

Chart Of Accounts Business Rules

Effective 1 July 2011

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1 Executive Summary

This document provides the business rules that apply when reporting the F1 on a monthly basis to the department.

The Department of Health (DH) mandated that all Victorian health services implement a common chart of accounts for financial reporting, in 2004. Health services are also required to implement any amendments to the common chart that may be introduced from time to time.

The standardised chart of account names and codes, and accompanying business rules, support the implementation of the common chart of accounts by health services.

Ultimately, the aim is to support management best practice in health sector reporting, through consistent reporting formats, benchmarking and improved data tracking.

The key objective of the common chart of accounts is to provide the basis of financial performance measurement of health services, to ensure effective governance and accountability.

The report includes business rules for the following:

- Accounting for Salaries and Wages
- Accounting for Other Expenses
- Accounting for Revenue
- Accounting for Pathology and Medical Imaging Services
- Accounting for Allocation of Overheads
- Accounting for Pharmacy Allocations
- Accounting for Allied Health Allocations
- Accounting for Direct Cost Allocations
- Accounting for Capital Related Transactions
- The Cashflow Statement

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2 Introduction

From 1 July 2004, the Department of Health (DH) mandated that all Victorian health services implement a common chart of accounts for financial reporting to DH. The common chart of accounts utilises standardised names and codes, and provides rules to assist in implementation (Appendices 1 and 2, Code Formats and Implementation Timetable).

Implementation by health services aims to support management best practice in health sector reporting, through consistent reporting formats, benchmarking and improved data tracking. Health services are also required to implement any amendments to the common chart that may be introduced from time to time (Appendix 3, Policy Development Groups).

The key objective of the common chart of accounts is to provide the basis of financial performance measurement of health services to ensure effective governance and accountability.

The purpose of this document is to provide the business rules that apply when reporting the F1 on a monthly basis to the department. In many cases, tables with examples have been provided to assist understanding of the rules.

3 Accounting for Salaries and Wages

3.1 Superannuation

3.1.1 Account: 14400 Superannuation (Posting Range 14401 – 14499)

The superannuation expense is to be allocated to individual cost centres ie the cost centre where the employee's salary costs have been allocated.

3.1.2 As can be seen a range has been allocated to the Superannuation Expense. Users can elect to code all their superannuation expenditure to the one account or alternatively break this down into categories that are more meaningful for their health service - eg:

- Account – 14401 Defined Benefits Superannuation Payments
- Account – 14402 Superannuation Guarantee Contributions

3.2 Workcover

The following business rules (3.2.1-3.2.2) have been reviewed by the Chart of Accounts Urgent Issues Group.

3.2.1 Account: 14500 Workcover (Posting Range 14501 – 14599)

The workcover premium is required to be expensed to each individual HSA campus program eg acute inpatients, acute outpatients, sub-acute services, mental health services etc and to individual non HSA cost centres (where staff are employed). This can be achieved by direct allocation or indirectly through the corporate cost centres (R series). The methodology for recharging the R cost centres to programs and other cost centres is done through transfer pricing as described in section 6.3.

3.2.2 Suggested Methodology: Allocate at a Program Level

The workcover expenses are to be allocated to individual programs including the Non HSA programs.

Step 1 Calculate Workcover Premium per site

Determine the workcover premium per site – the total of all site premiums must equal the total of the Health Service premium.

Step 2 Calculate Total monthly Workcover Expense as follows:

Seasonalise the workcover premium over the year

Step 3 Calculate the monthly % allocation per program as follows:

Total of Individual program (per relevant site) Centre Salaries and Wages/Total Site Salaries and Wages

Step 4 Allocate the Total monthly Workcover Expense to individual programs per site as follows:

Total Workcover Expense_{Monthly} = Step 2 results * Step 3 results

3.3 Employee Entitlements

- 3.3.1 Outlined below is the accounting treatment to be applied for all leave entitlements. On a monthly basis leave entitlements will be required to be allocated to individual cost centres ie the cost centre where the employees salary costs have been allocated. Further, the Leave Entitlement provisions must be balanced to the Leave Liability reports on a monthly basis.

3.4 Monthly Calculation of Leave Entitlement Expenditure

- 3.4.1 The below treatment of Employee Leave is to be applied to Annual, Long Service and ADO's. A 7 step methodology has been developed to eliminate the anomalies experienced when an employee transfers cost centres (Appendix 4, The 7 Step Process). The 7 step process ensures that the new cost centre only incurs the monthly expenditure for leave entitlements.

3.4.2 DH Long Service Leave Grant

The DH LSL Grant – at a minimum should be coded to the corporate cost centres within each HSA program E.g. Corporate Inpatients, Corporate Emergency, Corporate Non Admitted, Corporate Sub Acute etc.

It is further suggested that to assist in alleviating fluctuations at a cost centre level caused by the adjustments to the long service expense as a result of bond rate and wage inflation rates that the DH LSL Grant be allocated to an individual cost centre level.

3.5 Annual Leave Adjustments Required by AASB119

- 3.5.1 AASB119 requires liabilities for short-term employee benefits to be measured at nominal amounts and liabilities for long-term employee benefits to be measured at present value (AASB 119.10 and 119.128).
- 3.5.2 At present this calculation is being performed manually (outside the employee entitlements system).
- 3.5.3 As this calculation is based on award classifications and is not broken down to individual employees – the impact of the adjustment should be coded to the corporate cost centres within each program (including the non HSA programs) E.g. Corporate Inpatients, Corporate Emergency, Corporate Non Admitted, Corporate Sub Acute etc.

3.6 Provision for Sabbatical Leave

The following business rule (3.6.1) has been reviewed by the Chart of Accounts Urgent Issues Group.

- 3.6.1 As sabbatical leave is a non-vested employee benefit a provision for sabbatical leave is not required. Sabbatical leave payments are to be coded directly to basic pay.

3.7 Allocation of Medical Salaries

- 3.7.1 This should occur through the Payroll System and should include separate Cost Centres for all of the hospitals Inpatient Medical Units and the hospital's Outpatient VACS clinics. All medical overtime should be allocated to the doctors Inpatient Medical Unit. Where the doctor is split between inpatient and outpatient cost centres on the masterfile and their timesheet does not stipulate where the overtime is worked the payroll department must code the overtime only to the inpatient cost centres. To assist in identifying these occurrences it would be worthwhile updating the timesheets to highlight all cost centres the doctor is employed under (snapshot from the masterfile).

3.8 Hospital Medical Officers

3.8.1 Health Service Rotating Doctors – Expense

The salary costs of the health service's doctors on rotation to other health services should be allocated to the HMO cost centre – P0851 – P0900.

3.8.2 Health Service Rotating Doctors – Revenue

The revenue received from other health services for HMO's on rotation should be classified as revenue and coded to 57001 – 57049 - Title: Income – Salary Recoveries External Organisations

3.8.3 Health Service HMO's

The HMO salary costs of HMOs working within the hospital are to be allocated to their clinical unit. For those directly employed by the hospital their salary costs will be allocated via the payroll system. For those doctors employed by other health services their salary costs charged by the other hospital should be coded to Account 13051 – 13099 – Title: External Doctors on Rotation.

3.9 System Generated Salaries and Wages

3.9.1 Summary Payroll Accounts

In consultation with the payroll providers DH will provide all Health Services with a mapping table for VCODES / PAYCODES – to system generated salaries and wages account codes. This will enable the preparation of the payroll journals to be automated from the payroll system. System Generated Salaries and Wages Account Codes are as follows:

Table 1 Summary Payroll Account

Summary Account	Summary Account Name
10000	Basic
10100	Sick Pay
10200	Overtime/Recall – Unrostered
10300	Overtime – Rostered
10400	Penalties (other than public holiday)
10500	Public Holiday Penalties
10600	Allowances
10700	Workcover
10800	Departure Expenditure
12000	Fee for Service

3.9.2 Salaries and Wages Categories

Again, in consultation with payroll provides DH will provide all Health Services with a mapping table for employee award classifications – to system generated salaries and wages account codes. As you will see from the example below there are now 8 labour categories for each account type:

For Example:

Table 2 Labour Categories and Account Types

Account Number	Account Name
10010	Basic Pay - Nursing - System Generated
10020	Basic Pay -Administration and Clerical - System Generated
10030	Basic Pay - Medical Support - System Generated
10040	Basic Pay - Hotel and Allied Services - System Generated
10050	Basic Pay - Medical Officers - System Generated
10060	Basic Pay - Hospital Medical Officers - System Generated
10070	Basic Pay - Sessional Clinicians - System Generated
10080	Basic Pay - Ancillary Support (Allied Health) - System Generated

3.9.3 Monthly Salaries and Wages Accrual

Health Services should automate their monthly salaries and wages accrual. The monthly system generated accrual should be coded to the System Generated Salaries and Wages account codes mentioned above.

3.9.4 The accounts listed below should only be used for ad hoc accruals such as accruals for late timesheets, and not the main monthly salaries and wages accruals.

Table 3 Account Codes for Ad Hoc Accruals

Account No.	Account Name
10901	Accrual - Late Timesheets
10921 - 10949	Salaries and Wages - Accruals Other

3.9.5 Accounting for Employees on Workcover

Employees on workcover should remain in their original cost centre and the cost and corresponding recoveries from the insurer should be coded to this cost centre and the account code detailed below:

Table 4 Employees on Workcover

Account No.	Account Name
10980 – 10999	Workcover Recoveries

3.9.6 Salary and Wages Recoveries – Internal/Recharges (11001)

This commonly used to rectify incorrect charging of salary and wages to a wrong cost centre. At any time, this account has a nil balance.

3.10 Public Holiday Penalties

3.10.1 Public Holiday penalties should be expensed in the month in which they are paid.

3.11 Fee for Service

3.11.1 Visiting medical Officers (VMOs) may be engaged on a contract for employment, in which case they are paid through the payroll, or engaged on a contract for service, in which case they are paid on the basis of invoices received and processed through accounts payable.

In addition to the basic range of salary codes, VMO payments can be coded to the account codes shown in Table 5. VMOs are normally assigned the PC code LR (i.e. Labour Category 07 Award 31) and should be coded to Sessional Clinicians in the Standard Account Codes.

