



Washington State
Hospital Association

Washington State Hospital Association

999 Third Avenue, Suite 1400

Seattle, WA 98104

DATABANK Manual

Utilization, Income Statement and Balance Sheet

Reporting **Financial Statement** data to the
DATABANK Program

<https://dataservices.mychadata.com/gallery>

DATABANK PROGRAM REPORTING MANUAL

-UTILIZATION, INCOME STATEMENT, BALANCE SHEET -

Overview

Colorado Hospital Association established the DATABANK Program in 1985 to collect financial and utilization data from hospitals throughout the United States. In addition to providing information with which to represent and advocate the interests of 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 policymaking has increased dramatically. State Hospital Associations (SHAs) regularly provide aggregate DATABANK information to Congressional Delegations, elected and appointed state officials, the media and general public on important issues such as adequate payment, charity care and rural health care.

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.

Role as the DATABANK Contact Person

DATABANK User responsibilities include, but are not limited to:

1. Submission/entry of the DATABANK data within 45 days of the end of a quarter. However, monthly submissions are strongly encouraged to ensure deadlines are not missed.
2. Answering questions that the state hospital association may have about the data you submit. In some cases, you will be contacted by phone. Otherwise, we will contact you by email.
Careful review of the reports, which are available to you on DATABANK. The reports will be made available to all users who have valid usernames and passwords to DATABANK.
To carefully administer usernames 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 online reports.

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3. To change your password on a regular basis. Tip: make your password is a word not in the dictionary, i.e. “kr22dc4”. Substitute numbers for vowels, a=1, e=2, l=3 etc.
4. 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 or email us. Please let us know how we can make DATABANK more useful for your organization. Once again, we appreciate your participation!

Data Collection

It is easy to participate in DATABANK, and therefore to receive the useful information the Program provides.

Submitting Data

The DATABANK Input Form collects utilization and financial information from the previous calendar month.

IMPORTANT: The response deadline date will always be within 45 days of the quarter’s end. To receive your reports online, you must submit the DATABANK information.

Please log on to <https://dataservices.mychadata.com/gallery> then use the provided input template form to enter the monthly data and upload the completed form on the website. **Be sure to save each monthly input template in a central location so if changes need to be made, the input template can be updated and resubmitted on DATABANK.**

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 website 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

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the impact of the corrections. However, future quarterly and annual comparative reports will reflect any changes.

For many hospitals, the fiscal year end is Dec. 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 that could affect your December reports. However, it is critical that the December data, even if unadjusted, is entered by the regular deadline in mid-February.

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.

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, an association representative will contact 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 email 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 website 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 (coming soon to the new Databank platform)

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There are many reports on the DATABANK website that give you feedback on the accuracy of the data submitted. As you upload monthly data, 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 your hospital association has determined. If it exceeds the preset standard deviation for your state, a soft error is generated and displayed to the user.

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 website compared to what you have submitted for previous months. Please note that a prior month is required to run this report.

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.

Another data quality validation process that is used is utilized on the input template. The input template will not allow negative values to be entered for certain fields. When a negative value is entered, the user will receive a pop-up error message. If you are making an adjustment for a previous month, you will need to go back to the previous months and correct the entries.

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.

