

OHA DATABANK Manual

*Reporting Income Statement data to
the Oklahoma Hospital Association's
DATABANK Program*

databank.org

Last updated: June, 2013



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DATABANK PROGRAM REPORTING MANUAL

- INCOME STATEMENT -



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Overview

For many years hospitals have had issues, which require the need for data, but they lacked financial and statistical information to tell others about those issues or to know how their hospital compared to others.

As time went on, various organizations made attempts to collect data about the hospital industry. Unfortunately, the reporting requirements were oftentimes burdensome and the resulting information was very outdated.

In response to these considerations, the *Colorado Hospital Association* (CHA) Board of Directors established the **DATABANK** Program in 1985 to collect financial and utilization data from hospitals throughout the state. In addition to providing information to CHA with which to represent and advocate the interests of its member hospitals, one of the major considerations for the **DATABANK** Program was, and continues to be, that it provides data, which is informational and useful to the hospitals. The other major principles governing the Program are **timeliness, accuracy, completeness, simplicity** and **uniformity**.

Since its inception, the use of **DATABANK** information before a variety of audiences to influence policy-making has increased dramatically. CHA regularly provides aggregate **DATABANK** information to our Congressional Delegation elected and appointed state officials, the media, and general public on important issues such as adequate payment, Charity care and rural health care. In the spring of 1990, CHA released its first annual hospital-specific report from the **DATABANK** Program titled *Colorado Hospitals Reference Guide to Financial & Utilization Data*, demonstrating that Colorado hospitals are industry leaders in efforts to be publicly accountable. **DATABANK** has earned the reputation as **the** credible source of timely financial and utilization data in the State of Oklahoma.

As **DATABANK** continues to evolve to meet the challenges of a changing health care market, we look forward to working with you in to keep the **DATABANK** Program vital and provide you accurate and timely decision-making information. Each hospital's participation in the program is important and encouraged.

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Your Role as the DATABANK Contact Person

As the designated **DATABANK Contact Person** for your hospital, you play an important role in the success of the Program in your state!

Your responsibilities include, but are not limited to:

1. Completion of the **DATABANK** Input Form on-line in accordance with the instructions contained in this manual.
2. Submission of the **DATABANK** input form by the **25th of each month** following the reporting month.
3. Answering questions the hospital association may have about the data you submit. In some cases, you will be contacted by phone. Otherwise, we will contact you by E-mail.
4. Careful review of the reports, which are available to you on the **DATABANK** Web Site. The reports will be made available to all users who have valid user names and passwords to the **DATABANK** Web Site.
5. To carefully administer user names and passwords to the appropriate people within your hospital. Two levels of security are afforded to your hospital; your level allows you to perform the data entry and another level allows users to view the on-line reports.
6. To change your password on a regular basis. Tip: make your password a word not in the dictionary, i.e. "kr22dc4". Substitute numbers for vowels, a=1, e=2, I=3 etc.
7. Keep your hospital profile up to date with the most accurate information available.

We aim to make your participation in the **DATABANK** Program easy! If you have questions or suggestions, please call us or drop us an email. Please let us know how we can make **DATABANK** more useful for your organization. Once again, we appreciate your participation!

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Data Collection

It is easy to participate in **DATABANK**, and therefore to receive the useful information the Program provides. If you have Internet access, you will submit your **DATABANK** information to the **DATABANK** Web Site. If you don't have Internet access, you are encouraged to call your hospital association for advice on how to attain the necessary hardware, software and connection so that your hospital will be able to take advantage of all the benefits of submitting and reporting electronically.

Submitting Data

The **DATABANK** Input Form collects utilization and financial information from **the previous calendar month**. A copy of the **DATABANK** Input Form is provided on the web site for you to download.