Table 5 The Coding of VMO Services

Contract	Payroll System	Accounts Payable
Contract for Employment	Account Code: 10000 – 10900 (classified as Salaries and Wages in F1). This is for sessional VMO working under employment contract and include the following costs: <ul style="list-style-type: none"> ➤ Basic ➤ Sick Pay ➤ Overtime/Recall (excludes CMBS charges) ➤ Overtime (Rostered) ➤ Penalties ➤ Public Holiday Penalties ➤ Allowances ➤ Workcover ➤ Departure Expenditure ➤ Other Salaries and Wages 	
Contract for Service	Account Code: 12030 or 12070 (Classified as Fee for Service in F1). This is for sessional VMOs who charge the health service on a fee for service basis. This is in addition to the contracted sessions these VMOs are remunerated for.	Account Code: 12201 - 12399 (New range effective 1.7.2006. Classified as Fee for Service in F1). This is for VMO who are: <ul style="list-style-type: none"> ➤ Paid for activities (Fee for Service) ➤ Billing hospital for services rendered (account payable)

The account code range 10960 –10979, was phased out at the end of the 2006-2007 financial year.

4 Accounting for Other Expenses

4.1 Allocation of Direct Administration Expenses

- 4.1.1 Administration costs are to be coded directly to program cost centres wherever possible - where these relate to patient care areas (e.g. Pathology Administration, Radiology Administration etc) and should only include administration costs incurred solely for that function. This may include salaries and wages for a receptionist/clerical support officer, rental, telephones, photocopier, general stationery, tea & coffee, special functions etc.

4.2 Netting of Costs

- 4.2.1 All costs should be disclosed at their gross value. The only exception is for volume discounts or volume rebates – these can be netted off the cost of items.
- 4.2.2 Example:
The most common example of where net funds are received or paid is the trade in of assets – particularly motor vehicles. In this instance the sale price should be added back to the net cost to obtain a gross cost of the new asset being purchased.
- 4.2.3 Private Patient Excess Waiver Costs should not be reported as Administrative Expenses in the F1. This should be treated as a *discount* on private patient revenue and netted off the appropriate Admitted Patient Fees (50000 range).

4.3 Intra-Hospital Transactions

- 4.3.1 Intra Hospital transactions – ie recharging of services/goods within the health service can be accounted for in one of two ways:
- Transfer pricing (net of ancillary income); or
 - Using the same expenditure code.
- Alternatively, direct charging of goods and services to cost centres is encouraged.
- 4.3.2 These transactions should not result in the transferring department gaining a profit from the transferor department.
- 4.3.3 For example – the Finance and HR department share the same administrative facilities – the expenses incurred such as photocopying, stationery etc are charged directly to the Finance Cost Centre. Finance should then charge the HR cost centre their portion of these costs via the photocopying and stationery account codes.
- 4.3.4 Revenue accounts should never be used when journaling intra hospital transactions.

4.4 Consultancies or Contractors

4.4.1 Consultancies are to be treated as expenses and allocated to the cost centre responsible for purchasing the service.

4.4.2 A consultancy is an arrangement where an individual or organisation is engaged:

- to provide expert analysis and advice which facilitates decision making;
- to perform a specific, one-off task or set of tasks; and
- to perform a task involving skills or perspectives which would not normally be expected to reside within the health service.

Note: To be classified as a consultancy, an arrangement should meet all of the criteria for a consultancy.

4.4.3 In contrast, an arrangement with a contractor has the following attributes:

4.4.4 Contractors - An individual or organisation engaged:

- to provide goods, works or services;
- to perform all or part of a new or existing ongoing function to assist a department carry out its defined activities and operational functions; and
- to perform a function involving skills which would normally be expected to reside within the department but which are not currently available.

4.4.5 The expenses for works undertaken by contractors should be recorded using the Contracted services.

4.4.6 Contract / Consultancy Register

4.4.7 Each health service is to maintain a consultancy register as a record of all contractors / consultants engaged and the status of current engagements.

4.4.8 As a minimum, health services should record the following information for each contract/consultancy over \$100,000:

- brief description of the contract /consultancy project;
- name of the contract/consultancy firm and principal consultant;
- type of contract/consultancy based on standardised criteria;
- approved value and end cost;
- date signed and expected and actual completion dates;
- name of health service contact officer;
- description of the type of selection procedures used, e.g., written quotes, public tender, exemption granted; and
- registry file no/reference

4.4.9 For contracts/consultancies less than \$100,000 health services should record a brief description of the consultancy and the contract approved values and end cost.

5 Accounting for Revenue

5.1 Allocation of DH Grant Income

- 5.1.1 At a minimum DH grants should be coded to the corporate cost centres within each program. E.g. Corporate Inpatients, Corporate Emergency, Corporate Non Admitted, Corporate Sub Acute etc.
- 5.1.2 At the discretion of the Health Service – DH grants may be allocated to specific cost centres within Programs if required eg. Harp/HDM specific cost centres, Pharmacy (High Specialised Drugs)
- 5.1.3 DH will code grants using the general corporate cost centres and to the first number within the specific range (where ranges are provided) – eg: DH Acute Specified grants Highly Specified Drugs will be coded by DH to Cost Centre – Corporate Non Admitted – Account – 53301 DH Grant – Other Specified Grants (i.e. first code in the range 53301-53350). Health services may then reallocate to their specific number within that range if required.

5.2 Allocation of Other Income

- 5.2.1 Other income should be allocated to the cost centre where the income was raised. Wherever possible this should be a direct cost centre otherwise the program corporate cost centre should be used.
- 5.2.2 Where other income derived by the Health Service is deemed material consideration should be given as to whether this income (and the corresponding expenditure) should be allocated to a special purpose fund.
- 5.2.3 For example:
Where a hospital is providing services to another hospital such as payroll support and processing; engineering services and/or linen services and the revenue derived by the hospital is seen to be material then these services should be managed within an internal Special Purpose Fund.
- 5.2.4 Where a hospital receives dual funding for a service eg program % funded from DH and % funded from the Commonwealth – then this income should be coded to the appropriate HSA cost centre.

5.3 Private Patient Fees

The following business rules (5.3.1-5.3.6) have been reviewed by the Chart of Accounts Urgent Issues Group.

- 5.3.1 Fees Raised Using The Hospital Provider Number - All fees raised using the hospital provider number should be allocated to the relevant program within the Health Service Agreement. At a minimum this revenue should be coded to the program corporate cost centre.
- 5.3.2 Fees Raised Using The Doctors Provider Number

The accounting treatment below only pertains to patient fee revenue used when the doctor uses their individual provider number as opposed to the hospital provider number. This revenue is generally more commonly termed Private Practice Revenue. This Private Practice Revenue should be coded to a specific purpose fund with the corresponding expenditure also coded to the special purpose fund.

5.3.3 100% Donation/Made Over Model

As the name suggests Private Practice Fees raised under a 100% donation model should be coded to the following account.

Table 6 Private Practice Fees

Account No.	Account Name
50901 – 50999 59111 - 59499	Private Practice Fees (Revenue)

5.3.4 Fees Split: % Facility Fee - % Donation/Made Over (Total = 100%)

Under this model assuming the arrangement is that the health service charges a 60% facility fee and the remaining 40% is donated to the health service. The accounting for this should be as follows assuming the total fee charged is \$100:

CR: Recoupment Hospital Facilities – Private Practice \$60
 CR: Private Practice Revenue \$40

5.3.5 Fees Split: % Facility Fee - % Taken By The Doctor

Under this model assuming the arrangement is that the health service charges a 60% facility fee and the remaining 40% is taken by the doctor. The accounting for this should be as follows assuming the total fee charged is \$100:

CR: Recoupment Hospital Facilities – Private Practice \$60
 CR: Other Creditors (assuming the hospital collects
 the funds on behalf of the doctor) \$40

5.3.6 100% Assignment Of Income To The Health Service

As the fees raised under this arrangement are still raised by the doctors using their individual ABN number accounting for this income should be as for a) above.

5.4 Patient and Resident Revenue, and Other Revenue

5.4.1 Patient/Resident Revenue

Revenue in the form of fees and charges derived from both private and public patients and residents are to be reported here. This represents all revenue received by and due to the hospital in respect of individual patient/resident liabilities for such things as accommodation, theatre fees, pharmaceuticals It also includes fees or recoveries from the provision of such things as, television hire, equipment hire and services for non-admitted patients such as the provision of spectacles, hearing aids, pharmaceuticals, aids and appliances, surgical supplies, home modifications, prosthetics, home oxygen, etc. It also includes fees from day centres, district nursing, community health centres etc. **Note: Other revenue excludes specific purpose fund revenue.**

Table 7 Patient and Resident Revenue

Account Roll - up Number	Roll-up Account Name
50000	Admitted Patient Fees
50400	Non-admitted Patient Fees

5.4.2 Other Revenue

Other revenue represents all revenue received by and due to the hospital from hospital visitors, boarders, and staff for such things as accommodation, meals etc. All recoveries other than those related to use of hospital facilities as outlined in section 4.3 should be recorded here. Other revenue excludes specific purpose fund revenue.

Table 8 Other Revenue

Account Roll - up No.	Roll-up Account Name
50900	Private Practice Revenue
57000	Other Operating Income
58000	Coordinated Care Trial Income

5.5 Donations

5.5.1 Capital Purpose Donations

Donations that are made specifically for the purchase of Capital equipment should be recorded as Capital Revenue. For example, if a donation is made with the request that the funds are to be used to purchase equipment, whether or not a specific piece of equipment has been identified, the donation should be recorded as capital income.

5.5.2 Specific Purpose

Donations that are specifically designated for a Ward or program/function and which have not been identified for the purchase of a capital item should be recorded in special purpose funds. For example, if the family of a patient would like to recognise the care given to their relative by the staff in a particular ward by way of a \$500 donation, this should be recorded as a donation in a special purpose cost centre.

5.5.3 All other donations that do not fit into the above categories should be recorded as donations to a Specific Purpose Fund.

5.6 Capital Purpose Income

5.6.1 Hospitals receive grants from a variety of sources. All grants are to be recognised as operating revenue unless supporting documentation specifically labels or designates the grant to only be used for capital purpose. Where there is discretion to use the grants between capital and operating purposes, then the policy of the Department is that these grants be recognised as operating grants regardless of whether it generates an asset except for the treatment of accommodation payments as prescribed in Section 5.7.1 - Admitted Patient Fees – Residential Aged Care Accommodation Payments (50351 – 50399).

