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Changing Concepts in Hospital Accounting

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During the formative years in the development of hospital accounting procedures, hospitals tended to adhere to the accounting principles prescribed for "non-profit institutions." These principles differed in many respects from those established for commercial enterprises. Among the more notable differences, representing practices followed by many non-profit institutions but not generally found in commercial enterprises, are:

- Use of fund accounting
- Adherence to the cash basis or modified accrual basis of accounting
- Failure to record depreciation on fixed assets

CONTRASTING THEORIES AND PRACTICES

The question of whether to provide for depreciation of fixed assets in non-profit institutions has long been the cause of much controversy, particularly in the area of hospital accounting. In 1933, Herbert R. Sands made the following remarks in addressing the New York Conference on Hospital Accounting:

> Depreciation is a current expense and is continuous throughout the useful life of the property. But as applied to hospital buildings, it is an expense which has to be paid only once in, say, a generation. Inasmuch as most hospitals are in reality non-profit organizations, finding it difficult to obtain sufficient current income to cover current expense, and therefore ending the fiscal year with a deficit, it is not desirable or necessary to increase the deficit by appropriating any part of the current income as provision for replacement of buildings when they shall have worn out or become obsolescent. As past and present generations have provided existing hospital buildings, it is both fair and financially sound to let following generations make similar provision.

While this would appear to have been a fair statement at the time it was made, it does not reflect the financial situation to be found in most hospitals today.

In 1953, twenty years later, Lloyd Morey, then acting president of the University of Illinois and a well-known institutional accounting authority, wrote as follows in *The Modern Hospital:*

1) Depreciation accounting along customary commercial lines is not appropriate for non-profit hospitals because the functions of such accounting are to distribute costs over useful life and recovery of expenditures, and since costs have not been provided by those who own and operate the hospitals, it is not appropriate that they be included in the accounts.
2) Depreciation has no relation to current values and current values have no significance in non-profit institutions; hence, any attempt to reduce the book value by amount of depreciation is meaningless.
3) Depreciation has a usefulness for rate making, but the procedures recommended by the American Hospital Association committee are not such as to provide a consistent and logical accounting of it as an element of cost.

Mr. Morey went on to say in his article:

I am opposed to a bookkeeping charge of depreciation, unless a corresponding amount of cash is set aside from current funds to be available for future replacement expenditures. Particularly unsatisfactory is the plan of depreciation accounting in which the item is entered as an expense and then offset by a fictitious credit through reduction of the account for investment in plant, leaving current surplus unaffected by the depreciation entry. No precedent in any kind of accounting will be found for such a procedure, and no beneficial result can possibly accrue from it.

We have in this statement issued seven years ago, a rather strong denunciation of depreciation accounting as it is practiced by the majority of hospitals today. While there is much to be said for the theory on which Mr. Morey's opinions are based, the preponderance of thinking appears to lean in the opposite direction, probably in recognition of the fact that the test of any particular accounting procedure is the usefulness of the information presented to those who have a legitimate interest in it. This theory of usefulness was specifically recognized by the American Institute of Certified Public Accountants in the following pronouncement issued in 1946:

> Financial accounting is still in the process of evolution. Out of a study and comparison of methods evolved to meet varying needs in different fields, there should emerge principles, procedures, and forms of presentation that will make accounting in all fields more useful for the purposes which it is designed to serve. . . .

A number of study groups have considered the accounting problems of hospitals and have recommended procedures designed to achieve uniformity in hospital accounting. In 1922 the American Hospital Association developed a manual on hospital accounting, which has undergone revision from time to time, the latest one having been issued in 1959. This publication contains the following remarks on the subject of depreciation:

> Depreciation of hospital buildings and equipment should be recognized as an element of hospital expense. The depreciation in value of buildings and equipment represents a real cost of hospital service, even though such assets may have been contributed originally to the hospital and even though no cash or other funds are set aside to replace such assets.

Further support of this line of thinking can be found in the Accountants' Handbook, an authoritative publication, which comments as follows:

> The emphasis on cost analysis, control, and rate setting in recognition of cost of providing service has caused the recognition of depreciation on plant assets with an expected service life of longer than five years to be generally recommended procedure (in hospital accounting). Equipment with an expected service life of less than five years should be accounted for at cost on an inventory basis.