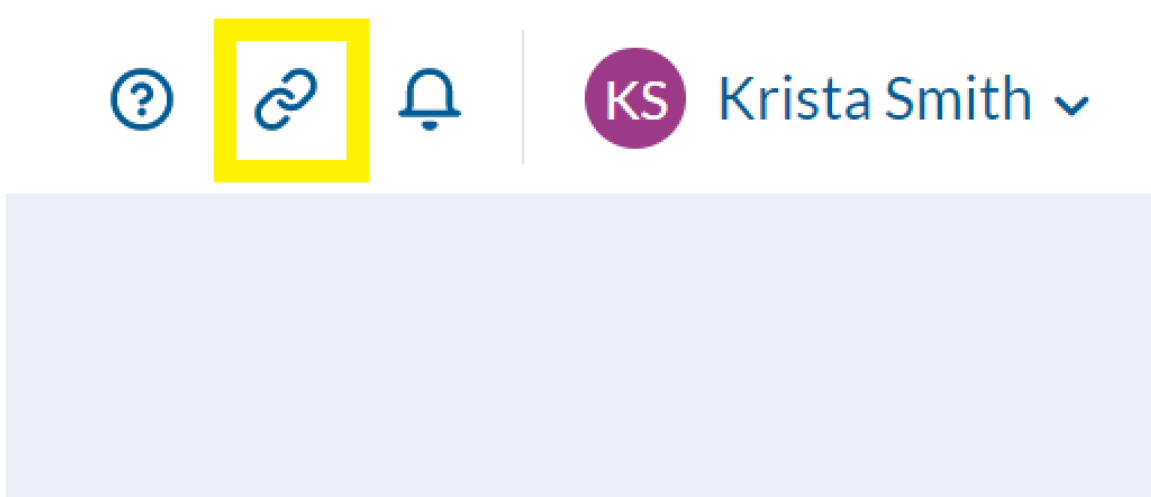
Reports

Most DATABANK reports are available in the Microsoft Platform, Power BI. There are graphical representations of the data as well as the ability to download the data supporting each visualization.

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The DATABANK platform will include a link that takes users directly to the Power BI dashboards and reports.



1. Reports that display your hospital's data (no peer group information) can be viewed immediately, if you have supplied the requested data. These reports are:
2. Reports that include peer groups can be viewed when the threshold for the peer group has been met. If the report displays nulls, 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.

Participation Report – The participation report displays the status of hospital submissions. All state associations and hospitals will have access to this report.

- **Participation Matrix Report** shows is a graphical representation so you can see which hospitals are current with their data submissions and which ones are not. Green represents completed data submission and red represents incomplete data submissions.

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State		DATABANK submission status													Submitted	Duplicated	Not submitted
Year	State	2021-00	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12			
<input checked="" type="checkbox"/> 2021	CO	1	67	67	67	67	67	67	67	67	66	65	65	65			
	Arkansas Valley Regional Medical Center	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	Avista Adventist Hospital	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	Banner Fort Collins Medical Center	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	Boulder Community Health	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	Castle Rock Adventist Hospital	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	Centura Health	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	Children's Hospital Colorado	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	Colorado Canyons Hospital & Medical Center	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓			
	Colorado Plains Medical Center	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X			
	Craig Hospital	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	Delta County Memorial Hospital	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	Denver Health	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	East Morgan County Hospital	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	Good Samaritan Medical Center	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	Gunnison Valley Health	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	HealthONE	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	Heart of the Rockies Regional Medical Center	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	Lincoln Community Hospital	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	Littleton Adventist Hospital	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	Longmont United Hospital	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	Lutheran Medical Center	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	McKee Medical Center	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	Memorial Regional Health	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	Total	1	76	76	78	76	76	77	76	76	76	74	74	74			

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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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Service Levels and Payer 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 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.

Reporting Entity

Report all operations of the health care enterprise that have a common balance sheet (single or multiple hospitals and other health services within an integrated health care delivery system). Depending on the structure of the health care 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

ACUTE INPATIENT 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 (e.g., rehab, psych, and chemical dependency) which are separately certified by Medicare.

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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

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.

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.

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.

COMMERCIAL

(a.k.a. "commercial" managed care): Include HMO, PPO, and direct contracting where the patient is being "managed", other than the payer categories listed elsewhere (Medicare, Medicaid, Self-Pay). 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.

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.

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OTHER

All other payers not reported elsewhere.

HEADER INFORMATION

LICENSED BEDS

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

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.

CASE MIX INDEX (CMI)

The Case Mix Index (CMI) is the average relative DRG weight of a hospital's **acute** inpatient discharges, calculated by summing the Medicare Severity-Diagnosis Related Group (MS-DRG) weight for each **acute** discharge and dividing the total by the number of **acute** discharges. The CMI reflects the diversity, clinical complexity and resource needs of all the patients in the hospital. A higher CMI indicates a more complex and resource-intensive case load. The CMI should include DRGs for all payers, not just Medicare.