5.6.2. Capital Purposes Grants: This relates to all grants specifically received for the purpose of acquiring non-current assets such as capital works, plant and equipment. These grants, depending on the source, should be reported as revenue from Department of Health (Account Code 56000 range), Other Victorian State Agency Grants (Account Code 56600 range), or Commonwealth (Account Code 56100 range) in the 'Capital & Specific Items' column.

5.6.3 Hospital Program Grant (HPG) provided by Commonwealth for the radiotherapy program is a capital payment and should be reported as capital purpose income under Account Code 56100 range in the 'Capital & Specific Items' column. These payments should be used for

replacement and refurbishment of the equipment and enhancement for the purpose of improving the performance and safety of the radiotherapy machine. However, HPG provided to Radiotherapy Single Machine Unit (SMU) trial sites are allowed to be used as recurrent revenue for the SMU.

- 5.6.4 General Equipment and Infrastructure Maintenance Grants: The annual infrastructure and maintenance grant is provided to hospitals and health services for general equipment and infrastructure maintenance purposes. The grant is provided as a contribution towards maintenance costs of the agencies. Separate funding is provided by the department to agencies for the replacement of equipment (see Targeted Equipment Grants). The funding source for this grant is the Department of Treasury and Finance's (DTF) appropriation to the department for the funding of hospital/health service outputs. DTF's Financial Reporting Direction 2A (FRD 119)—Contributed Capital, requires that all appropriations for the provision of outputs (FRD 119 – paragraph 5.4b) must be recognised as revenue. (Website: <http://www.dtf.gov.com.au>)
- 5.6.5 Given the above background and the existing practice of recognising maintenance costs as operating expenses, the department requires all public hospitals/health services to treat the infrastructure and maintenance grants as an item of operating revenue in the HSA section of the F1. The department has issued Circulars 17/2002 and 7/2003 advising hospitals of this treatment. Accordingly, these grants should be reported as revenue from Department of Health (Account Code 53601 range) but not as revenue in the 'Capital & Specific Items' column.
- 5.6.6 Targeted Equipment Grants: From this funding pool MHS/hospitals bid for grants towards higher cost replacement or new items of equipment not funded under other special purpose capital funding programs. The allocation of these grants is submission based and for the purchase of equipment only. As such funding received under this program has to be reported as capital purpose income. Hospitals should also note the requirement of FRD 2A on reporting capital grants as contributed capital.

All Targeted Equipment Grants not reported as contributed capital should be reported as revenue from Department of Health (Account Code 56000 range) in the 'Capital & Specific Items' column.

- 5.6.7 Donations and Bequests: Donations and bequests specified by donors for the purchase of fixed assets should be reported as Donation and Bequests (Account Code 58200, 58400 range) in the 'Capital & Specific Items' column.
- 5.6.8 All other income received for the specific purpose of acquiring non-current assets such as capital works, plant and equipment should be reported as revenue in the 'Capital & Specific Items' column. The common items to be included here are:
- The cost of equipment donated by medical practitioners
 - Capital interest

5.7 Aged Care

- 5.7.1 Cost Centres – Each residential aged care service (RACS) has a Commonwealth RACS ID and generally should be allocated its own cost centre.
- Generic high and low care
- J2000 range for High Care RACS (formerly nursing homes)
 - J0000 range for Low Care RACS (formerly hostels)
- Aged persons mental health (APMH)
- H8802 -H8850 range for High care RACS (formerly Psychogeriatric Nursing Homes)
 - H8752-8800 range for Low Care RACS (formerly Psychogeriatric Hostels)

NB: If a RACS is classified as Mixed i.e Commonwealth approved High and Low Care places then it will be allocated according to the greater proportion of the approved places.
eg. the Lodge with RACS ID 9999 has 30 high care and 20 low care approved places - majority is high care therefore allocate to cost centre J2000 range

5.7.2 Admitted Patient Fees – Residential Aged Care – Daily Fees (50201 – 50249)
All daily fees should be reported separately under this account range using the appropriate cost centre

5.7.3 Admitted Patient Fees – Residential Aged Care Accommodation Payments (50351 – 50399)

Treatment of interest earned on accommodation bonds from residents, retention amount that may be deducted from accommodation bonds and accommodation charges paid by residential aged care residents is formalised in Circular 13/2005 as follow.

“These revenues must initially be treated as capital purpose income in the capital fund.

These revenues should be applied firstly to capital works and secondly for the retirement of debt relating to residential care as prescribed by the Aged Care Act 1997.

Where capital expenditure reasonably necessary to comply with the certification principles and meeting accreditation requirements is less than the amount received as capital purpose income, the balance of these accommodation payments can be used to improve the quality and range of aged care services. At this point the nature of the income changes from capital to operating. It is appropriate at that time (not before) to classify the income as operating revenue in order to match the expenses incurred.

As these revenues are used for aged care services as prescribed, these should be reported in the 50351 - 50399 revenue range under the X0000 series of cost centres. Additionally, accommodation payments include residential aged care accommodation supplements. These should be reported in the 51601 – 51699 revenue range under the X0000 series of cost centres. If the nature of these revenues changes from capital to operating, the J0000 and J2000 series of cost centres should be used.”

Interest earned on Accommodation Bonds should be reported in 58517.

Accommodation Charges and Retentions on Accommodation Bonds must be accounted for using separate account codes.

5.7.4 Community Aged Care Packages (50701 - 50749) & (51401 – 51499)

CACPs and EACH for client (care recipient) fees and commonwealth grants should be recorded under separate account codes

5.7.5 Commonwealth Grants – Residential Care Subsidy (51501-51599)

Includes the basic RCS and ACFI permanent and respite subsidy, oxygen, enteral feeding and the respite supplements. The RCS and ACFI subsidies should be allocated under separate account codes.

5.7.6 Commonwealth Grants – Residential Aged Care Accommodation Supplements (51601 – 51699)

Includes concessional, assisted resident, transitional, charge exempt and ex-hostel supplements. It also includes the Accommodation supplements introduced from March 2008 – the interim accommodation, accommodation, accommodation charge top up and the

transitional accommodation supplements. These are to be reported in the 51601 – 51699 range using a separate account code for each type of supplement i.e. concessional under one account code and transitional under another account code.

5.7.7 Commonwealth Grants – Residential Aged Care Other Supplements (51801 – 51899)

Includes any hardship, income tested and compensable *reductions* (negative amounts) that are not recorded elsewhere in the 51000 series of account codes It also includes the Conditional Adjustment Payment (CAP), Residential Respite Incentive (RRI), pensioner and viability supplements.

The CAP and Income Tested Reductions should be recorded using a separate account code for each type. i.e. CAP under one account code and Income Tested Reduction under another account code.

5.7.8 DH Grants – Support Supplements (55211 – 55219)

Includes Residential Aged Care revenue under the R&RHS Division Policy and Funding Plan Activity 13031 13107 and 35011.

5.7.9 DH Grants – Other Supplements (55231-55299)

Includes any other DH grants supplements that have not been allocated under other account code descriptions.

5.7.10 DH Grant – Clinical Inpatient care – Residential Aged Care (54716-54720)

Includes activity numbers 15049 and 15250 APMH supplements

5.8 GST on Funding and Payments

GUIDELINES FOR HOSPITALS ON GST APPLICABLE TO FUNDING AND PAYMENTS

5.8.1 Outside the scope of GST

The Goods and Services Tax Public Ruling GSTR 2006/11 Appropriations has made it clear that the majority of funding provided by the Department of Health to public hospitals, ambulance services and other Victorian Public Service (government related) entities is an appropriation falling within section 9-15(3)(c) of the Goods and Services Act 1999.

The funding includes weighted inlier equivalent separation (WIES), specific grants, capital and regular payments which are sourced from a relevant Appropriation Act and can be verified via Budget Papers number 3.

Commonwealth payments made directly to government related entities including public hospitals and ambulance services are also outside the scope of GST providing they satisfy the following criteria:

- there has to be an appropriation under an Australian law;
- the payment must be made by a government related entity to another government related entity; and
- the payment must be specifically covered by the appropriation.

A typical payment for this category is residential aged care funding from the Department of Health and Ageing to public hospitals.

Appropriations also capture Commonwealth and State funding to DH and subsequent funding from DH to government related entities including public hospitals.

5.8.2 No GST

Payment from DH to public hospitals and ambulance services on Transport Accident Commission funding is not consideration for a taxable supply as DH only pays public hospitals on behalf of TAC.

5.8.3 GST Free Services

Public hospitals may also receive payment from the public, government departments or health insurance companies for their GST free services pursuant to section 38-20 Hospital treatment or 38-25 Residential care of the Goods and Services Act 1999.

5.8.4 Commercial Transactions

Public hospitals that issue assessment reports for insurance companies must charge GST on these services as they are not covered by section 38-20 of the GST Act 1999.

The GST-free treatment of medical services only applies where the supply is made directly to the patient and consequently commercial payments for goods and services between public hospitals and DH will attract GST. On the same basis, if a public hospital orders a service or treatment for its patient from another public hospital then that transaction is a taxable supply.

Payments between public hospitals and private entities for commercial leases, pathology or referral services always attract GST pursuant to section 9-5 of the Goods and Services Act 1999.

5.8.5 Exclusion

These revised arrangements do not apply to denominational hospitals.

6 Accounting for Pathology and Medical Imaging Services

6.1 Overview

6.1.1 As part of the Chart of Accounts roll out (effective 1 July 2004) DH now require hospitals to treat pathology and imaging services as separate "Business Units" within the HSA segment of their activities.

6.1.2 The allocation of pathology/imaging costs has been driven by the classification of patients as follows:

- Public = HSA – charge to clinical units;
- Private = Internal SPF; and
- Other – tests performed for non hospital patients = Internal SPF.

The special purpose funds relating to "Private" and "Other" patients can be combined into one SPF.

6.1.3 It is important to note that for internal reporting purposes the model used by individual hospitals does not need to change provided it can be recut for reporting to DH.

6.1.4 It should be further noted that the HSA Business Units at the end of each year should breakeven (refer allocation methodology below). Profits would only be made in the SPF/SPF's relating to private patients and other non hospital patients – this further assumes that the pathology/imaging costs for public patients are fully reallocated out to the appropriate clinical unit.

