of balance-sheet items and a sample balance-sheet with three subdivisions: current funds, investment funds (endowments) and plant funds. In the past,

the hospital world has kept little record of the permanent assets, even though the capital investment of the average 100-bed hospital approximates half a million dollars. In a study of the capital investment in American hospitals, which exceeds three billion dollars, I have found many instances where plant and equipment valued at several million dollars were given no record in the double-entry accounts. The committee recommends that appropriate records be kept of all assets, whether they be vegetables, corporation bonds or permanent buildings and whether received from taxes, gifts, bank loans or private investment. In the recommendation of a hospital balance-sheet, this report may be said to break new ground in hospital accounting.

The committee recognizes that present-day trends in hospital care have changed the hospital from a dormitory or hospice to a complex professional workshop. Consequently, the classification of income and expense accounts must be adapted to reflect this situation. There is no one unit of hospital service which adequately describes the varied activities of a hospital. In the wards or rooms, the patients receive service by the day, which includes bed, meals, general nursing and certain other services. In the operating room, x-ray department, pharmacy or clinic service is not rendered in terms of days but in terms of operations, films, treatments, prescriptions or visits. The committee recommends, therefore, that unit-costs be expressed in terms of the most significant unit of hospital service, rather than according to a single inclusive service.

The foregoing recommendation means that less emphasis shall be placed upon the value cost-per-patient-day or, as it is variously called per-diem cost or per-capita cost. Cost-per-patient-day is the most widely discussed, most abused and least understood of all financial units of hospital activity. This cost-unit should be used with care and a realization of its limitations. Cost-per-patient-day, even when calculated on a uniform basis, is not an adequate index of hospital efficiency. Many factors, such as percentage of occupancy, local price and wage levels, amount and kind of capital investment, scope and complexity of professional services, are not under the control of the administrator. Within limits, cost-per-patient-day can be adapted to the needs of hospital administration, and the committee recommends the following rules which will make it possible for the results to be compared among hospitals and for different periods of time.

1. Use only operating expenses as the basis for comparative costs. Exclude all interest, building depreciation, taxes and expenses of non-hospital services. These excluded items are expenses but not for the purposes of calculating costs-per-patient-day for comparisons.

2. Use only in-patient expenses as the basis for costs. Exclude the expenses of all services to out-patients or private ambulatory cases.

3. Exclude the number of new-born-infant days from calculations. This means that a somewhat higher unit cost would result than if infant-days were included on the same basis as adults and children. In the case of a hospital with a very active maternity service, the average cost-per-patient-day would be greatly affected by the inclusion or exclusion of infant-days. Some administrators may wish to calculate the cost-per-patient-day both with and without infant-days, but they should indicate clearly which method has been used in each case.

4. So far as possible, the costs of "day-rate-service" should be determined separately from the costs of the other professional services. This recommendation is not to be considered mandatory.

The committee report contains six parts, which are not all of equal interest or importance to each administrator or accountant. Part I, the introductory statement, explains the scope and purpose of the committee's activities. Part II includes some suggested sample financial summaries and statistical tables. Part III is the uniform classification of financial accounts. Part IV contains a list and definitions of hospital facilities and services. Part V deals with special problems of business procedure, such as the handling of cash, transactions with patients and cost analysis. The final section, part VI, gives a detailed list of hospital supplies and equipment with the expense accounts to which they are to be charged at time of use or replacement.

The report is not perfect. It will not serve every purpose of hospital administration. Each administrator or accountant will find it necessary to adapt the manual to his particular needs. Uniform accounting and statistics, however, should enable an institution to express its individuality more effectively through making the description of its activities more intelligible. The following exhibits are included as parts of the committees report, pages 20–23 inclusive.