IMPORTANT: The response deadline date will always fall on or around the 25th of each month. **To receive your reports on-line, you must submit the DATABANK information.**

To make it easy to participate, you may submit data via the web site. Please log on to www.databank.org. Then, complete the **DATABANK** Input Forms on the **DATABANK Web Site** (Utilization, Charges, Operating Expenses and Other Financial Data). You will be prompted for your user name (first initial of your first name, your last name followed by Oklahoma's state code, "ok", i.e. Mia Johnston would be mjohnstonok) and your password. **You must enter both your user name and password in lower case.**

Estimating Data

If information for a specific data element is unavailable at the response deadline, you are encouraged to **estimate** its value to the best of your ability. When the correct information is available, simply log on to the web site and correct the data.

Changes to previously submitted data can be made at any time during the calendar year and the change will be reflected in the month for which the correction applies. Peer group and ad hoc aggregations previously reported to providers will not be updated for the impact of the corrections. However, future quarterly and annual comparative reports will reflect any changes.

For many hospitals, the fiscal year end is December 31. Frequently, due to year-end adjustments, the financial statements for December are not prepared on the same schedule as other months. We recognize there may be annual fiscal year-end adjustments

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that could affect your December reports. However, it is extremely important that we have the December data, even without adjustments, reported by the regular time deadline in January.

What we suggest is this: submit December data including all adjustments that you are aware of at the time you prepare the **DATABANK** Input Form, as well as estimates of remaining adjustments. After your year-end audit is completed, log on to the **DATABANK Web Site** and correct the data, making the appropriate comments about this data being, "**DECEMBER-ADJUSTED**". Please remember that prior year corrections are not to be made after the prior year cut-off date.

Late Data

Timely data submission is essential to the success of the **DATABANK** Program. Data not received by the response deadline will not be included in the reports every hospital in the state reviews for that month, thereby skewing the database. Keeping **DATABANK** valid and statistically significant is in everyone's best interest. You can help by submitting your data in a timely manner.

If your **DATABANK** information is not submitted via the web site or faxed to the association, an association representative will call the hospital **DATABANK Contact Person** for the information. If the data is not available at that time, the association will not be able to produce your summary and peer group reports for that month until it is received. An e-mail stating that the information was not received will be sent to the users in your hospital stating that statistical output for that time period will be unavailable on the web site until the information is provided to the database.

It is very important to submit your data - *even if you miss the response deadline*. By submitting the information after the deadline, you will be allowed to access the available reports. **A complete, accurate and timely database is in everyone's best interest!**

Data Review – Soft Errors

There are many reports on the **DATABANK** Web Site that give you feedback on the accuracy of the data submitted. As you enter data on-line or using the Excel Upload Template, you are given feedback via "**soft errors**." Soft errors are calculated using an average of the last 12 months (not including the month you are submitting) and this is compared to the standard deviation. If it exceeds 5 standard deviations, a soft error is generated and displayed to the user when the submit button is clicked. Then, you have the opportunity to review the soft error and make any adjustments as necessary. Another report that is helpful during the process is the **Edit/Review Report**. This allows you to verify the accuracy of the data you have submitted to the **DATABANK Web Site** compared to what you have submitted for previous months. *Please note that a prior month is required to run this report.*

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However, if you use the soft error system to its potential, you are reviewing your data as you input it into DATABANK and may not need to run the Edit/Review Report.

Please remember, it is your responsibility to submit accurate and complete data. Also, please review the data for general reasonableness and accounting sense. Appropriate relationships between data elements and percentage changes from the prior month should be examined. If you detect obvious errors during your review process, go back to the section that contains the error and correct the data. The data is immediately updated and you can then run new reports with the updated information.

Corrections can be made at any time during the calendar year. The reports will always be kept current and accurate.

Reports

All reports are offered for you to download from the **DATABANK** web site. Please keep two important points in mind when requesting a report from the **DATABANK** web site:

1. Reports that display your hospital's data (no peer group information) can be viewed immediately, as long as you have supplied the requested data. These reports are:
 - **Dashboard Report**
 - **Edit/Review Report**
 - **Trend Report**
 - **Accumulation Report**
 - **Statement of Operations Report**
2. Reports that include peer groups can be viewed when the threshold for the peer group has been met. If the report displays "N/A" the threshold has not been met. If you have questions about the threshold levels for peer groups, your state hospital association can answer your questions.