6.2 Costing and Allocation Methodology

6.2.1 Diagnostics charges will need to be allocated to the relevant clinical unit cost centres for HSA patients and Special Purpose Fund for private or other patients based on the following:

- Outsourced Services – rate charged by external provider (generally a % of CMBS).
- In house Services:
 - Pathology – % CMBS
 - Imaging – CMBS Schedule

6.2.2 HSA Clinical Units to be charged are as follows:

Table 9 HSA Clinical Unit Cost Centres

Program	Cost Centre Range
Acute Inpatients	A4002 – A7450
Emergency	B0002 – B0400
Acute Non Admitted Patients	C0002 - C2150
Other Acute Funded Services	D0002 – D0600
Sub Acute	F0252 – F0400
Mental Health	H0252 – H0400
Mental Health Residential Care	H8702 – H8850
Aged Residential Low Care	J0002 – J0050
Aged Residential High Care	J2002 – J2050
HACC	J5002 – J5400
Aged Care – Other	J7002 – J7150
Primary Health	L0002 – L0400
Drug Prevention Services	M0002 – M0850
Disability Services	M1002 – M1400
Public Health	M1502 - M1600
Dental Services	M2002 – M2400
Other Programs	M4002 – M4500

6.2.3 In order to ensure that this methodology is consistently applied the following need to be defined:

- Elements of the pathology/imaging business unit; and
- Cost base of the pathology/imaging business unit.

6.3 What is to be Included in Pathology/Imaging Service?

6.3.1 It is acknowledged that the range and complexity of pathology and imaging services will differ from hospital to hospital. The Chart of accounts cost centre listing prescribes various cost centres for pathology and radiology – refer below.

Extract from Chart of Accounts:

Table 10 Pathology and Radiology Cost Centres

Y	0000	Diagnostic Laboratory Services	Diagnostic Laboratory Services	Business Units
Y	0002 - 0050	Anatomical Pathology	Diagnostic Laboratory Services	Business Units
Y	0052 - 0100	Animal House	Diagnostic Laboratory Services	Business Units
Y	0102 - -0150	Biological Research Unit	Diagnostic Laboratory Services	Business Units
Y	0152 - 0200	Collection Centres	Diagnostic Laboratory Services	Business Units
Y	0202 - 0250	Molecular Biology	Diagnostic Laboratory Services	Business Units
Y	0252 - 0300	Biochemistry	Diagnostic Laboratory Services	Business Units
Y	0302 - 0350	Genetics	Diagnostic Laboratory Services	Business Units
Y	0352 - 0400	Haematology	Diagnostic Laboratory Services	Business Units
Y	0402 - 0450	Microbiology	Diagnostic Laboratory Services	Business Units
Y	0452 - 0500	Mortuary	Diagnostic Laboratory Services	Business Units
Y	0502 - 0550	Tissue typing services	Diagnostic Laboratory Services	Business Units
Y	0552 - 0600	Nursing	Diagnostic Laboratory Services	Business Units
Y	0602 - 0700	Corporate	Diagnostic Laboratory Services	Business Units
Y	0702 - 0999	Restricted for DH Use		
Y	1000	Medical Imaging Services	Medical Imaging Services	Business Units
Y	1002 - 1050	Angiography	Medical Imaging Services	Business Units
Y	1052 - 1100	Nuclear Medicine	Medical Imaging Services	Business Units
Y	1102 - 1150	Radiology -other	Medical Imaging Services	Business Units
Y	1152 - 1200	MRI	Medical Imaging Services	Business Units
Y	1202 - 1250	PET	Medical Imaging Services	Business Units
Y	1252 - 1300	CT Scanner	Medical Imaging Services	Business Units
Y	1302 - 1350	Ultra-sound	Medical Imaging Services	Business Units
Y	1352 - 1400	Nursing	Medical Imaging Services	Business Units
Y	1402 - 1500	Corporate	Medical Imaging Services	Business Units
Y	1502 - 1999	Restricted for DH Use		

6.3.2 In addition the following services should also be incorporated within the pathology/imaging Business Units:

- Vascular laboratory (excludes the cardiac catheter lab) (imaging));
- Nursing Services (pathology and imaging); and
- Mammography (excluding Breastscreen Services) (imaging).

If you are unclear on whether specific activities should be included in the pathology/imaging business unit please contact DH for further clarification.

6.3.3 It is common for Blood Gas machines to be located at key points within the hospital eg emergency, ICU, CCU, Operating Theatres. The tests performed using these machines are generally performed by clinical staff. The cost and responsibility for maintaining these machines is borne by pathology. When a test is performed using the blood gasses machinery it should be recorded within the pathology system – if pathology is outsourced then the external provider will charge for this test.

6.3.4 The costs incurred in maintaining these machines should be included within the pathology department and the tests performed charged out to the relevant unit as part of the transfer pricing.

6.3.5 Mobile imaging equipment is often maintained within the following areas – Emergency, Operating Theatres, ICU, CCU. As above the costs of maintaining and servicing these machines should be captured in imaging cost centre and then transfer priced out. When a test is performed using the machinery it should be recorded within the imaging system – if imaging is outsourced then the external provider will charge for these tests.

6.4 Cost Base of the Pathology/Radiology Business Unit

6.4.1 OVERHEAD ALLOCATIONS

6.4.2 In House Services

Where pathology services are provided by the hospital for the hospital and others, overheads should be allocated to the pathology and imaging cost centres. These allocations should be based on the appropriate cost drivers relating to the costs being charged.

6.4.3 Outsourced Services

No overheads are to be allocated to the pathology and/or imaging cost centres where the service is fully contracted out to an off-site provider.

Where the services are provided on-site (by the third party provider), overheads should be allocated to the pathology and/or imaging cost centres based on the appropriate cost drivers. Depending on the nature of the contract with the third party provider, these costs may then be recoverable from the third party provider or alternatively will be added to the cost base of providing the service.

6.4.4 Allocation of Depreciation

Depreciation, relating to items owned by the hospital utilised by the pathology and/or imaging departments, should be allocated to the pathology/radiology cost centres. This allocation should be made via transfer pricing account 61899 – Depreciation Transfer Pricing. The depreciation cost will then be included when calculating the cost of the services provided.

6.4.5 Basis of Allocation – Gross Expenditure vs Net Expenditure

When determining the underlying cost basis for pathology/imaging allocations, gross costs only should be utilised.

Income and gross costs allocated to the HSA pathology/imaging cost centres should be transfer priced out separately. The income reallocations should be to program corporate cost centres only. Refer example below.

Further, DH grant income can only be allocated to HSA cost centres.

Revenue generated from private patients or outside services should be allocated directly to the appropriate SPF.

6.4.6 Treatment of Private Patient and Outside Hospital Costs and Revenue

Non-public patient costs should be transfer priced to the appropriate Special Purpose Fund. The associated revenue, which includes recoupment from private practice – is to be allocated directly to the internal specific purpose fund.

6.4.7 Treatment of non-CMBS/Pathology Schedule Items

It is widely recognised that diagnostic services performed may not be covered under the CMBS/Pathology schedule for varying reasons. Services that do not have a CMBS/Pathology number should be managed through a separate cost centre within the HSA range provided. The costs associated with these services should be charged to the appropriate clinical units based on usage and these costs should not be included in the calculation of the average CMBS/Pathology rate.

For example: HIV Tests performed currently do not have a CMBS item no. The costs associated with conducting these tests should be isolated within the pathology department and then recharged to the relevant cost centres (this may result in an internal estimate per test) – ie the cost centres responsible for ordering the test. If the testing is performed on non-hospital patients the cost should be charged back to the pathology Special Purpose Fund.

6.5 Allocation Methodology

6.5.1 Diagnostics charges will need to be allocated to cost centres based on a % of CMBS/Pathology schedule (% of cost basis) - as follows:

Where the hospital is providing services from the same laboratory for both public patients, private patients and outside services the % of cost basis used to charge the tests to individual cost centres should be the same. This is based on the analogy that the cost calculated to perform a test for a hospital patient should be no different than the cost to the hospital to perform the same test for an external party. The % of cost basis used should be determined on a monthly basis. Formula as follows:

<p>Actual % of Cost Used =</p> $\frac{\text{Total Pathology Business Unit Expenditure (including Transfer Pricing expenses)}}{\text{Total Costs for actual tests (based on 100% of cost per test)}}$
--

6.5.2 When setting the % of cost basis to charge back to cost centres the hospital should ensure that the services provided for both public, private and outside services results in expenditure net of transfer pricing equalling \$0. That is the total expenditure incurred by

the service in providing these services net of the transfer pricing recovery should equate to \$0.

6.5.3 All cost reallocations relating to pathology and imaging services should be recorded in the transfer pricing account range.

Account: Pathology – Transfer Pricing Range: 60100 – 60199
Account: Radiology – Transfer Pricing Range: 60200 – 60299
Pre 1 July 2005

The allocation to cost centres for 2004/05 should be as follows:

- Public Patients – Corporate HSA cost centres (at a minimum) or alternatively to the relevant clinical HSA cost centre;
- Private Patients – SPF cost centre; and
- Other - tests performed for non hospital patients – SPF cost centre.

Post 1 July 2005

Effective 1 July 2005 Pathology and Imaging costs relating to public patients, will be required to be charged to individual cost centres within the clinical units range (refer detailed listing above).

6.5.4 Out of Hours Services – Charged at Premium Rates - Where there are additional recognised costs for providing out-of-hours services eg salary loadings, a premium should be added to the cost of providing the service. This should be calculated by establishing an average premium for all out of hours work.

6.5.5 Out of hours means a service that requires the labour to be un-rostered and purchased through on-call/re-call arrangements.

6.5.6 The methodology for doing this would mean that for the same test the hospital would set two prices:

- Normal price would be based on the standard schedule
- Out of Hours rate would be based on the standard schedule + the calculated Out-of-Hours premium.

6.5.7 To enable this to be costed and allocated appropriately when collecting the monthly data a mechanism would need to be set up to identify the Out-of-Hours work. This may be determined by the time the service was provided or other mechanisms as identified by the hospital.

For example – Calculation of Radiology Premium for the month:

<p>Out of hours premium for the month =</p> $\frac{\text{Total Out of Hours Costs (On Call/Re Call Costs + incidentals)}}{\text{No. of imaging exams performed outside rostered hours}}$
--

6.5.8 Charging Out Services Relating to Complex Cases (may cross more than one Clinical Unit) Allocations of appropriate clinical units should be to the lowest level comfortably accommodated by the hospital's systems.

Refer to appendices 5 and 6 for examples of in house and outsourced services.

7 Accounting for Allocation of Overheads

The following business rules have been reviewed by the Chart of Accounts Urgent Issues Group.