The editor then goes on to say:

> Although the fund concept is recommended in hospital accounting, the recording of depreciation entries violates a basic principle of this procedure, namely that each fund is a completely separate and independent accounting entity.

This latter is in recognition of the often heard complaint of accounting theorists that where hospital depreciation is not "funded" the effect of depreciation entries is to charge operations and credit surplus in the current funds section, and to charge plant-funds principal and credit the depreciation reserve in the plant-funds section. This is admittedly

true, but hospital accountants, reverting to the aforementioned principle of usefulness, have concluded it is more important that the operating statement reflect depreciation, even though the depreciation provision may be offset by a credit to the current funds surplus account. This position is based in part on the desire to present cost figures that are comparable with those of other hospitals and to give recognition in the operating statements to all costs for which reimbursement is being sought.

DIFFERENCES IN FINANCIAL PURPOSE

A basic difference exists between the financial purposes of hospitals and those of other types of non-profit institutions on which the early beginnings of hospital accounting were based. A hospital renders services for which it charges fees, and, although ultimate collection is based on ability to pay, the current trend in the majority of instances is that these fees are collected. Consequently, accurate determination of the cost of rendering services is necessary to the establishment of fair rates to be billed for such services, particularly where third-party reimbursement is concerned. A further difference between hospitals and other types of non-profit institutions is the thought in the minds of many that future generations will not be willing or able to make voluntary contributions to hospitals in sufficient amounts to provide the plant replacement required to maintain the desired level of service. In most voluntary hospitals today the widespread acceptance of hospitalization insurance and the increased use of hospital facilities by the paying public has brought about a situation where patient income is the major source of revenue. This increasing emphasis on income from patients has paved the way for the introduction in hospitals of accounting procedures that resemble more nearly the practices followed by commercial enterprises. Government agencies as well as most medical insurance plans have come to recognize depreciation of buildings as an allowable item of cost in arriving at rates to be paid to hospitals for the services they render.

RECOGNITION OF DEPRECIATION

AHA POSITION

As a result of these developments, the American Hospital Association, as previously mentioned, has been among the leaders in recommending that hospitals recognize depreciation as an element of cost. Their concurrent recommendation on the use of the accrual basis has

led to the adoption of depreciation and accrual accounting by a sufficiently large number of hospitals as to establish their recognition as generally accepted accounting principles for such organizations.

AICPA STATEMENT

The matter of generally accepted accounting principles for nonprofit organizations is discussed by the American Institute of Certified Public Accountants in its Statement on Auditing Procedure No. 28, issued in 1957, which states in part (and this is an approximate quotation):

> . . . the statements of a nonprofit organization may reflect accounting practices which differ in some respects from those followed by business enterprises organized for profit. In those areas where the auditor believes generally accepted accounting principles have been clearly defined (as indicated by authoritative literature and accepted practice, etc.) he may state his opinion as to the conformity of the financial statements either with generally accepted accounting principles, or (alternatively, but less desirably) with accounting practices for nonprofit organizations in the particular field; in either event it is assumed that the auditor is satisfied that the application of such accounting principles and practices results in a fair presentation . . . or that he will state his exceptions thereto.

LITERATURE AND PRACTICE

Thus the independent auditor must assume responsibility for determining whether generally accepted accounting principles have been clearly defined for a particular type of activity, such determination to be based on the existence of authoritative literature defining practices considered acceptable. And further, he has the responsibility to determine whether such principles shall have become generally accepted in practice through the adoption, by a large majority of those in the particular field, of substantially all the recommendations contained in the literature.

It is generally conceded that the American Hospital Association and others have prescribed for voluntary hospitals standards of accounting acceptable to many hospitals; such standards are in agreement concerning depreciation and accrual concepts with principles of accounting generally accepted for the use of business enterprises or-

ganized for profit. It should be noted that the recommendations relating to depreciation contained in the authoritative literature on hospital accounting have not yet been accepted in practice by some non-profit hospitals. Generally the hospitals not yet putting these principles into practice are the ones still anticipating that since the present hospital plant was derived from charitable contributions, future additions or replacements will be provided from similar sources. Inasmuch as literature and practice are not in complete harmony, the independent auditor must exercise judgment in reporting on the fairness of financial statements of hospitals. There are several alternatives that could be appropriate under varying circumstances:

1) Since the recommended accounting procedures for hospitals are essentially the same as those generally accepted for business organized for profit, financial statements of hospitals *that follow the recommendations of the American Hospital Association* may be said to be "in conformity with generally accepted accounting principles."