Dashboard Report – This one page report shows your data compared to data for four peer groups. Keep in mind that peer group data is averaged.

Monthly Report – Displays hospital and peer group data. The report reflects the current month's hospital data and peer group data for that month. This report can also be produced in a year to date format, up to twelve months.

Comparative Reports are also available for download. These reports compare 1st Quarter of the current year to the 1st Quarter of the prior year, for example. Or, these reports could compare the current year to the prior year.

The data items and calculated indicators that are reported are the identical to those contained on the **Monthly Report**.

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Please note that to be included in a year to date, **Monthly Report's Peer Groups**, the hospital must submit every month for the requested time period.

Similarly, a hospital must submit all six months of a Comparative Report's data, for example, three months from the current period and three months from the prior period.

A **Trend Report** is also available. The **Hospital Trend Report** shows the calculated indicators over time. This can display one month per column, three months per column or even as many as 12 months per column. The number of columns can also be specified. This is helpful if you wanted to run a quarterly report for just one year, you'd select 4 for the number of columns prompts and 3 for the number of months per column prompts. Finally, you have the ability to run a peer group Trend Report.

There are two reports that may or may not be displayed depending on your hospital association's preference. The **Missing Report** shows a list of hospitals that haven't participated and the **Participation Report** shows you a list of hospitals that have. A graphical **Participation Matrix Report** is also available. At a glance you can see which hospitals have been "good" and which ones haven't (this is also nicknamed the "Christmas Tree" Report because of the colors used to indicate participation and lack thereof.)

Oklahoma Hospital Association Matrix Participation Report												KEY		
Color Black and White													Income Statement and Balance Sheet submitted	
													Income Statement submitted	
													Income Statement in-progress	
													No Data submitted or in-progress	
	Jun 2012	Jul 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	Apr 2013	May 2013		
Councils: GOCHC														
Deaconess Hospital														
INTEGRIS Baptist Medical Center	B	B	B	B	B	B	B	B	B	B	B	B		
INTEGRIS Canadian Valley Hospital	B	B	B	B	B	B	B	B	B	B	B	B		
INTEGRIS Health Edmond	B	B	B	B	B	B	B	B	B	B	B	B		
INTEGRIS Southwest Medical Center	B	B	B	B	B	B	B	B	B	B	B	B		
Mercy Hospital El Reno	B	B	B	B	B	B	B	B	B	B	B			
Mercy Hospital Logan County	B	B	B	B	B	B	B	B	B	B	B			
Mercy Hospital Oklahoma City	B	B	B	B	B	B	B	B	B	B	B			
Midwest Regional Medical Center														
Norman Regional Health System	B	B	B	B	B	B	B	B	B	B	B	B		
Northwest Surgical Hospital														

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Peer Groups

Your hospital association will select the peer groups in which your data is aggregated. Each hospital's data will be included in:

- a) Statewide data
- b) The Applicable Medicare Payment Methodology (MPM) group - either Large Urban, Urban or Rural
- c) The applicable geographic peer group
- d) The applicable Operating Expenses Peer Group or Bed Size Peer Group.

The Monthly and the Comparative Reports display the calculated indicators for your hospital along with the indicators for each peer group in which your hospital's data has been aggregated. As an added feature, you also have the functionality to compare your hospital's performance to peer groups in which your data is not aggregated.

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Definitions and Instructions

Overview

The following definitions and instructions are designed to aid you in the completion of the **DATABANK** information. They are generally consistent with the **AICPA** Audit and Accounting Guide for Health Care Organizations (New Edition as of June 1, 1996), and generally accepted accounting principles. **DATABANK** reports are designed to provide useful information about hospital operations, and therefore certain elements of traditional reporting have been preserved, such as gross charges and deductions from revenue. We recognize that some hospital accounting and data collection systems may not be structured to comply precisely with these instructions. However, to the extent possible, we encourage you to conform to the definitions so that the resulting reports will be comparable and therefore, more useful to the hospital and other users of the data. We also encourage your feedback about the definitions and instructions. We consider this feedback in terms of needed modifications to definitions to promote usefulness of the data and comparability among hospitals and health systems.