7.1 Minimum Requirements for Overhead/Clinic Support Cost Allocations

- 7.1.1 All Infrastructure Services, Corporate Services Cost Centres (all R Cost centres) costs and Clinical Support Costs (all P Cost Centres) should be charged to the corporate cost centres within each H SA program EG Corporate Inpatients, Corporate Emergency, Corporate Non Admitted, Corporate Sub Acute etc. via transfer pricing and directly to Non H SA cost centres (where applicable).
- 7.1.3 Please note that charging to corporate cost centres is a minimum requirement – charges can be allocated to individual cost centres if required.

7.2 Use of Cost Drivers to Calculate Allocations

- 7.2.1 When reallocating costs to programs, spf's and capital cost centres the most appropriate cost driver should form the basis of reallocation. EG Fuel, light and power – floor space, payroll services – payslips.
- 7.2.2 Where the hospital has not identified a specific cost driver - for example floor space, meals served or hours worked, they should otherwise be allocated to the program level using cost centre FTE as the allocation statistic. Where corporate costs are allocated to contracted services, contracted FTE should be estimated as the basis of the overhead allocation except where, as above, a more specific cost driver has been identified by the hospital.

7.3 Allocation Methodology

All reallocations relating to the above must be charged back using transfer pricing account codes. The transfer pricing codes are as follows:

Transfer Pricing Codes relating to recharging of P cost centres:

Table 11 Transfer Pricing Codes Relating to Recharging of P Cost Centres

60000	Transfer Pricing Accounts - Patient Expenses
60700 - 60799	Clinical Services - Transfer Pricing

Transfer Pricing Codes relating to recharging of R cost centres:

Table 12 Transfer Pricing Codes Relating to Recharging of R Cost Centres

61000	Transfer Pricing Accounts - Other Expenses
61001 - 61009	Domestic / Cleaning Services – Transfer Pricing
61010 - 61019	Laundry Services – Transfer Pricing
61100 - 61199	Finance - Transfer Pricing
61200 - 61299	Fuel Light and Power - Transfer Pricing
61300 - 61399	IT Services - Transfer Pricing
61400 - 61499	Human Resources - Transfer Pricing
61500 - 61599	Payroll Services Transfer Pricing
61600 - 61699	Hotel Services - Transfer Pricing
61700 - 61799	Engineering Services - Transfer Pricing
61800 - 61899	Other Infrastructure Services - Transfer Pricing
61900 - 61998	Other Administrative Services - Transfer Pricing

At a minimum the 61800 account code range and the 61900 account code range should be utilised to transfer price back infrastructure and administrative costs.

All costs associated with clinical support, infrastructure and administration should be charged to the appropriate P or R cost centre. At the end of each month the total costs incurred (net of any ancillary income) should be collated and transferred back to the program/spf/capital cost centres using the transfer pricing account codes highlighted above.

Please note – that wherever possible costs should be allocated to program related cost centres.

7.4 Actual Versus Budget

Transfer pricing allocations can be on either the budget figures or actual figures. However, if the budget is materially different to the actual data then the allocations should reflect the actual costs.

8 Accounting for Pharmacy Allocations

Pharmacy cost allocations are broken into two categories:

- Drug usage allocations
- All other related cost allocations

8.1 Drug Usage Allocations

Inpatients

Table 13 Drug Usage Allocations for Inpatients

Method of Dispensing	Allocation Methodology	Business Rule
<p><i>Inpatients:</i> Issues to general ward imprests which are then issued to patients.</p>	<p>As the information is readily available relating to ward issues propose allocation is to wards</p>	<p>Issues from the main pharmacy to ward imprests are expensed in the books of the health service at the time of dispensing from the main pharmacy.</p> <p>Via transfer pricing accounts – 60300 – 60399 Pharmacy Drugs Transfer Pricing - these issues are charged out to the appropriate corporate cost centre or to individual wards.</p>
<p><i>Inpatients:</i> Issues directly to inpatients based on scripts sent directly to the pharmacy (therefore bypassing the usage of the ward imprest).</p>	<p>On receipt of a script the pharmacy department are aware of the patient ward (as this is where the drugs are delivered) – they are not always certain of the prescribing doctor as handwriting often difficult to decipher. Therefore propose that allocations are to wards.</p>	<p>Inpatient Scripts dispensed directly to patients from the pharmacy are expenses at the time of dispensing from the main pharmacy.</p> <p>Via transfer pricing accounts - 60300 – 60399 Pharmacy Drugs Transfer Pricing - these issues are charged out to the appropriate corporate cost centre or to individual wards per the scripts.</p>
<p><i>Inpatients:</i> Upon discharge patients are often given scripts to fill at the hospital pharmacy – at this point the pharmacy dispense the drugs and obtain details of the patient ward that discharged the patient. <i>The patient contribution must be recorded as Admitted Patient Fees – Other under account range 50301 – 50349 Commonwealth Grants -PBS - Drug Receipts must be recorded under account range 51101 - 51199</i></p>	<p>As the pharmacy has details of the discharge ward the proposed allocation would be back to the discharging ward if required.</p>	<p>Discharge issues from the pharmacy department directly to patients are expensed at the time of issue. The cost of these drugs is covered by a combination of the patient PBS contribution and the Commonwealth PBS contribution. As the cost of these drugs is covered by PBS receipts there is no further need to allocate these drug issues to wards or to the appropriate corporate cost centre from pharmacy.</p> <p>NOTE: If these costs are allocated out to wards, the corresponding PBS income must also be allocated out to the wards.</p>

Outpatients

Table 14 Drug Usage Allocations for Outpatients

Method of Dispensing	Allocation Methodology	Business Rule
<p><i>Outpatients:</i> Issues to outpatients are generally done via the outpatient presenting a script to the pharmacy department.</p> <p>This may include VACS clinics and the Emergency department. NB: Patients attending federalised outpatient clinics must present their scripts to a community pharmacy – unable to get their script filled by the hospital pharmacy.</p>	<p>At present the outpatient script details are broken into two groups – Outpatients and Emergency. Therefore propose that these issues are allocated to the outpatients or emergency.</p>	<p><i>Issues to outpatients should be expensed at the time of issue.</i></p> <p>Via transfer pricing accounts - 60300 – 60399 Pharmacy Drugs Transfer Pricing - these issues should be charged to the outpatients or emergency department.</p>
<p><i>Outpatients:</i> High Cost Drugs/Section 100 are only recorded when issued to outpatients – at the time of issue the pharmacy department note that the drugs are of the “High Cost/Section 100” nature.</p> <p>NB the same drugs may be issued as normal drugs in other circumstances.</p>	<p>At the point of issue the pharmacy department record the patients relevant outpatient clinic.</p>	<p>Issues to outpatients should be expensed at the time of issue. These should be separately identified as High Cost/S100 expenses (as opposed to standard pharmacy expenses) – account 27101.</p> <p>As High cost/S100 drugs are supported by a grant from DH the effect on the health service of this expense is offset by the corresponding revenue. Therefore there is no further requirements to allocate these costs out of pharmacy. Where the drugs are not allocated out of pharmacy the High cost/S100 grant from DH must also be allocated to the pharmacy cost centre.</p> <p>NOTE: Where the High Cost/S100 drugs are allocated out to outpatients the corresponding grant from DH must also be allocated to outpatients.</p>

Other

Table 15 Drug Usage Allocations for Other

Method of Dispensing	Allocation Methodology	Business Rule
<p><i>Other:</i> Where the pharmacy department issue drugs to parties that are not classified as hospital patients eg outside entities, hospital staff. <i>Sales to outside entities and hospital staff contribution must be recorded as Sale Pharmacy Goods under account range 57601-57649</i></p>	<p>At the point of issue the pharmacy department should record the issue to other parties.</p>	<p>These issues and the corresponding revenue should be run through a separate Internal SPF cost centre. This cost centre should also receive s share of the pharmacy overheads and the corresponding income relating to the sale of these pharmacy items.</p>
<p>Pharmacy Returns: It is common practice for unused pharmacy items to be returned to the pharmacy department. This can include liquids, complete packages of tablets or individual tablets.</p>	<p>All pharmacy departments will have recycling policies which take into consideration materiality and quality control factors. It is common practice for high value tablets to be reissued out to other departments once all quality control measures have been cleared.</p>	<p>All returns that are to be recycled (not disposed) should be re-entered into the pharmacy stock system as a credit to the returning department. These credits should then be incorporated into the monthly pharmacy issues journals. This will ensure that the same drugs are effectively only costed once to wards (initial issue offset by the credit on return),</p>

8.2 All Other Pharmacy Cost Allocations

All other pharmacy costs should be charged to the corporate cost centres within each H SA program EG Corporate Inpatients, Corporate Emergency, Corporate Non Admitted, Corporate Sub Acute etc. via transfer pricing and directly to Non H SA cost centres (where applicable). The amount charged back should be net of any ancillary income.

Please note that charging to corporate cost centres is a minimum requirement – charges can be allocated to individual cost centres if required.

When reallocating costs to programs and spf's the most appropriate cost driver should form the basis of reallocation. In pharmacy this should be pharmacy issues (not pharmacy costs – allocating based on pharmacy costs may lead to distortions due to issues around low volume, high cost drugs).

All reallocations relating to the above must be charged back using transfer pricing account codes. The transfer pricing codes are as follows:

Transfer Pricing Codes relating to other pharmacy allocations:

Table 16 Transfer Pricing Codes Relating to Other Pharmacy Allocations

60000	Transfer Pricing Accounts - Patient Expenses
60400 - 60499	Pharmacy Other - Transfer Pricing

Transfer pricing allocations can be on either the budget figures or actual figures. However, if the budget is materially different to the actual data then the allocations should reflect the actual costs.

9 Accounting for Allied Health Allocations

Allied Health staff can be set up in one of two ways within the health services.

9.1 Allocated Directly to Programs

Where allied health staff work directly for programs they can be allocated directly to the program – i.e. on the master file the employee would be allocated directly to the relevant program cost centre. All consumables and other expenses incurred in delivering the service would then also be costed to the appropriate program cost centre.

9.2 Allocated to Pool Cost Centres

An extract from the chart of accounts cost centre listing is detailed below highlighting the ranges for Allied Health Cost Centres.