Exhibit "A"

BALANCE-SHEET—LOCAL GENERAL HOSPITAL

December 31, 19—

Assets			*Liabilities, reserves, capital*	
		Current funds		
Cash		$ 2,000	Accounts payable	$ 2,700
Accounts receivable—patients	$ 15,000		Notes payable	400
Notes receivable—patients	1,200		Accrued salaries and wages	410
Other accounts and notes receivable	2,040		Other current liabilities	260
	$ 18,240		Total	$ 3,770
Less—reserve for bad debts	4,800	13,440		
Supplies and materials (inventories)		6,200	Working capital	18,720
Prepaid expenses		850		
Total		$ 22,490	Total	$ 22,490
		Investment funds (endowments)		
Bonds, stocks and other securities		$ 41,000	Investment fund capital	$ 43,600
Real estate		2,600		
Total		$ 43,600	Total	$ 43,600
		Plant funds		
Land		$ 15,000	Bonds and mortgages payable	$150,000
Buildings	$450,760		Other plant liabilities	16,000
Less—reserve for depreciation	29,240	421,520	Plant capital	304,390
		$436,520		
Fixtures and equipment	$ 62,380			
Less—reserve for depreciation	28,510	33,870		
Total		$470,390	Total	$470,390

Exhibit "B"

SUMMARY STATEMENT OF INCOME AND EXPENSE
LOCAL GENERAL HOSPITAL
Year ended December 31, 19—

Net income from patients (exhibit C)			$109,810
Operating expenses:			
Administration		$11,400	
Dietary		25,200	
Household and property			
Housekeeping	$ 8,400		
Laundry	7,500		
Heat, light, power, water	11,100		
Maintenance and repair	4,350		
Motor service	2,800		
Depreciation of equipment	6,140	40,290	
Professional services			
Medical and surgical service	$14,000		
Nursing service	15,220		
Medical records and library	2,100		
Social service	2,200		
X-ray service	2,400		
Laboratories	1,800		
Other special services	2,000	39,720	
Total			$116,610
Excess of operating expenses over net income from patients			$ 6,800
Non-operating income:			
Net income from non-hospital service		$ 650	
Individual contributions	$ 1,400		
Community chest	3,650	5,050	
Interest and dividends		2,245	
Income from county government		2,730	
Total		$10,675	
Non-operating expenses:			
Interest on short-term loans	$ 280		
Interest on long-term loans	3,130	$ 3,410	
Excess of non-operating income over non-operating expense			$ 7,265
Net gain for year			$ 465

Exhibit "C"

NET INCOME FROM PATIENTS
LOCAL GENERAL HOSPITAL
For year ended December 31, 19—

Gross earnings from hospital service		
Day rate service		$ 83,000
Special professional services:		
Operating room	$15,200	
Delivery room	3,600	
X-ray service	11,400	
Laboratories	3,900	
Physiotherapy	1,840	
Other special services	3,120	39,060
General OPD Services		2,500
Total		$124,560

Deductions from gross earnings		
Courtesy allowances	$ 2,330	
Charity allowances	5,590	
Transfers to income from county (exhibit B)	2,730	
Allowances for bad debts	4,100	14,750
Net income from patients (exhibit B)		$109,810

Exhibit "D"

COST-PER-PATIENT-DAY

Total operating expenses for in-patient service (see exhibit "E")		$103,755
Number of in-patient days	$26,508	
Number of infant days	1,914	
Cost-per-patient-day (excluding infant days)		$3.91
Cost-per-patient-day (including infant days)		3.65

NOTE.—The figures for cost-per-patient-day shown above include both the day-rate service, provided patients by the day or week, and the various special professional services received by in-patients, such as operating room, delivery room, x-ray, laboratory and physiotherapy.

Exhibit "E"

APPORTIONMENT OF OPERATING EXPENSES BETWEEN SERVICES TO IN-PATIENTS AND OUT-PATIENTS

For year ended December 31, 193—

Account number and title	Total	In-patient service	Out-patient service
General administration	$ 11,400	$ 10,730	$ 670
Dietary	25,200	24,400	800
Housekeeping	8,400	7,740	660
Laundry and linen	7,500	6,400	1,100
Heat, light, power, water	11,100	10,200	900
Maintenance and repair	4,350	3,900	450
Motor service	2,800	2,500	300
Depreciation of equipment	6,140	5,200	940
Medical and surgical service	14,000	12,380	620
Nursing service	15,220	13,020	2,200
Medical records and library	2,100	1,700	400
Social service	2,200	1,600	600
X-ray	2,400	1,600	800
Laboratories	1,800	1,200	600
Other special services	2,200	1,185	815
Total	$116,610	$103,755	$12,855

NOTE.—The data for this exhibit do not appear in the double-entry records. It is a "work sheet," prepared only when a statement of income and expense is presented; for example, quarterly or semi-annually.