Reporting Entity

Report **all operations of the healthcare enterprise** that have a common balance sheet (single or multiple hospitals and other health services within an integrated healthcare delivery system). Depending upon the structure of the healthcare enterprise, activities reported for **DATABANK** could include ambulatory providers, long-term care providers or other non-acute providers as well as medical office building operations. Depending on the nature of these activities relative to the direct patient care activities of the hospital, these activities could be classified as either operating or nonoperating.

Hospitals that are part of a larger system are encouraged to submit individual input forms. To the best of your ability, try to include your hospital's portion of corporate overhead support.

Levels of Care

Utilization and charge information should be reported separately for the levels of care specified below. (Contractual adjustments should be reported for acute care and all other.)

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Acute Care

Report inpatient and outpatient data for **all operations comprehended under the general acute care hospital license**, except for Swing-Bed and Distinct Part Unit activity (rehab, psych, and chemical dependency) which are separately certified by Medicare.

Swing Bed

Report data for operations, which are separately certified by Medicare and/or Medicaid as Swing Bed. This includes both skilled and custodial Swing-Bed care. Note that the skilled care is a benefit of the Medicare Program while custodial care is a Medicaid-only benefit.

Subacute/LTC (Long-Term Care)

This category is for all patient care that is not captured in the Acute Care, Swing Bed and Distinct Part Unit categories. It represents all operations comprehended under the separate **NCF (Nursing Care Facility) licensure**, and includes subacute, transitional, step-down, skilled nursing, and long-term custodial care.

Distinct-Part Unit (DPU)

This data element captures activity, which is separately certified by Medicare as Distinct Part. The term originates for those services that are exempt from the Medicare DRG payment system and includes rehab, psych, and/or chemical dependency.

Utilization Input Form

State Code:	OK	Hospital ID:	10645	Beds Avail:	0	Beds Avail in Profile:	25
Month:	May	Year:	2013	Beds Lic:	0	Beds Lic in Profile:	25

Please fill out all fields and hit the submit button at the bottom. You should use the tab key to move between fields. JavaScript must be turned on for this form to work properly.

1 Discharges	A Medicare	B Medicaid	C Self-Pay	D Worker's Comp	E Managed Care	F Commercial	G Others	H Total
1a Acute Care	0	0	0	0	0	0	0	0
1b Swing Bed	0	0	0	0	0	0	0	0
1c Subacute/LTC	0	0	0	0	0	0	0	0
1d DPU	0	0	0	0	0	0	0	0
1f Total	0	0	0	0	0	0	0	0

Data entry screen showing payers and levels of care.

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Payer Categories

Utilization, charge information, contractual adjustments, and gross patient accounts receivable are reported separately for the following payer categories:

Medicare

Report all Medicare activity including fee for service and managed care/risk contracting.

Medicaid

Report all Medicaid activity including fee for service and managed care/risk contracting.

Self Pay

This category represents patients with no proof of insurance, patients filing their own insurance claims, patients paying their own bill, Hill-Burton cases, charity cases, etc.

Workers Compensation

Report all Workers Compensation activity including fee for service and managed care/risk contracting.

Managed Care

(a.k.a. "commercial" managed care): Include HMO, PPO, and direct contracting where the patient is being "managed", other than the payer categories listed above (Medicare, Medicaid, Self-Pay, Workers Compensation). Managed is defined as an organized program to control the use of health services, designed to ensure the medical necessity of the proposed service and the delivery of the service at the most effective level of care.

Commercial

(a.k.a. "traditional" commercial): This category includes all indemnity insurance payment arrangements including non-managed care discount off charge arrangements.