Table 17 Allied Health Cost Centres

Cost Centre Code		Unit
N	2000	Allied Health Services
N	2002 - 2050	Allied Health Services
N	2052 - 2100	Audiology
N	2102 - 2150	Chemotherapy
N	2152 - 2200	Child Abuse
N	2202 - 2250	Child development centre
N	2252 - 2300	Chiropody/Podiatry
N	2302 - 2350	Clinical Psychology
N	2352 - 2400	Cystic fibrosis
N	2402 - 2450	Dental
N	2452 - 2500	Diabetes Education
N	2502 - 2550	Dietetics
N	2552 - 2600	Immunology
N	2602 - 2650	Interpreters
N	2652 - 2700	Music therapy
N	2702 - 2750	Occupational Therapy
N	2752 - 2800	Oncology Services
N	2802 - 2850	Optometry
N	2852 - 2900	Orthoptics
N	2902 - 2950	Orthotics
N	2952 - 3000	Patient Appliance Centre
N	3002 - 3050	Physiotherapy
N	3052 - 3100	Play Centre
N	3102 - 3150	Radiotherapy
N	3152 - 3200	Reception and booking
N	3202 - 3250	Remedial Gymnastics
N	3252 - 3300	Sexual Assault Clinic
N	3302 - 3350	Social Work & Welfare Services
N	3352 - 3400	Speech Therapy
N	3402 - 3450	Stomal

At the end of each month Allied Health Costs net of ancillary income are required to be charged to the relevant program cost centres. This allocation should be to the program corporate cost centres at a minimum.

The basis for allocating costs to program cost centres should be based on the relevant cost driver based on the activity records highlighting where staff are working. At the commencement of the year an allocation methodology can be pre-determined based on historical activity records where these records are reflective of the current years expected activity. Where actual activity differs significantly from the historical data, a realignment of these data is required to reflect the actual activity.

Transfer pricing allocations can be on either the budget figures or actual figures. However, if the budget is materially different to the actual data then the allocations should reflect the actual costs.

All reallocations relating to the above must be charged back using transfer pricing account codes. The transfer pricing codes are as follows:

Table 18 Transfer Pricing Codes for Allied Health Services

60000	Transfer Pricing Accounts - Patient Expenses
60500 - 60599	Allied Health – Transfer Pricing

10 Accounting for Direct Cost Allocations

Direct cost allocations relates to specific expenses that are allocated to specific cost centres. Examples:

- Patient Meals
- Linen Costs
- Interpreting Expenses
- Phone Expenses
- Stationary Costs
- Patient Transport – Ambulance costs.

Wherever possible these costs should be allocated to specific program or non-HSA cost centres.

These costs will be derived from either an in-house service or from an external provider.

10.1 In-House Provider

Where these costs are obtained from an in-house provider an individual cost per item provided should be calculated and then charged to the internal cost centres. For example – a health service may provide all patient meals from their internal kitchens. A price per meal issued would need to be established to enable the patient meal costs to be charged. The recharging of the costs should be allocated via transfer pricing codes. The account code used to charge out the patient meals would be as follows:

Table 19 In House Charges

60000	Transfer Pricing Accounts - Patient Expenses
60600 - 60699	Patient Meals - Transfer Pricing

The remaining costs in the cost centre established to manage the patient meals – e.g. R0152 – R0200 – Food & Dietary Services – would then be cleared out as part of the other overhead allocation process highlighted at section 6 above.

10.2 External Provider

Where services have been outsourced the cost of those services is still required to be allocated to individual cost centres where possible. The total cost of the service should be allocated to a central cost centre and then transfer priced out to the individual cost centres.

For example – a health service has contracted to purchase all their patient meals from an external provider. The external provider invoices the health service monthly for patient meals. The Health Service should cost the entire bill to a central cost centre e.g. R0152 – R0200 – Food & Dietary Services, account code 29011- External Contracted Food Supplies, and then this will be allocated to individual cost centres using the transfer pricing methodology highlighted above. To ensure this is not an administrative burden the health service has arranged with the external provider to obtain an electronic copy of the invoice to enable the split to cost centres to be as simple as possible.

11 Accounting for Capital Related Transactions

11.1 Acquisitions

11.1.1 All Asset purchases are to be capitalised into the Capital Fund. Asset purchases are budgeted for and can be coded to all cost centres – Operating, SPF and Capital, depending on the funding source. The assets are then capitalised into the capital fund.

11.2 Capital Cost Centres Structure

11.2.1 The capital cost centre structure is as follows:

Table 20 Capital Cost Centre Codes

Cost Centre Range	Description
X0002 – X0500	Capital – Corporate
X0502 – X1000	Capital – Fundraising
X1002 – X2000	Capital - DH Funded Projects – Capital
X2002 – X3000	Capital - DH Other Funded Projects
X3002 – X4000	Capital – Commonwealth Funded Projects
X4002 – X5000	Capital - Internally Funded Projects
X5002 – X6000	Capital – Other

11.2.2 Capital Corporate

This is the main capital cost centre used to capture depreciation charges and all assets (that do not relate to a separate capital cost centre)

11.2.3 Capital Fundraising

This cost centre range is to be used to capture all capital fundraising projects and the associated assets. When these projects are finalized these cost centres may be closed and the balances transferred to the Capital Corporate Cost Centre

11.2.4 Capital – DH Funded Projects – Capital Management Branch

This cost centre range is to be used (where necessary) for all DH Funded Projects – Capital Management Branch (some health services may have a separate reporting system to record this information) – again when the project is completed the cost centre may be closed and all balances transferred to the main capital cost centre above.

11.2.5 Capital – DH Funded Projects – Other

This cost centre range is to be used (where necessary) for all DH Funded Projects – Other (some health services may have a separate reporting system to record this information) – again when the project is completed / acquisitions have been purchased the cost centre may be closed and all balances transferred to the main capital cost centre above

11.2.6 Capital – Internally Funded Projects

This cost centre range should be used (where necessary) for all internally Funded Projects (some health services may have a separate reporting system to record this information) – again when the project is completed the cost centre may be closed and all balances transferred to the main capital cost centre above.

11.2.7 Capital – Other

Where your needs are not met by any of the above – this range is available.

11.3 Capital Works in Progress

11.3.1 All capital projects are managed within the capital fund. Depending on agency's delegations a separate cost centre or project code should be established to monitor the ongoing project.

11.3.2 All expenses relating to capital projects are to be expensed to the capital cost centre including those disbursements that do not meet the capitalisation principals included in the relevant accounting standards or the department's capitalisation policy.

11.4 Depreciation

11.4.1 The depreciation charge is allocated to a capital cost centre within the capital fund. The actual depreciation charge is to be calculated and posted monthly.

11.4.2 Depreciation charges can be allocated to specific cost centre using the Depreciation Transfer Pricing Accounts in the following instances:

- Pathology and Radiology Business Units – please refer to 5.4.4
- Internally Managed SPF's where appropriate eg Linen Service Business Unit, Car Parking Business Unit
- Restricted Special Purpose Funds which require specific reporting requirements including depreciation allocations

11.5 Allocation of Expenditure – Relating to Capital Funded Projects

11.5.1 Where programs / projects are funded by capital grants all expenses relating to these projects should be captured within the capital cost centre including those that do not meet the capitalisation principals included in the relevant accounting standards or the department's capitalisation policy (Appendix 7, Examples).

12 The Cashflow Statement

12.1 General

12.1.1 The key issue in the preparation of the cash flow statement lies in determining what constitutes cash. The cash flow statement represents inflows and outflows of cash and cash equivalents. The distinction between cash and cash equivalents is crucial to the classification of cash flows in the cash flow statement.

12.1.2 Sales and purchases of investments for cash is reported under Investing Activities, but if the investment is regarded as a cash equivalent it would not appear or be identified at all, being simply a rearrangement of cash resources.

12.1.3 The applicable Standard is AASB 107. Under this Standard all readily convertible short-term liquid investments are qualified as cash equivalents. Under this definition, it may permit items such as short-term money market investments that are convertible to cash but not at investor's option to be included as cash equivalents. Investment maturity period with an original maturity period of three months or less can be cash equivalent.

12.2 Definition of Cash

12.2.1 Cash means cash on hand and cash equivalents:

- Cash on hand means notes and coins held, and deposits held at call with a financial institution. These include current account balance including bank overdraft and demand deposits.
- Cash equivalents are highly liquid investments with short periods to maturity, which are readily convertible to cash on hand at investor's options, and are subject to insignificant risk of changes in value, and borrowings which are integral to the cash management function and which are not subject to a term facility.
- The cash equivalents are restrictive as to maturity periods, conversion options and risk of changes in value. Short periods to maturity general means that an investment qualifies as a cash equivalent only when it has a maturity **of three months of less** from the date of acquisition. At call investments would qualify as a cash equivalent as it is readily convertible to cash on hand at investor's option

12.2.2 If short-term investment meets the definition of cash, it should be classified as Investment - Cash / Cash Equivalents (Account code range 70301 to 70329) in the balance sheet (item 82).

Cash at End of Period in the cash flow statement must tie up with the sum of Cash Assets (balance sheet item 80 – account codes 70001 to 70199), Bank Overdraft (balance sheet item 64) and Note 10 Short-term Investment Cash (Account Code range 70301 to 70329 and 70401 to 70449 – Investments General).

Due to the above validation requirement, short-term investment – general should be used to record general investment that meets the definition of cash and cash equivalents.

12.3 Monies Held in Trust

Monies Held in Trust includes Patient Trusts, Entry Contribution, Accommodation Bonds, Patient Accommodation Deposits and Information Technology Alliance.

Monies Held in Trust are balance sheet items with the liabilities supported by an equal amount of assets.

Cash / cash equivalents representing monies held in trust **is not included in Cash at Bank / On Hand in the balance sheet**. As such, they should not be included as part of the cash flows.

12.4 Salary Packaging

The following business rule has been reviewed by the Chart of Accounts Urgent Issues Group.

Salary packing is a continuing arrangement between employers and participating employees that allow the employees to draw down on the amount packaged.

Cash or cash equivalents representing salary packaging should be included in the cash flow statement. Although salary packaging is not treated as Monies Held in Trust, it should not be used for operating purposes.

13 Appendices

Appendix 1 Common Chart of Account Code Formats

Mandated codes that are correctly formatted, are to be used when reporting financial information to the department using the common chart of accounts.