Note: The CMI should not include sub-acute inpatient discharges such as swing bed, LTC, or DPU visits.

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Utilization Line Item Definitions and Instructions:

UTILIZATION

DISCHARGES – ACUTE INPATIENT

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). An acute patient is a patient bed on the acute medical unit (AMU) of the hospital that is a dedicated unit that acts as the focus for acute medical care for patients that have presented as medical emergencies or illness to hospitals or who have developed an acute medical illness while in hospital.

DISCHARGES – ACUTE OUTPATIENT

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). An Acute Outpatient is a patient treated in outpatient hospital ancillary and clinic facility (as differentiated from physician).

DISCHARGES – SUB-ACUTE INPATIENT

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). A subacute patient is a patient bed not in an acute medical unit (AMU) of the hospital that receive less intensive care. Sub-Acute Inpatients are cared for in a dedicated unit for patients in swing bed unit, subacute long-term care (LTC), or another distinct part unit (DPU) (rehab, psych, etc.) of a hospital.

PATIENT DAYS – ACUTE INPATIENT

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. This should include Boarder Baby days, which are babies that remain in the hospital after the mom is discharged as well as infants transferred from other facilities. 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.

An acute patient is a patient bed on the acute medical unit (AMU) of the hospital which is a dedicated unit that acts as the focus for acute medical care for patients that have

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presented as medical emergencies or illness to hospitals or who have developed an acute medical illness while in hospital.

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

PATIENT DAYS – ACUTE OUTPATIENT

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. An Acute Outpatient is a patient treated in outpatient hospital ancillary and clinic facility (as differentiated from physician).

PATIENT DAYS – SUB-ACUTE INPATIENT

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.

A subacute inpatient is a patient bed not in an acute medical unit (AMU) of the hospital that receive less intensive care. Sub-Acute Inpatients are cared for in a dedicated unit for patients in swing bed unit, subacute long-term care (LTC), or another distinct part unit (DPU) (rehab, psych, etc.) of a hospital.

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.

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.

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

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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 in Patient days, not newborn patient days.

INPATIENT ADMISSIONS FROM EMERGENCY ROOM

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

OUTPATIENT VISITS

EMERGENCY DEPARTMENT VISITS

Report the total number of patients seen in an emergency unit who are not later admitted as inpatients. This total may include freestanding emergency rooms that are owned by the hospital or hospital system if they have a common balance sheet with the hospital. If the freestanding emergency room reports financial data separately, do not include them in the Emergency Department Visits. For example, if the freestanding emergency room expenses, revenues, and staffing are included in the income statement and balance sheet then they should be reported here. If not, they should be excluded from all fields.

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. This total may include ambulatory surgery centers that are owned by the hospital or hospital system as long as they have a common balance sheet with the hospital. If the ambulatory surgery center reports financial data separately, do not include them in the Ambulatory Surgery Visits. For example, if the freestanding ambulatory surgery center expenses, revenues and staffing are included in the income statement and balance sheet then they should be reported. If not, they should be excluded from all fields.

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.

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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.

ALL OTHER VISITS

Report all other visits not covered by the above fields. An outpatient visit is a visit to each organized outpatient care program by a person who is not an inpatient. Count each appearance of an outpatient visits in each organized outpatient program not otherwise reported elsewhere. For example, if a patient receives lab work in an outpatient setting, it is counted once. If a patient receives lab work then goes to a physical therapy visit and both are billed separately, those visits would be counted twice, one for the lab visit and one for the physical therapy visit. However, if a patient goes to physical therapy and gets lab work during the same visit and both are billed on the same claim, it would be counted just once. This total may include other freestanding facilities that are owned by the hospital or hospital system if they share a balance sheet as well as any outpatient telehealth or virtual services. If the freestanding and/or telehealth expenses, revenues and staffing are included in the income statement and balance sheet then they should be reported. If not, they should be excluded from all fields.