Other

Report everything not reported in the above categories.

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Line item definitions/instructions:

UTILIZATION

Line 1 - DISCHARGES

An inpatient discharge is the termination of the granting of lodging in the hospital and the formal release of the patient (include patients admitted and discharged the same day). When a mother and her newborn baby are discharged at the same time, count one discharge. When the baby stays beyond the mother's discharge (boarder baby), count one discharge for the mother and another when the boarder baby is discharged. If a patient is discharged from an acute care unit and transferred to a Swing-Bed, there would be a count for acute discharge and another discharge from Swing-Bed when that occurs.

Line 2 - PATIENT DAYS

A patient day is the unit of measure denoting lodging provided and services rendered to inpatients between the census taking hours (usually at midnight) of two successive days. A patient formally admitted who is discharged or dies on the same day is counted as one patient day, regardless of the number of hours the patient occupies a hospital bed. For patients switched from observation to inpatient status, the patient day count should begin on the day the patient was officially admitted as an inpatient.

NOTE: Exclude newborn days (see definition 5) and outpatients in observation (holding) beds who do not meet Professional Review Organization (PRO) criteria for admission.

Line 3 - NUMBER OF INPATIENT SURGERIES

Record the number of operations performed on inpatients, (i.e., those who remain in the hospital between two census taking hours -- usually at midnight -- of two successive days.) Report each patient undergoing surgery as one surgical operation regardless of the number of surgical procedures that were performed while the patient was in the operating or procedure rooms. Include cesarean deliveries.

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Line 4 - NUMBER OF BIRTHS

Report the total number of live births in the hospital during the reporting period including cesarean deliveries that are counted as one surgical operation. Exclude fetal deaths and infants transferred from other facilities.

Line 5 - NUMBER OF NEWBORN PATIENT DAYS

Report the total number of days of care rendered to newborn infants, regardless of the **level** of care (i.e., routine, intermediate, or intensive). However, **exclude** days of care rendered to boarder babies as well as infants transferred from other facilities. Boarder babies are those that remain in the hospital after the mother has been discharged. Patient days for boarder babies and infants transferred from other facilities should be reported on line 2.

Line 6 - INPATIENT ADMISSIONS FROM EMERGENCY ROOM

Report the total number of Inpatient Admissions from the Emergency Room during the reporting period.

OUTPATIENT VISITS

Line 7 - EMERGENCY DEPARTMENT VISITS

Report the total number of patients seen in an emergency unit who are not later admitted as inpatients.

Line 8 - AMBULATORY SURGERY VISITS

Report surgeries performed on patients who are not admitted as inpatients. Each person on whom a surgical procedure occurs counts as one visit regardless of the number of surgical procedures performed during that visit. Include all outpatient operations whether performed in the inpatient operating rooms or in procedure rooms located in an outpatient facility.

Line 9 - OBSERVATION VISITS

Report the total number of observation visits that did not result in an inpatient admission. Observation is used for those patients whose condition requires assessment over time to establish the need for hospitalization. (If observation patients generate separate emergency room and/or ambulatory surgery visits, those visits should be counted separately).

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Line 10 - HOME HEALTH VISITS

Report the total number of home health visits if that service is defined as a hospital operation per the preamble of these instructions. If more than one intervention occurs during the visit (e.g. physical therapy and oxygen therapy and home health aide), count a separate visit for each.

Line 11 - ALL OTHER VISITS

Report all other visits not covered by the above line items. An outpatient visit is a visit to each organized outpatient care program by a person who is not an inpatient. Include in the other outpatient visit count **each appearance** of an outpatient in **each organized outpatient program** not otherwise reported on lines 7 through 10. **DO NOT** include the number of diagnostic and/or therapeutic treatments the patient received in the ancillary departments.

Example: A patient presents himself in the emergency room and receives a lab test and two X-rays. The patient is put in a holding bed for observation and ultimately goes home without being admitted. This generates four separate visits - one emergency room, one observation, and two all other visits (one for the lab department and one for the X-ray department).