Table 21 Code Strings for Financial Reporting using the Common Chart of Accounts

Code Name	Level	String	Description
Entity	Parent – is transmissible.	12345	Each hospital is required to have an Entity Code. This Code will be issued to hospitals by DH, to distinguish hospitals. The entity code (at parent entity level) may be up to five digits long and is numeric only.
	Child – is transmissible.	12345	The entity code (at child entity level) is a five digit code. This code is required for hospital networks that are required to prepare more than one balance sheet.
Campus		123	Within each entity, each hospital may have one or many campuses. Hospitals are required to establish (if not already reporting this way) a campus code for each campus. This will mean that DH reporting will be via program, via campus. The campus code is a three digit code and may be alphabetic, numeric or alphanumeric.
Cost Centre	Parent – is not transmissible (header code).	A1234	DH has issued a list of cost centre codes (see http://www.health.vic.gov.au/accounts/). This list mandates the numbering of all cost centres into specified ranges. Hospitals are required to adopt this numbering for their respective charts of accounts. Any queries when using this list should be directed to DH. The cost centre code is a five digit alphanumeric code. Only the first digit is alphabetic.
	Child – is transmissible.	A1234	The cost centre codes at child level are the same format as those at parent level - five digit alphanumeric code with the first digit alphabetic. For reporting purposes, the child level cost centre codes roll up into the parent cost centre codes, above.
Account	Parent – is not transmissible (header code).	12345	DH has issued a standard account code list, see http://www.health.vic.gov.au/accounts/ . This list mandates the numbering of all account codes either specifically or via specified ranges. Hospitals are required to adopt this numbering for their respective charts of accounts. Any queries when using this listing should be directed to DH. The account code is a five digit numeric code at parent level.
	Child – is transmissible.	12345	For reporting purposes, the child level account codes roll up into the parent account codes, above.
Sub Account		123	The sub account code is a three digit code for sub accounts, where hospitals may require a wider range than is already specified.

Appendix 2 Common Chart of Accounts Implementation Timetable

Table 22 Common Chart of Accounts Implementation Timetable

Component	Description	Effective From (Date)
Business Rules	Unless otherwise stated, the Business Rules detailed are effective from 1 July 2006.	1 July 2006
Pathology and Radiology Services	Consistent with the common chart of accounts, these services are to be maintained as Business Units. To ensure that the appropriate costs are reported within the Health Service Agreement (at a minimum), those costs pertaining to public patients only, were required to be transferred (as a minimum) to the <i>corporate cost centre</i> within each program, prior to July 2004. These transfers were recorded in the <i>transfer pricing account range</i> .	By July 2004
	Pathology and Radiology costs were required to be charged to individual cost centres within the clinical units range.	1 July 2005
Clinical Services - Pharmacy and Allied Health Services	These services are required to be charged out at the program level (as a minimum). Hospitals already recharging these costs, may continue to do so using the <i>transfer pricing account codes</i> .	1 July 2005
Clinical Support, Infrastructure and Corporate Overheads	These services are required to be charged out at the program level (as a minimum). Hospitals already recharging these costs, may continue to do so using the <i>transfer pricing account codes</i> .	1 July 2005
Inpatient – Outpatient Splits	Hospitals are required to split services between Inpatient Services and Outpatient (non-admitted) Services within the acute program. Hospitals already reporting this way may continue to do so. Medical and Nursing costs need only be allocated to the Medical and Nursing cost centres, within the non-admitted patient range, and need not be allocated at a clinic level (unless this is the current practice). Admitted patients need to be allocated (as a minimum) to the appropriate <i>corporate cost centre</i> . Hospitals already recharging these costs in more detail, may continue to do so using the <i>transfer pricing account codes</i> .	1 July 2005

Appendix 3 Common Chart of Accounts Policy Development Groups

Chart of Accounts Urgent Issues Group

Members:

The group comprises 9 members, made up of 3 representatives from each of:

- Department of Health
- Metropolitan Health Services
- Rural Health Services

Terms of Reference:

- To resolve any matters relating to the Chart of Accounts brought forward by the Chart of Accounts Technical Committee.
- Decisions of this Group will be binding on all health services required to maintain the Common Chart of Accounts.

Frequency of Meetings:

Meetings are hosted on a needs basis.

Chart of Accounts Technical Group

Members:

The group comprises 9 members, made up of:

- Department of Health (3)
- Metropolitan Health Services (4)
- Rural Health Services (2)

Terms of Reference:

- To establish a standard chart of accounts and corresponding business rules to be utilised by Health Services when recording transactions in their general ledger and reporting to DH
- Matters that are not able to be resolved by the Chart of Accounts Technical Group will be referred to the Chart of Accounts Urgent Issues Group for resolution.

Frequency of Meetings:

- Meetings will continue to be held on a weekly basis, when the common chart of accounts and corresponding business rules are being established.

Appendix 4 The 7 Step Process for the Treatment of Employee Leave

STEP 1

For each pay period, any leave paid is to be expensed to the relevant provision. It is not to be directly allocated individual cost centres.

Table 23 Leave Types and Code Ranges

Leave Types	GL A/C RANGE
Annual Leave	86400-86499
Long Service Leave	86200-86299
ADO's	86500-86599

STEP 2

After Leave Liability reports have been run at month end (Note, these must be projected to the last day of the month), consolidate the \$ value of the Leave Liability for each individual (ie, do not use any cost centre splits).

Table 24 Leave Liability Cost Centres

EMPLOYEE #	COST CENTRES	FEB LEAVE BALANCE
11200	C2000	\$2000
13000	D3000	\$1300
13000	C2000	\$3900

Table 25 Employee Leave Balance

EMPLOYEE #	FEB EMPLOYEE LEAVE BALANCE
11200	\$2000
13000	\$5200

STEP 3

Calculate the total **Leave Movement** for each individual by subtracting the individual's leave balance for the prior month from that of the current month. (eg. **Feb Employee Leave Balance – Jan Employee Leave Balance**).

Table 26 Leave Movement

EMPLOYEE #	FEB EMPLOYEE LEAVE BALANCE	JAN EMPLOYEE LEAVE BALANCE	LEAVE MOVEMENT
11200	\$2000	\$1750	\$250
13000	\$5200	\$5500	-\$300

STEP 4

Add back any leave paid out for the current month (also by individuals).

Table 27 Leave Expense

EMPLOYEE #	LEAVE MOVEMENT	LEAVE PAID IN FEB	EMPLOYEE LEAVE EXPENSE
11200	\$250	\$0	\$250
13000	-\$300	\$700	\$400

STEP 5

Once you have calculated the total **Employee Leave Expense**, apply the master file cost centre splits as at the end of the month to arrive at the cost centre expense. This will ensure that you do not experience any big fluctuations caused by employee's moving between cost centres. Please note that for any transfers that occur in that month, the new cost centre will incur the full months expense.

Table 28 Apply Master File Cost Centre Splits

EMPLOYEE #	MASTERFILE COST CENTRES	COST CENTRE SPLIT %	EMPLOYEE LEAVE EXPENSE	COST CENTRE EXPENSE
11200	C2000	100%	\$250	\$250
13000	D3000	25%	\$400	\$100
13000	C2000	75%	\$400	\$300

STEP 6

This expense will be allocated to the following accounts for each cost centre

Table 29 Leave Type Allocations

Leave Types	GL A/C
Annual Leave	14001
Long Service Leave	14201
ADO's	14101

STEP 7

Any variance between the monthly Leave Liability reports and statutory reporting requirements (eg. AASB 1028) can be allocated to a corporate cost centre (R1702). This should be recalculated each quarter.

Appendix 5 Example: An In House Service

ABC Hospital has an internal pathology service. It provides services to three categories of clients:

- Public Patients
- Private Patients
- Other Health Services

ABC Hospital will be required to set up a Business Unit (within the HSA range for DH reporting) for their main pathology service. This Business Unit will be used to capture all costs associated with providing the pathology service and any ancillary income. ABC Hospital does not perform any tests that are not covered by a CMBS rate but if they did they are aware that the costs associated with these tests need to be captured separately and not included in their calculations for the average % of cost rate.

Pathology Service Profit and Loss as at 31 July 2004 (HSA Business Unit) (this does not include the revenue from private practice or outside services or the direct expenditure associated with these services as it is assumed that this is allocated directly to the appropriate SPF).

Table 30 In-House Services

Account Description	\$
Expenses:	
Salaries and Wages	650
Superannuation	10
Consumables	200
Other Expenses	10
Total Direct Expenditure (A)	870
Transfer Pricing:	
Overhead allocations	100
Depreciation Transfer Pricing	30
Total Indirect Expenditure (B)	130
Total Expenditure (A) + (B)	1000
Revenue:	
DH Grants	200
Consulting Revenue	20
Other Income	10
Total Revenue (C)	230
Net Deficit	770

Step 1 Capturing Patient Data for the Month of July

ABC Hospital uses Kestral to record all their pathology activity. The finance department of the hospital have been liaising with the pathology department and now receive an excel file monthly which details all tests performed for the month by patient. An extract from the report as follows:

Table 31 Patient Data Capture

Kestral No.	Service Date	Surname	First	UR No.	DOB	Hospital ID Code	Billing Code	Dr Code	Inpatient Y/N	Ward / Clinic	CMBS Item No.
04G035104	5/04/2004	APPLE	KEVIN REGINALD	222222	27/05/1938	ACC	AHO	MURD	Y	HRA	65060
04G039079	20/04/2004	PEAR	JUNE ANITA	333333	30/12/1954	ACC	AHO	STRB	N	JLDH	65070
04G038588	19/04/2004	BANANA	DIANNE JOY	444444	21/01/1954	BMC	MC	KINN	N	EXT	65080
04G041733	26/04/2004	PINEAPPLE	LESLIE	555555	4/01/1948	BMC	MC	KINN	N	EXT	65090
04G041040	22/04/2004	KIWI	KAYE	666666	27/07/1952	BMC	MC	PAYBMC	N	EXT	65060
04G039830	21/04/2004	LEMON	IRENE MONA	777777	13/08/1918	CREEK	MC	SASS	N	EXT	65060
04G035331	6/04/2004	GRAPE	BERYL	888888	4/10/1927	EMG	MC	DUKR	N	EXT	65070
04G041147	23/04/2004	TOMATO	HILDA	999999	20/01/1918	EMG	MC	DUKR	N	EXT	65080

Step 2 Assigning Patient Data to Clinical Cost Centres

From the data obtained at Step 1 each test performed must be assigned to a clinical cost centre. ABC Hospital are able to do this based on the information they have obtained regarding the patient. They have designed a number of internal business rules based on the Kestral data to assist them in this process. As follows:

Hospital Code - Assists in determining campus patient was based in – be it the main acute campus, a sub-acute facility, nursing home or mental health unit.