2) Where the accounts are maintained on the accrual basis except that depreciation has not been provided and the circumstances indicate that depreciation should have been recorded the independent auditor might state, ". . . except for the omission of provision for depreciation of property, the accompanying statements present fairly in conformity with generally accepted accounting principles. . . ."

3) In a similar situation where the independent auditor feels that the omission of the depreciation provision is appropriate (as in the case of government supported hospitals or one that consistently relied on charitable contributions for plant replacements) the following might be appropriate:

> In accordance with practices common to hospitals which rely upon government support, charitable sources, etc. for capital improvement, the hospital keeps its accounts on the accrual basis and does not provide for depreciation of its basic hospital plant.
>
> . . . the accompanying financial statements present fairly . . . in conformity with the above-mentioned basis. . . .

ACCOUNTANT'S REPORT

EFFECT OF SPECIALIZATION

It is generally recognized that the increase in medical knowledge has led to a great deal of specialization in medical practice. The rather

sudden application to hospitals of specialized business knowledge appears to have followed the same sectionalized pattern. Thus the functions of a hospital are an aggregation of specialties without strong integration. The importance to the accountant of these characteristics of hospital organization is that no strong line of authority and accountability exists around which to build a control mechanism. The accountant must therefore supply detail to strategic points and analyze the transactions for exceptions to established practices. He must produce reports that are not complex so as to encourage their use by non-accountants, yet he is required to supply a large volume of necessary information, which he must do through the extensive use of original transaction documents.

PRINCIPLES AND OBJECTIVES

Within this framework, certain principles and objectives have been evolved.

- Income from patients, and expense, should be accrued on a monthly basis. Hospitals may eventually change to a weekly basis for control purposes but this change does not appear to be imminent. Allowances and adjustments are not accrued because they generally cannot be determined before the discharge of the patient. All income from patients is strictly accrued within the month when the services were rendered.
- Supplies from stores are charged in the month in which they are received by the departments and no departmental inventories are taken except for food in the main kitchen and fuel where that is a material item.
- Receipts of goods or services should be charged in the month in which they are received.
- Salaries are accrued to the last day of the month.
- Monthly provision is usually made for bad debts and for depreciation.
- Income from investments is usually estimated and pro-rated equally over each month, as are contributions from the Community Chest and similar sources. A more logical approach would be to use a monthly budget that anticipates such supplementary income, and to record the actual receipts in the month in which they are received.

FUNCTION CYCLES

The functions of a hospital have a weekly and an annual cycle. The cycles of income and expense have an annual relationship. The factors of operation should be individually judged each month. This judgment is more readily accomplished by changing to thirteen four-week accounting periods or, alternatively, to two four-week months followed by a five-week month each quarter. The month just referred to will then be either a four-week period or a five-week period as concerns transactions affected by the weekly cycle.

DESIGN OF ACCOUNTING SYSTEM

The inability to measure transactions precisely in a hospital makes it necessary to retain their identity to the point immediately preceding their entry in the accounts. Consequently, greater detail is necessary in hospital accounting than in business accounting. The extraordinary detail required makes it desirable to design books of account that will produce the data in the form in which they are needed and to use the books themselves as reports wherever possible. In order to accomplish this purpose, two objectives are sought:

- Elimination of intermediate bookkeeping.
- Conveyance of information to the administrator through the original documents of transactions. (If this is not practical, then the information should be conveyed through books of account designed in report form.)

This system visualizes the use of report strips designed to present every account in general use as prescribed in the AHA manual. These strips should be kept in a post binder and arranged in such a way that the figures for each month and cumulative figures are visible. The following report strips could be used:

Trial balance—balance sheet
Income statement
Total operating expense
Operating expense detail, i.e.,
    Salaries and wages
    Supplies and expenses
    Other expenses, etc.
Total income from patients
Details of patient income by type of accommodation

Figures on the detail report strips should be obtained directly from summaries of the original transactions for the period. The detail income and expense strips are then summarized on the total income and expense strips from which general-ledger postings can be made.