TOTAL OUTPATIENT VISITS

A *calculated field* that reports the Total Visits is the sum of all reported outpatient visits above.

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Income Statement Line Item Definitions and Instructions

CHARGES

ACUTE INPATIENT CHARGES

Gross inpatient charges are the sum of all charges made to acute inpatients for routine and ancillary services for the month, by payer category, 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.

ACUTE OUTPATIENT CHARGES

Gross outpatient charges are the sum of all charges made to acute outpatients for hospital ancillary and clinic facility (as differentiated from physician) services for the month, by payer category. 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.

SUBACUTE INPATIENT CHARGES

Gross subacute inpatient charges are the sum of all charges made to subacute inpatients for routine and ancillary services for the month, by payer category, including patients treated under capitated contracts. Subacute patients as defined above in the Service Line definitions include Sub-Acute Inpatients that are cared for in a dedicated unit for patients in swing bed unit, subacute long-term care (LTC), or another distinct part unit (DPU) (rehab, psych, etc.) of a hospital.

GROSS INPATIENT CHARGES – OTHER

Gross inpatient charges are the sum of all charges made to non-acute (all other inpatient charges not listed in acute inpatient charges above) inpatients for services for the month, by payer category, including patients treated under capitated contracts. It

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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.

GROSS OUTPATIENT CHARGES – OTHER

Gross outpatient charges other are the sum of all charges (all other outpatient charges not listed in acute outpatient charges above) made to outpatients for hospital ancillary and clinic facility services for the month, by payer category. 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.

TOTAL CHARGES

A *calculated field* that reports the total sum of all charges.

CONTRACTUAL ALLOWANCES

CONTRACTUAL ALLOWANCES – ACUTE INPATIENT

For acute inpatient charges 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.

CONTRACTUAL ALLOWANCES – ACUTE OUTPATIENT

For acute outpatient charges 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.

CONTRACTUAL ALLOWANCES- OTHER INPATIENT

For all inpatient activity other than acute inpatient (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.

CONTRACTUAL ALLOWANCES- OTHER OUTPATIENT

For all outpatient activity other than acute outpatient, report the current month's difference between the amounts charged based on the hospital's full established (gross)

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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. This number should not be recorded as a negative number.

TOTAL CONTRACTUALS ALLOWANCES

A *calculated field* that reports the total of Contractual Adjustments for Acute Inpatient, Acute Outpatient, Other Inpatient, and Other Outpatient.

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 by payer categories.

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 Charge.

BAD DEBT (previously an operating 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. This number should not be reported as a negative number. **Report this amount on a gross charge basis by payer categories.**

Note: As of Feb. 4, 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-°©-07), 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."

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OPERATING EXPENSES

PAYROLL EXPENSE - FACILITY PAYROLL

Include all salaries and wages paid and accrued internally to employees, contracted nurses and other contracted labor (other than physicians, interns, residents and other trainees, which are separately reported in Payroll Expense for Physician Payroll), including salaries or imputed salaries for members of religious orders. Also include home-office wages, which are directly allocated to your hospital. Salaries include vacation, holiday, sick leave, call pay and overtime pay. Do not include employee benefits (these payments should be reported in Benefit Expenses).

PAYROLL EXPENSE - PHYSICIAN PAYROLL

Include all salaries and wages paid and accrued internally to physicians, interns, residents, physician assistants, contracted medical groups and other trainees who are on the payroll as employees of the health care enterprise. Physicians paid in any other capacity should be reported in All Other Expense or as Non-Operating Expense depending on your health enterprise's circumstances.

Note: For hospital systems, if the payroll for the employed physician or group is attributed to an individual hospital, it should be reported to either Other Expenses or Non-Operating Expenses. If the payroll for the employed physician or group is not attributed to an individual hospital but to the hospital system, the payroll amount should be reported under Physician Payroll.

TOTAL PAYROLL EXPENSE

A *calculated field* reporting total payroll for Facility and Physician Payroll.

PAID HOURS - FACILITY PAYROLL

The hours to be reported are the accrued, paid hours for all employees as described in Facility Payroll 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.