Line 12 - TOTAL OUTPATIENT VISITS

The Total Visits is the sum of the visits reported on lines 7 through 11.

CHARGES

Line 13 - GROSS INPATIENT CHARGES - ACUTE

Gross inpatient charges are the sum of all charges made to acute inpatients for routine and ancillary services for the month, by payer category (defined on page 2), including patients treated under capitated contracts. It should be recorded on an accrual basis at the hospital's established rates including charges made to charity care patients. Do not reduce for discounts and/or allowances.

Line 14 - GROSS OUTPATIENT CHARGES - ACUTE

Gross outpatient charges are the sum of all charges made to outpatients for hospital ancillary and clinic facility (as differentiated from physician) services for the month, by payer category (defined on page 14). It should be recorded on an accrual basis at the

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hospital's established rates including charges made to charity care patients. Do not reduce for discounts and/or allowances.

Line 15 - SWING-BED CHARGES

Line 16 - SUBACUTE/LTC CHARGES

Line 17 - DPU CHARGES

Line 18 - (Not used)

Line 19 - HOME HEALTH CHARGES

Report total charges for the above levels of care, by payer category. They should be recorded on an accrual basis at the hospital's established rates including Charges made to charity care patients. Do not reduce for discounts and/or allowances.

Line 20 - TOTAL CHARGES

Total lines 13 - 19.

CONTRACTUALS

Line 21 - CONTRACTUAL ADJUSTMENTS - ACUTE

For inpatient and outpatient acute activity reflected on lines 13 and 14 above, report the current month's difference between the amounts charged based on the hospital's full established (gross) charges and the amount received and/or due from the payer. For capitation contracts, appropriate adjustments should be recorded so only the amount of contract revenue is reflected.

Line 22 - CONTRACTUAL ADJUSTMENTS - ALL OTHER

For all activity **other than** inpatient and outpatient acute (i.e., Swing-Bed, Subacute/LTC, DPU, and Home Health), report the current month's difference between the amounts charged based on the hospital's full established (gross) charges and the amount received and/or due from the payer. For capitation contracts, appropriate adjustments should be recorded so only the amount of contract revenue is reflected.

NOTE: All contractual adjustments should be reported on an accrual basis. Additionally, the contractual adjustments should be adjusted for retroactive cost report settlements, disproportionate share payments, lump sum payments, etc. in the period that the settlements occur.

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Line 23 - TOTAL CONTRACTUALS

Total lines 21 and 22.

Line 24 - CHARITY CARE

The dollar amount of free care, based on a hospital's full established rates, provided to patients who are determined by the hospital to be unable to pay either all, or a portion of their bill. Charity refers to self-pay accounts that the patient is unable to pay and should be recorded in accordance with the hospital's policy for identifying charity care.

Report this amount on a gross charge basis. Charity care write offs should be reduced by donations for charity care such as gifts, grants or endowments restricted by donors to assist charity patients, as well as payments received from state agencies for medically indigent programs. The charity care dollar write off amounts should correspond to the Total charges reported on lines 13 through 20.

Line 30 - BAD DEBT (previously an expense)

The current month's difference between the amount charged to patients and the amount received or expected to be received. Bad debts refer to self-pay accounts which the patient is unwilling to pay. Generally this amount will represent the charge to the "Provision for Bad Debts" Account.

Note: as of February 4th, 2013, the amount for **Bad Debt** has been removed from Total Operating Expense. This change was precipitated by the following:

The Financial Accounting Standards Board (FASB), in an update from July 2011 (No. 2011-^o07), states: "The amendments require health care entities that recognize significant amounts of patient service revenue at the time the services are rendered even though they do not assess the patient's ability to pay to present the provision for bad debts related to patient service revenue as a deduction from patient service revenue (net of contractual allowances and discounts) on their statement of operations."