While this example may be oversimplified, it is intended to bring out the point that like transactions should be summarized to the greatest extent possible before being posted to the general ledger. By this means much of the administrative problem created by the large volume of detail transactions that must be processed can be overcome.

STATISTICS IN COMMON USE

Report strips can also be used to compile statistical data. The following statistics are in common use by hospital accountants:

- *Cost per Patient-Day.* The average daily expense applicable to in-patients usually is divided among private, semi-private, and ward. This is the most important and most widely used unit of performance measure in hospitals. It is developed by dividing each of the applicable departmental costs and expenses by the total number of patient-days in each classification. Both the expenses and the patient-days applicable to the newborn are usually excluded from the total cost per patient-day and made the subject of a separate group of statistics. Likewise, the per-visit cost of out-patients should be considered as a separate statistic.
- *Percentage of Occupancy.* Relation of total occupied-bed days to total available bed days. Where possible, this statistical data should be obtained by months for comparable hospitals and should be on the basis of private, semi-private, and ward, as well as on the basis of total accommodations.
- *Average Length of Stay.* Number of patient-days divided by number of admissions. These statistics should also be obtained for the private, semi-private, and ward categories.
- *Number of Employees per 100 Patients.* Relation of average number of hospital employees to each 100 patient-days. This is a highly important statistic, since payroll constitutes approximately 55 per cent of the average hospital's total costs and expenses.
- *Food Cost per Meal Served.* The prime food statistic is the food

cost per patient-meal served, representing the cost of raw food served to patients divided by number of patients' meals. The cost of meals served to employees is separately calculated on the same basis.

- *Patient Income per Patient-Day.* Total income received in payment of care of in-patients divided by number of in-patient days. These statistics also are further classified by their private, semi-private, and ward components.

Many hospitals also operate "pay" cafeterias for the use of certain employees, doctors, and visitors. A few hospitals operate full-scale restaurants. Where this type feeding operation prevails, statistics showing the ratio of raw-food cost to dollar sales are applicable.

The average receipt per clinic visit is also an important statistic.

INCOME AND OUTGO

The minimum financial objective of any hospital must be to acquire income equal to expected outgo. Hospital income may arise from several sources:

Charges for services rendered to patients;
Appropriations from governmental bodies;
Earnings from endowment funds;
Charitable contributions;
Tuition from student nurses; and so on.

Hospitals may also borrow money to meet expected outgo which includes the cost of day-to-day operations of the hospital (nursing, laundry, dietary, laboratories, pharmacy, etc.) plus replacement and expansion of hospital facilities.

A problem facing hospital administrations is the determination of the contribution of each element of income necessary to cover the expected outgo. Budgets and cost analysis are effective management tools that many hospitals are adopting to assure attainment of their financial objectives. In this respect hospitals have continued the trend toward administering their affairs in much the same way as any successful business.

REPORTING SYSTEM

It can readily be seen that cost information is useless unless

communicated to the individuals who need it. Budgeting and cost analysis, to produce the desired results, must be geared to an adequate reporting system. Although reports should be designed to meet the specific requirement of each organization, there are some rules of general applicability. Any report should—

- Be for a specific purpose, and should cover an activity of significance to the administrative level receiving the report.
- Be complete, simple, and concise.
- Compare actual performance with what it was reasonably expected to do.
- Accent exceptional performance.
- Segregate controllable from noncontrollable items so that the need for action is not obscured.
- Be distributed only to those who need it. Detail presented should be commensurate with need for detail. In order to determine just what information a specific official at a given level should have, the following general questions should be asked:
  a) What is the individual's area of responsibility?
  b) What decisions and appraisals is he required to make?
  c) What information does he need to make these decisions and appraisals?
- Be issued promptly, regularly, and at appropriate intervals.
- Be designed to flow upward along organizational lines.
- Distinguish generally between reports for planning and for appraisal of performance.

CONCLUSION

In conclusion I should like to reiterate: Developments of the last few years have resulted in establishing generally accepted accounting principles for hospitals that have been reflected in the literature prepared by the AHA and that have been followed in practice by a number of hospitals. These developments would appear to lay to rest many of the objections raised at the time certain of these principles were first announced. Even though not followed by all hospitals they may with confidence be said to be generally accepted accounting principles and should be recognized and followed.