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PAID HOURS - PHYSICIAN PAYROLL

Report total hours of service related to the physician payroll expense reported in Physician Payroll above.

TOTAL PAID HOURS

A *calculated field* that reports the total paid hours for Facility and Physician.

EMPLOYEE BENEFIT EXPENSE

Report the health care 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 in Facility and Physician expenses.

SUPPLY EXPENSE

Report those expenses that constitute supplies. This includes:

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

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.

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: Bad Debt, has been moved above to reflect that bad debt is now a deduction from revenue; please see Bad Debt above.

PROFESSIONAL FEE EXPENSE

Professional fees are an administrative claim of a professional for compensation for services rendered or reimbursement of costs, expenses or other charges, and expenses incurred during a hospital encounter. These charges include the cost of providing all other aspects of care which are **billed separately from professional services such as hospital stay, support staff, supplies, and medications.**

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OTHER EXPENSE

Report all other incurred costs not covered by previous fields.

TOTAL OPERATING EXPENSE

A *calculated field* that represents the sum of all expenses reported above Total Payroll Expense for Facility and Physician, Benefit Expense, Supply Expense, Depreciation Expense, Interest Expense, and All Other Expense. 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

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 in the Tax Subsidies field). 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.

NOTE: 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 in Other Operating Revenue).

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 in Net Nonoperating Gains field).

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.

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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.

OPERATING MARGIN

The operating margin is a *calculated field* that results from the additions of Total Charges less Total Contractual Adjustments, less Charity Care, less Total Operating Expense, plus Other Operating Revenue.

NON-OPERATING REVENUE

Non-operating income is the portion of an organization's income that is derived from activities not related to its core business operations. It can include items such as dividend income, profits or losses from investments, as well as gains or losses and asset write-downs.

NON-OPERATING EXPENSE

A non-operating expense is an expense incurred from activities unrelated to core operations. Non-operating expenses are deducted from operating profits. Examples of non-operating expenses include interest payments.

NET NONOPERATING GAINS

Net Operating Gains is a *calculated field* that results from Non-Operating Revenue less Non-Operating Expenses. Net Nonoperating Gains reports the net amount of non-operating revenues and expenses that result from the health care 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 in Other Operating Revenue). However, tax-subsidies that meet this definition should be separately reported in Tax Subsidies, below.

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TAX SUBSIDIES

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

TOTAL MARGIN

The total margin is a *calculated field* that results from the addition of the operating margin reported, plus net non-operating gains (or minus net non-operating losses), plus tax subsidies.

Balance Sheet Line Item Definitions and Instructions

CURRENT ASSETS

CASH AND SHORT-TERM INVESTMENTS

Cash and cash equivalents should include all cash and highly liquid investments that are both readily convertible to cash and so near to maturity that they present insignificant risk of changes in value because of changes in interest rates.

Note: Short-Term Investments meet two important criteria: (a) ready marketability and (b) a clear management intention to convert them to working capital in the near future.

GROSS PATIENT ACCOUNTS RECEIVABLE

Show gross amounts due (based on full-rate charges) from patients and/or by payer category including amounts generated from the care of charity patients that 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.

Note: The payer categories 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

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vs. self-pay.) If you have significant changes to a particular payer classification (e.g., if your hospital classifies accounts pending Medicaid eligibility determinations as self-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. (Patient Accounts Receivable should be net of *Contractual Allowances*.)

ALLOWANCE FOR DOUBTFUL ACCOUNTS

Allowance for Doubtful Accounts includes amounts owed to the organization that it expects it will never receive.

NET ACCOUNTS RECEIVABLE

Net Accounts Receivable is a *calculated field* and is equal to Total Patient Accounts Receivable less Allowance for Doubtful Accounts.

INVENTORIES

Report the value of supplies owned by the hospital as reported on the hospital's balance sheet. Inventories typically include medical and surgical supplies, pharmaceuticals, linens, uniforms, garments, food and other commodities, housekeeping, maintenance and office supplies.