OPERATING EXPENSES

Line 25.A -PAYROLL EXPENSE - FACILITY PAYROLL

Include all salaries and wages paid and accrued internally to **employees** (other than physicians, interns, residents and other trainees, which are separately reported on line 24.B), including salaries or imputed salaries for members of religious orders. **ALSO REPORT** amounts paid for **contracted nurses** and other **contracted labor** for services, which would otherwise have to be hired for internally. (Contracted labor has become an integral part of many hospital's staff planning and labor costs, and therefore should be incorporated into the measure of labor costs to obtain consistency and comparability of information across hospitals.) Also include home-office wages, which are directly allocated to your hospital. Salaries include vacation, holiday, sick leave, call pay and

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overtime pay. Do **not** include employee benefits (these payments should be reported on Line 26.)

Line 24.B - PAYROLL EXPENSE - PHYSICIAN PAYROLL

Include all salaries and wages paid and accrued internally to physicians, interns, residents, and other trainees who are on the payroll as employees of the healthcare enterprise. Physicians paid in any other capacity should be classified as operating (line 31 - all other operating expense) or as non-operating depending on your health enterprise's circumstances (see definition of non-operating revenue).

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Line 25.C - TOTAL PAYROLL EXPENSE

Total payroll for lines 25.A and 25.B.

Line 25.D - PAID HOURS - FACILITY PAYROLL

The hours to be reported are the accrued, paid hours for all employees as described in line 25.A above. Paid hours include vacation, holiday, sick leave, call time (worked) and overtime hours. Do **not** include physician hours.

NOTE: If the month you are reporting contains an extra payroll period, report only the hours which pertain to the month, on an accrual basis, so that there is a proper matching of payroll expense and paid hours.

Line 25.E - PAID HOURS - PHYSICIAN PAYROLL

Report total hours of service related to the physician payroll expense reported on line 24.B. above.

Line 25.F - TOTAL PAID HOURS

Total paid hours for lines 24.D and 24.E.

Line 26 - EMPLOYEE BENEFIT EXPENSE

Report the healthcare enterprise's share of social security (FICA), state and federal unemployment insurance, group health insurance, group life insurance, pensions, annuities, retirement benefits, worker's compensation, group disability insurance, and other employee benefit programs for all hospital employees included on line 25 above.

Line 27 - SUPPLY EXPENSE

Report those expenses that constitute supplies. This includes:

1. General supplies such as office;
2. Medical and ancillary department supplies; and
3. Support department supplies, i.e., housekeeping, dietary and maintenance.
4. Minor equipment not capitalized

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Line 28 - DEPRECIATION EXPENSE

Include the depreciation and/or amortization recorded on land and buildings, fixed and moveable equipment, as well as leases and rentals. Do not include price level depreciation amounts, but rather depreciation recorded on an historical cost basis only.

Line 29 - INTEREST EXPENSE

Report interest expense on mortgages, bonds, notes, and any other short-term and long-term borrowings. Do not reduce for interest income on borrowed funds held by a trustee.

(**Note:** Line 30, Bad Debt, has been moved (and not renumbered) above to reflect that bad debt is now a deduction from revenue; please see p.18 above).

Line 31 - ALL OTHER EXPENSE

Report all other incurred costs not covered by lines 25 - 30.

Line 32 - TOTAL OPERATING EXPENSE

Represents the sum of all expenses reported on lines 25.C through 31. Total operating expense includes salary and non-salary items, reported on an **accrual** basis. Expenses include, but are not limited to, materials, supplies, contract services, management fees and corporate home office allocations, depreciation, interest, taxes, consultants' services, utilities, pharmaceuticals, insurance, and physician remuneration. **Do not include non-operating expenses.**

OTHER FINANCIAL DATA

Line 33 - OTHER OPERATING REVENUE

This data element is analogous to "other revenue" defined in the Audit Guide (however, for **DATABANK** reporting purposes, tax subsidies should be separately disclosed on line 36). Other operating revenue normally includes revenue from services other than health care provided to patients, as well as sales and services to non-patients. Such revenue arises from normal day-to-day operations of most health care entities and is accounted for separately from health care service revenue.