Billing Code - This code determines whether the patient is public, private or Other.

Dr Code - This information may help in determining which clinical unit within the campus the patient belongs to.

Inpatient Y/N - This will help distinguish between inpatient and outpatient clinics

Ward/Clinic - This information should back the above information to assist in assigning the patient to a clinical unit eg a patient in the maternity ward would not generally be assigned to an aged care clinical unit.

Table 32 Patient Data Capture

Kestral No.	Service Date	UR No.	DOB	Hospital ID Code	Billing Code	Dr Code	Inpatient Y/N	Ward / Clinic	CMBS Item No.	Clinical Cost Centre
04G035104	5/04/2004	222222	27/05/1938	ACC	AHO	MURD	Y	HRA	65060	A4102
04G039079	20/04/2004	333333	30/12/1954	ACC	AHO	STRB	N	JLDH	65070	A6902
04G038588	19/04/2004	444444	21/01/1954	BMC	MC	KINN	N	EXT	65080	SPF
04G041733	26/04/2004	555555	4/01/1948	BMC	MC	KINN	N	EXT	65090	SPF
04G041040	22/04/2004	666666	27/07/1952	BMC	MC	BMC	N	EXT	65060	SPF
04G039830	21/04/2004	777777	13/08/1918	CREEK	MC	SASS	N	EXT	65060	SPF
04G035331	6/04/2004	888888	4/10/1927	EMG	MC	DUKR	N	EXT	65070	SPF
04G041147	23/04/2004	999999	20/01/1918	EMG	MC	DUKR	N	EXT	65080	SPF

Step 3 Calculation the Cost per Test Based on 100% Cost Basis

The next step for ABC hospital is to assign the cost to each individual item based on 100% cost basis. The lookup table used to obtain the costs for pathology is the National Schedule of Pathology Costs – this can be downloaded from the DH Chart of Accounts Website. Please note the cost per test used in the example below is not reflective of the pricing per the National Schedule of Pathology Costs – they have been:

Table 33 Cost per Test

Kestral No.	Service Date	CMBS Item No.	Clinical Cost Centre	Cost per Test – based on 100%
04G035104	5/04/2004	65060	A4102	50
04G039079	20/04/2004	65070	A6902	50
04G038588	19/04/2004	65080	SPF	150
04G041733	26/04/2004	65090	SPF	550
04G041040	22/04/2004	65060	SPF	50
04G039830	21/04/2004	65060	SPF	50
04G035331	6/04/2004	65070	SPF	50
04G041147	23/04/2004	65080	SPF	150
Total cost				1100

Step 4 Calculation of the Actual % Cost Basis

From the Pathology Business Unit Profit and Loss above we can see that the total expenditure is \$1,000. From Step 3 above we can see that the total cost base based on 100% is \$1100. Therefore to calculate the percentage of the cost basis that the pathology business unit is running at we divide the total expenditure by the 100% cost base – Formula:

<p>Actual % of Cost Used =</p> $\frac{\text{Total Pathology Business Unit Expenditure (including Transfer Pricing expenses)}}{\text{Total Costs for actual tests (based on 100% of cost per test)}}$ <p style="text-align: center;">= \$1000/\$1100 = 91%</p>

Step 5 Pathology Expenditure Transfer Pricing Journal

ABC Hospital is now required to prepare their pathology cost allocation journal.

Table 34 Pathology Cost Allocation Journal

Kestral No.	Service Date	CMBS Item No.	Clinical Cost Centre	Cost per Test – based on 100%	Cost per Test – based on 91%
04G035104	5/04/2004	65060	A4102	50	45
04G039079	20/04/2004	65070	A6902	50	45
04G038588	19/04/2004	65080	SPF	150	137
04G041733	26/04/2004	65090	SPF	550	501
04G041040	22/04/2004	65060	SPF	50	45
04G039830	21/04/2004	65060	SPF	50	45
04G035331	6/04/2004	65070	SPF	50	45
04G041147	23/04/2004	65080	SPF	150	137
Total cost				1100	1000

The journal is to be processed as follows:

Table 35 Journal

Dr/(Cr)	Account	Cost Centre	Amount \$
DR	Pathology Transfer Pricing In - 60100	A4102	45
DR	Pathology Transfer Pricing In - 60100	A6902	45
DR	Pathology Transfer Pricing In - 60100	Pathology SPF	910
CR	Pathology Transfer Pricing Out - 60199	Pathology Corporate – Y0602	(1000)

Step 6 Income Transfer Pricing Journals

DH Grants will need to be reallocated to HSA cost centres only using transfer pricing accounts. Other revenue will need to be reallocated using appropriate cost drivers over all appropriate cost centres.

Step 7 Allocation of Private Patient Revenue

Private Patient Revenue relating to pathology services would be allocated directly to the Pathology SPF by ABC Hospital.

Step 8 Allocation of Other Revenue from Non Hospital Patients

As for Step 3 above this revenue would be allocated directly to the Pathology SPF by ABC Hospital.

Step 9 Allocation of Costs Relating Directly to the SPF – Private and Outside Hospital Patients

The only costs that should be directly costed to the above cost centre (excluding the transfer pricing) would be those that were directly attributable to servicing private patients or outside patients eg delivery costs for outside patients (Table 36 excludes the pathology SPF and is the HSA cost centre only).

Table 36 Amended Profit and Loss for the Pathology Business Unit of ABC Hospital.

	Account Description	\$
Expenses	Salaries and Wages	650
	Superannuation	10
	Consumables	200
	Other Expenses	10
	Total Direct Expenditure (A)	870
	Transfer Pricing:	
	Overhead allocations	100
	Depreciation Transfer Pricing	30
	Total Indirect Expenditure (B)	130
	Total Expenditure (A) + (B)	1000
	Expenditure Transfer Pricing	
Pathology Transfer Pricing Out (C)	(1000)	
Amended Total Expenditure (A) + (B) + (C)	0	
Revenue	DH Grants	200
	Consulting Revenue	20
	Other Income	10
	Total Revenue (C)	130
	Revenue Transfer Pricing	
	DH Grants	(200)
	All Other Revenue	(30)
	Total Revenue Transfer Pricing (D)	(230)
Amended Total Revenue	0	
Amended Net Deficit	0	

Appendix 6 Example: An Outsourced Service

XYZ Hospital has an outsourced pathology service. The hospital employs staff and incurs costs relating to consumables (relating to the pathology service) and has an agreement with the provider that they will fully recover all costs. The provider then sends XYZ Hospital a monthly invoice relating to public patients only. This invoice details the services provided to individual patients based. The provider retains all income pertaining to private patients. The contractual agreement is based on a set % of CMBS. To account for this arrangement XYZ Hospital has followed the following process:

Step 1 Recovery of Hospital Costs

Set up an internal SPF to capture all costs incurred by XYZ Hospital in relation to pathology services. On a monthly basis the total of these costs are then tallied and an invoice is sent to the provider.

Table 37 Example of the Internal SPF Balances at the Time

	Account Description	\$
Expenses	Salaries and Wages	100
	Superannuation	10
	Consumables	100
	Other Expenses	10
	Total Direct Expenditure (A)	220
Revenue	Employee Cost Recoveries from third party	110
	Other Recoveries from third party	110
	Total Revenue (B)	220
Net Result		0

Step 2 Receipt of Monthly Pathology Invoice from Provider

Upon receipt of the monthly invoice from the external provider the XYZ record the following entry:

Table 38 Journal

Dr / (Cr)	Account	Cost Centre	\$
DR	Contracted Pathology Service	HSA Pathology Cost Centre – Y0602	250
CR	Trade Creditors	Balance Sheet	(250)
DR	Pathology Transfer Pricing In - 60100	Acute Inpatient Corporate – A8502	100
DR	Pathology Transfer Pricing In - 60100	Acute Outpatient Corporate – C8502	100
DR	Pathology Transfer Pricing In - 60100	Sub-Acute Corporate – F8502	50
CR	Pathology Transfer Pricing Out - 60199	Pathology Corporate – Y0602	(250)

Example of HSA pathology Cost Centre balances at the end of the month:

Table 39 Cost Centre Balances

Account Description	\$
Expenses:	
Contracted Pathology Service	250
Total Direct Expenditure (A)	250
Expenditure Transfer Pricing	
Pathology Transfer Pricing Out (B)	(250)
Net Result	0

Appendix 7 Examples of Expenditure Allocations Relating to Capital Funded Projects

Example 1 – DH Capital Funded IT project

ABC Hospital has received a capital grant from DH – Healthsmart – relating to the pre-implementation of the patient management system. The costs expected to be incurred in this project are as follows:

- Employee assigned to the project related costs – salaries and wages and related oncosts
- Incidentals relating to computer upgrades – which are less than \$1,000 and therefore cannot be capitalised
- Training for staff on new systems – which cannot be capitalised
- Purchase of upgraded PC's
- Fit out of training room to accommodate the project

In this scenario a portion of the employees salaries and wages may be able to be capitalised where they can be directly related to the development of software. If the employee is only gathering information relating to existing systems and not developing software or implanting new software these costs would need to be expensed. The only other items, which may be eligible to be capitalised would be the PC's and the training room fit out.

As the funds received are required to be classified as a capital grant (per directive from Healthsmart), then the corresponding expenditure should be matched against the revenue. To enable this to happen we required expense items to be captured within the capital Fund.

Example 2 - DH Funded Redevelopment Project

XYZ Hospital has received capital grants to redevelop a wing of the hospital. The types of expenditure to be incurred are as follows:

- Building works – able to capitalised
- Medical Equipment > \$1,000 – able to be capitalised
- Furniture and Fittings which individually are < \$1,000 such as tables and chairs – these would need to be expensed.

To ensure that XYZ Hospital can keep track of all expenditure relating to the Redevelopment they need to be able to allocate both the capital and expenditure items to the Redevelopment cost centre. This will also ensure that capital revenue is matched with the appropriate expenditure.

Example 3 – Internally Funded Redevelopment Project

DEF Hospital has agreed to internally fund the redevelopment of their cafeteria. The board have agreed to utilise the previous profits made from the cafeteria business unit to fund this project. DEF Hospital has established a capital cost centre to capture all costs relating to the redevelopment. In this instance all items that are unable to be capitalised relating to this project would be required to be costed to an internally managed SPF as that is where the revenue originated.