OTHER CURRENT ASSETS

Report the value of all other current assets.

TOTAL CURRENT ASSETS

Total Current Assets is a *calculated field* equal to Cash and Short-Term Investments plus Net Accounts Receivable plus Inventories plus Other Current Assets.

RESTRICTED USE ASSETS

A Restricted Use Asset is cash or another item of monetary value that is set aside for a particular purpose, primarily to satisfy regulatory or contractual requirements. Restricted assets, subject to special accounting procedures, are segregated from other assets to mark clear delineations of their use.

LONG TERM INVESTMENTS

Short Term Investments meet two important criteria: (a) readily marketable and (b) a clear management intention to convert them to working capital in the near future. All investments *not* meeting both tests are classified as permanent or long-term investments. Examples for inclusion in Long-Term Investments are:

1. Investments in securities

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2. Investments in tangible fixed assets not currently used in operations: land held for speculation
3. Investments set aside in special funds: sinking funds, pension funds, plant expansion funds
4. Investments in non-consolidated subsidiaries or affiliated companies

PROPERTY PLANT and EQUIPMENT

Report the value of your hospital's Land, Buildings and Equipment (e.g., major and minor movable equipment that is capitalized) recorded on your hospital's books. Most property, plant and equipment figures are depreciable. Land is the exception. Typical accounts used to record property and equipment transactions are land and land improvements, buildings and improvements, leasehold improvements, equipment (fixed and movable) leased property and equipment, accumulated depreciation and amortization and construction in progress.

LESS ACCUMULATED DEPRECIATION

Report the amount on your hospital's balance sheet that reflects the cost of use (e.g., wear and tear and obsolescence) on buildings and equipment.

NET PROPERTY and EQUIPMENT

Net Property and Equipment is a *calculated field* and is equal to Property Plant and Equipment less Accumulated Depreciation.

OTHER NON-CURRENT ASSETS

Other assets may include prepaid expenses, deposits and deferred expenses. Prepaid costs, such as amounts paid to physicians for future services (for example, administering a hospital department or providing community services that further the organization's mission) may be deferred and amortized over the period benefited. Such assets are classified as current or noncurrent as appropriate.

TOTAL ASSETS

Total Assets is a *calculated field* that is equal to Total Current Assets plus Restricted Use Assets plus Long Term Investments plus Property, Plant and Equipment plus Other Non-Current Assets.

CURRENT LIABILITIES

CURRENT PORTION OF LONG-TERM DEBT

Report the amount that appears on the balance sheet for this liability. This is the portion of debt principal that is due in the next 12 months. Long-Term Debt is defined, as

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installment notes, specific-building bonds, collateral trust bonds and bank mortgages, minus the portion of debt principal that is due in the next 12 months.

ACCOUNTS PAYABLE AND ACCRUED EXPENSES

Report the amount that the hospital owes to ordinary business creditors plus the amount that has been accrued for the hospital's expenses. Included in the definition of accrued expenses are amounts for retainage and construction accounts payable, estimated third-party payer settlements, deferred third party reimbursement and advances from third-party payers.

OTHER CURRENT LIABILITIES

This line should contain liabilities falling due in the current operating cycle that have not been previously reported in previous sections.

DEFERRED REVENUES

Report the value in the liability account used for revenues and other cash receipts prior to the completion of the transaction.

TOTAL CURRENT LIABILITIES

Total Current Liabilities is a *calculated field* that is equal to Current Portion of Long-Term Debt plus Accounts Payable and Accrued Expenses plus Other Current Liabilities plus Deferred Revenues.

LONG TERM DEBT (excluding current portion)

Report the value of installment notes, specific building bonds, collateral trust bonds and mortgage loans, minus the portion of debt principal that is due in the next 12 months.

OTHER LIABILITIES

Report the value of all other liabilities not previously reported on the balance sheet.

NET ASSETS

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UNRESTRICTED NET ASSETS

Report the part of net assets of a not-for-profit organization that is neither permanently restricted nor temporarily restricted by donor-imposed stipulations. Report equity or stockholder's equity on this line.