The **Audit Guide** distinguishes "**other revenue**" from "**net non-operating gains/losses**". If the transaction is generated from activities other than direct patient care associated with the ongoing, major, or central operations of the individual hospital, it is classified as "**other revenue**" (and reported on line 33).

If it results from the hospital's peripheral or incidental transactions and from other events stemming from the environment that may be largely beyond the control of the provider and its management, it is classified as "**net non-operating gains**" (reported on line 35).

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Depending on the relationship of the transaction to the health care entity's operations, other (operating) revenue may include -

1. Physician fees collected on behalf of employed physicians that are paid a salary.
2. Revenue from educational programs, which includes tuition from schools and laboratory and X-ray technology.
3. Revenue from research and other gifts and grants, either unrestricted or for a specific purpose.
4. Revenue from miscellaneous sources, such as the following;
 - rental of health care facility space
 - sales of medical and pharmacy supplies to employees, physicians, and others
 - proceeds from sale of cafeteria meals and guest trays
 - proceeds from sale of scrap
 - proceeds from sales at gift shops
 - proceeds from parking lots
 - fees charged for transcripts, etc.

Line 34 - OPERATING MARGIN

Enter on line 34 the **operating margin** which results from the additions of **patient charges on line 20**, less **total contractual adjustments on line 23**, less **charity care on lines 24**, less **total operating expense on line 32**, plus **other operating revenue on line 33**.

Line 35 - NET NONOPERATING GAINS

Report the net amount of revenues and expenses which result from the healthcare enterprise's peripheral or incidental transactions and from other events stemming from the environment that may be largely beyond the control of the provider and its management (as distinguished from "other operating revenue" defined above on line 33). However, tax-subsidies that meet this definition should be separately reported on line 36, below.

Line 36 - TAX SUBSIDIES

Report tax revenues from cities, counties or special hospital districts, which assess mill levies to subsidize the hospital/healthcare enterprise.

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- INCOME STATEMENT -

Line 37 - TOTAL MARGIN

Insert on line 37 the **total margin** which results from the addition of the **operating margin** reported on line 34, plus **net non-operating gains** (or **minus** net non-operating losses) reported on **line 35**, plus **tax subsidies reported on line 36**.

Line 38 - GROSS PATIENT ACCOUNTS RECEIVABLE

Show gross amounts due (based on full-rate charges) from patients and/or their third party sponsors including amounts generated from the care of charity patients which have not yet been written off. Include patient receivables from services to inpatients not discharged, inpatients discharged, and outpatients. The amounts should be reported after the deduction of credit balances and advances from third parties; however, they should not be reduced for contractual adjustments, which are reflected on lines 21 - 23.

NOTE: The payer class assigned to accounts receivable should be consistent with that identified for charges in order to calculate a meaningful "days charges in accounts receivable" statistic. (Most general ledger systems capture the primary Payer at the time of admission when classifying charges whereas patient accounting systems oftentimes prorate individual accounts among sources of payment - i.e., third party Payer liability vs. self-pay). If you have significant changes to a particular payer classification (if your hospital classifies accounts pending Medicaid eligibility determinations as private pay until such time the eligibility determination is final), you should report such changes to **DATABANK** as they impact not only statistics, but also charges, accounts receivable, and contractual adjustments.

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- INCOME STATEMENT -

HEADER INFORMATION

Only report changes to the data, which is printed at the top of the reports.

LICENSED BEDS

Report the number of beds licensed by the State licensing agency.

CERTIFIED SWING BEDS

Report the number of beds certified by the Medicare and Medicaid programs as swing beds.

AVAILABLE BEDS (Staffed)

Available beds are those in service and patient ready for more than half of the days in the reporting period. Do not include beds ordinarily occupied for less than 24 hours, such as those in the **emergency department, clinic, labor (birthing) rooms, surgery and recovery rooms and outpatient holding beds.**

Include the number of swing beds.

Exclude newborn bassinets.