Independent Hospital Pricing Authority

IHPA

Hospital Patient Costing Standards

Version 3.1

July 2014

Australian Hospital Patient Costing Standards – Version 3.1 – July 2014

Contents

Abbreviations

Acronyms	Descriptions
ABF	Activity Based Funding
AHPCS	Australian Hospital Patient Costing Standard
ALOS	Average Length of Stay
AN-SNAP	Australian National Sub-acute and Non-acute Patient
AR-DRGs	Australian Refined – Diagnosis Related Groups
COAG	Council of Australian Governments
CT	Computerised Tomography
DEP	Depreciation
ECT	Electro convulsive therapy
ED	Emergency Department
FDR	Feeder system
GL	General Ledger
ICU	Intensive care Unit
IHPA	Independent Hospital Pricing Authority
IPTAAS	Isolated Patients Travel and Accommodation Assistance Scheme
LHN	Local Hospital Networks
LOS	Length of Stay
NAC	NHCDC Advisory Committee
NHCDC	National Hospital Cost Data Collection
NHHNA	National Health and Hospitals Network Agreement
NHPA	National Health Performance Authority
NHRA	National Health Reform Agreement
NPA	National Partnership Agreement on Hospital and Health Workforce Reform
OBD	Occupied Bed Days
OR	Operating room
PBS	Pharmaceutical Benefits Scheme
RVU	Relative Value Unit

Acronyms	Descriptions
SCP	Scope
SPS	Specialised Procedure Suite
S&W	Salary and Wages
TTR	Teaching, training and research
TWG	Technical Working Group
UDG	Urgency Disposition Group
URG	Urgency Related Groups
VMO	Visiting Medical Officer

About the Standards

Introduction

The Australian Hospital Patient Costing Standards (the Standards) have been developed in the context of significant health reform in Australia. A substantial body of work is underway to establish more transparent and equitable funding arrangements for public hospitals across Australia, that reflect the efficient cost of providing health services.

The National Health Reform Agreement (NHRA) signed by all jurisdictions at the Council of Australian Governments (COAG) in August 2011, sets out the intention of the Commonwealth Government and state and territory governments to work in partnership to improve health outcomes for all Australians. This includes Commonwealth and state and territory commitments in relation to public hospital funding including payments for services on an activity basis.

The Independent Hospital Pricing Authority (IHPA) is an independent government agency established under Commonwealth legislation on 15 December 2011 as part of the National Health Reform Agreement (NHRA). IHPA is charged with determining the National Efficient Price (NEP) for public hospital services, allowing for the national introduction of activity based funding (ABF). Each year IHPA receives cost data from jurisdictions via the National Hospital Cost Data Collection (NHCDC). This data underpins the NEP Determination.

This document sets out 37 standards based on the best available evidence and experience in hospital product costing. The generic term product costing is used throughout as it is considered best practice for hospitals to cost all products (patient and non-patient) simultaneously. The focus of the Standards is however on costing patient products (in the broad patient product categories of admitted, non-admitted and Emergency Department patients). It is expected that as product costing further evolves there will be more standards relating to costing non-patient products, particularly teaching, training and research (TTR).

It is recognised that compliance with the Standards represents a considerable challenge for those involved in hospital product costing. This document presents the standards and provides some assistance with interpretation; it is not intended to be a detailed set of implementation guidelines. The production of high quality reliable activity based costs data for hospitals by application of these standards is an essential component of the implementation of the national health reforms.

Purpose and intended audience

These Standards are intended for use by anyone that wishes to apply best-practice principles to costing hospital products. Consistent application of the Standards will generate high quality, reliable and comparable data that can be used by regulators, funders, providers and researchers to further develop the Australian hospital system.

Aside from the broad objective of disseminating best-practice, the Standards document specifies approaches to hospital product costing activities that the Independent Hospital Pricing Authority (IHPA) expects will be applied if the resultant data are to be used for purposes such as:

- setting the National Efficient Price;
- developing and/or refining classification systems to be used by IHPA;
- developing and/or refining relative value unit scales (including service weights); and
- the production of other reports and statistical collections including the NHCDC.

IHPA considers it imperative that any costing data it uses to carry out its statutory functions conform to the Standards. It is only through the use of consistent and reliable costing data by IHPA that stakeholders can be confident that the determinations made by IHPA reflect the best available knowledge of the efficient costs of operating hospitals in Australia.