RESTRICTED NET ASSETS

Restricted Net Assets are cash or other assets that are not needed to pay liabilities but still may not be spent freely. Restricted net assets may be earmarked for a specific purpose; alternately, law or regulation may require the restriction of some net assets.

Temporarily restricted net assets are usually earmarked by the donor for a specific program or project and must be used within a set time period.

Permanently restricted net assets are often the sum of money to be invested in perpetuity, with the proceeds available for a specified purpose.

TOTAL NET ASSETS

Total Net Assets is a *calculated field* that is equal to Unrestricted Net Assets plus Restricted Net Assets.

TOTAL LIABILITIES AND NET ASSETS

Total Liabilities and Net Assets is a *calculated field* that is equal to Total Current Liabilities plus Long Term Debt plus Other Liabilities plus Total Net Assets.

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-UTILIZATION, INCOME STATEMENT, BALANCE SHEET -

APPENDIX A – UTILIZATION FORMULAS

Utilization formulas are based on each state’s selection of payers and levels of service. For this appendix, the standard payers and levels of service are included. If your state chose customized payers or levels of service, those formulas are not included.

Standard Payers:

Medicare
Medicaid
Commercial
Self-Pay
Other

Standard Levels of Service:

Acute Inpatient
Swing Bed
Subacute & Long-Term Care (LTC)
DPU

DISCHARGES

Total Acute Discharges

A *calculated field* that takes the sum of all Acute discharges by payer (Medicare, Medicaid, Self-Pay, Tricare, Commercial-Managed Care, Commercial-Other, and Other).

Total Medicare Discharges

A *calculated field* that takes the sum of all levels of service (Acute) for Medicare patients.

Total Medicaid Discharges

A *calculated field* that takes the sum of all levels of service (Acute) for Medicaid patients.

Total Commercial Discharges

A *calculated field* that takes the sum of all levels of service (Acute) for Commercial patients.

Total Self Pay Discharges

A *calculated field* that takes the sum of all levels of service (Acute) for Self-Pay patients.

Total Other Discharges

A *calculated field* that takes the sum of all levels of service (Acute) for patients with a payer not listed above (Medicare, Medicaid, Self-Pay, Commercial).

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Total Discharges

A *calculated field* that takes the sum of all levels of service and all payers.

DAYS

Total Acute Days

A *calculated field* that takes the sum of all Acute days by payer (Medicare, Medicaid, Self-Pay, Commercial and Other).

Total Medicare Days

A *calculated field* that takes the sum of days for all levels of service for Medicare patients.

Total Medicaid Days

A *calculated field* that takes the sum of days for all levels of service for Medicaid patients.

Total Commercial Days

A *calculated field* that takes the sum of days for all levels of service for Commercial-Managed Care patients.

Total Self Pay Days

A *calculated field* that takes the sum of days for all levels of service for Self-Pay patients.

Total Other Days

A *calculated field* that takes the sum of days for all levels of service for Other Payer Patients.

Total Days

A *calculated field* that takes the sum of days for all levels of service and all payers.

OUTPATIENT VISITS

Total Outpatient Visits

A *calculated field* that reports the Total Visits is the sum of all reported outpatient visits above.

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APPENDIX B – INCOME STATEMENT FORMULAS

Certain Income Statement formulas are based on each state's selection of payers and levels of service.

Standard Payers:

Medicare
Medicaid
Commercial
Self-Pay
Other

Standard Levels of Service:

Acute Inpatient
Swing Bed
Subacute & Long-Term Care (LTC)
DPU

CHARGES

Total Acute Charges

A *calculated field* that takes the sum of all Acute Inpatient and Outpatient Charges by payer (Medicare, Medicaid, Self-Pay, Tricare, Commercial-Managed care, Commercial-Other, and Other).

Total Medicare Charges

A *calculated field* that takes the sum of charges for all levels of service for Medicare patients.

Total Medicaid Charges

A *calculated field* that takes the sum of charges for all levels of service for Medicaid patients.

Total Commercial Charges

A *calculated field* that takes the sum of charges for all levels of service for Commercial-Managed Care patients.

Total Self Pay Charges

A *calculated field* that takes the sum of charges for all levels of service for Self-Pay patients.

Total Other Charges

A *calculated field* that takes the sum of charges for all levels of service for Other Payer Patients.

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Total Charges

A *calculated field* that takes the total sum of all charges for all levels of service and all payers.

CONTRACTUALS

Total Acute Contractuals

A *calculated field* that reports the total of Acute Inpatient and Acute Outpatient Contractual Adjustments by payer categories.

Total Other Contractuals

A *calculated field* that reports the total of Other Inpatient and Acute Outpatient Contractual Adjustments by payer categories.

Total Contractual Allowances

A *calculated field* that reports the sum of all contractuals for all payer categories.

CHARITY CARE AND BAD DEBT

Total Charity Care

A *calculated field* that reports the sum of all charity care by all payer categories.

Total Bad Debt

A *calculated field* that reports the sum of all bad debt by all payer categories.

Total Medicare Net Patient Revenue

A *calculated field* that takes Total Medicare Charges less Total Medicare Contractual Allowances less Medicare Charity Care and less Medicaid Bad Debt.

Total Medicaid Net Patient Revenue

A *calculated field* that takes Total Medicaid Charges less Total Medicaid Contractual Allowances less Medicaid Charity Care and less Medicaid Bad Debt.

Total Commercial Net Patient Revenue

A *calculated field* that takes Total Commercial Charges less Total Commercial Contractual Allowances less Commercial Charity Care and less Commercial Bad Debt.

Total Self Pay Net Patient Revenue

A *calculated field* that takes Total Self Pay Charges less Total Self Pay Contractual Allowances less Self Pay Charity Care and less Self Pay Bad Debt.

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Total Other Net Patient Revenue

A *calculated field* that takes Total Charges less Total Contractual Allowances less Total Charity care and less Total Bad Debt.

OPERATING EXPENSES

Total Payroll Expense

A *calculated field* reporting sum of Facility Payroll and Physician Payroll.

Total Paid Hours

A *calculated field* that reports the total paid hours for Facility Payroll and Physician Payroll.

Total Operating Expense

A *calculated field* that represents the sum of all expenses reported above: Total Payroll Expense for Facility and Physician, Benefit Expense, Supply Expense, Depreciation Expense, Interest Expense and All Other Expense.

OTHER FINANCIAL DATA

Operating Margin

A *calculated field* that results from the additions of Total Charges less Total Contractual Adjustments, less Charity Care, less Total Operating Expense, plus Other Operating Revenue.

Net Operating Gains

A *calculated field* that results from Non-Operating Revenue Less Non-Operating Expenses.

Total Margin

A *calculated field* that results from the addition of the operating margin reported, plus net non-operating gains (or minus net non-operating losses), plus tax subsidies.

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APPENDIX C – BALANCE SHEET FORMULAS

Net Accounts Receivable

A *calculated field* and is equal to Total Patient Accounts Receivable less Allowance for Doubtful Accounts.

Total Current Assets

A *calculated field* equal to Cash and Short-Term Investments plus Net Accounts Receivable plus Inventories plus Other Current Assets.

Net Property and Equipment

A *calculated field* and is equal to Property Plant and Equipment less Accumulated Depreciation.

Total Assets

A *calculated field* that is equal to Total Current Assets plus Restricted Use Assets plus Long Term Investments plus Property, Plant and Equipment plus Other Non-Current Assets.

Total Current Liabilities

A *calculated field* that is equal to Current Portion of Long-Term Debt plus Accounts Payable and Accrued Expenses plus Other Current Liabilities plus Deferred Revenues.

Total Net Assets

A *calculated field* that is equal to Unrestricted Net Assets plus Restricted Net Assets.

Total Liabilities and Net Assets

A *calculated field* that is equal to Total Current Liabilities plus Long-Term Debt plus Other Liabilities plus Total Net Assets.