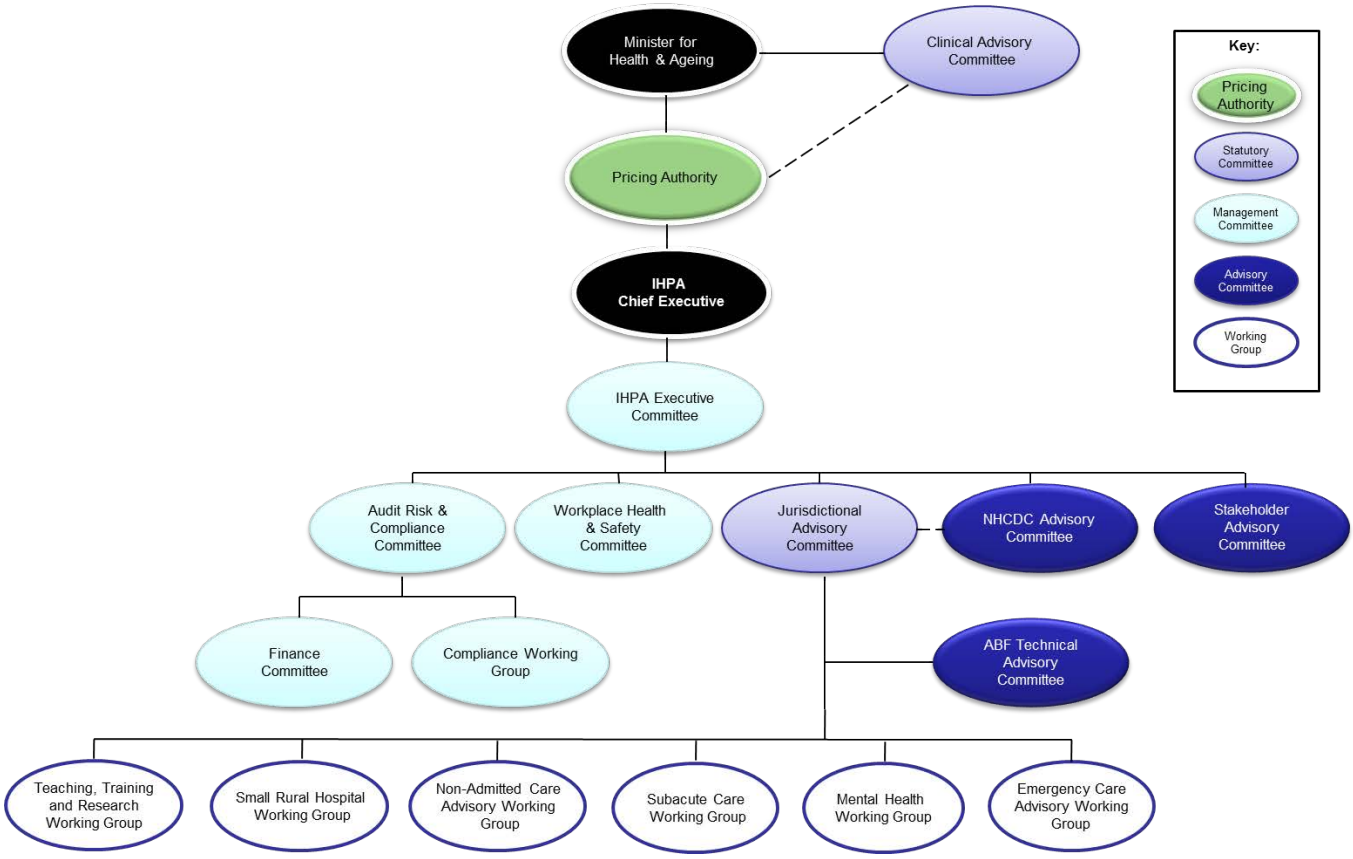
The use of patient costing data that is generated by application of the Standards is an important purpose of the Standards however it is not the only purpose. Patient costing data generated by the application of the Standards has other valuable applications such as allowing hospital funders and providers the opportunity to better understand hospital cost structures across both public and private sectors. It is anticipated that application of the AHPCS for local purposes will be just as important as IHPA's use of the data to generate the National Efficient Price.

Standards governance

IHPA is working with the NHCDC Advisory Committee (NAC) to develop and refine nationally consistent hospital costing standards. It is acknowledged that the Standards have a broader application than just the NHCDC. Accordingly, the development process has drawn on a wide range of sources (including hospital costing standards published by Australian and international professional bodies).

The NAC recommends new and revised Standards to the Pricing Authority. Figure 1 shows IHPA's committee structure and the role of the NAC within this structure.

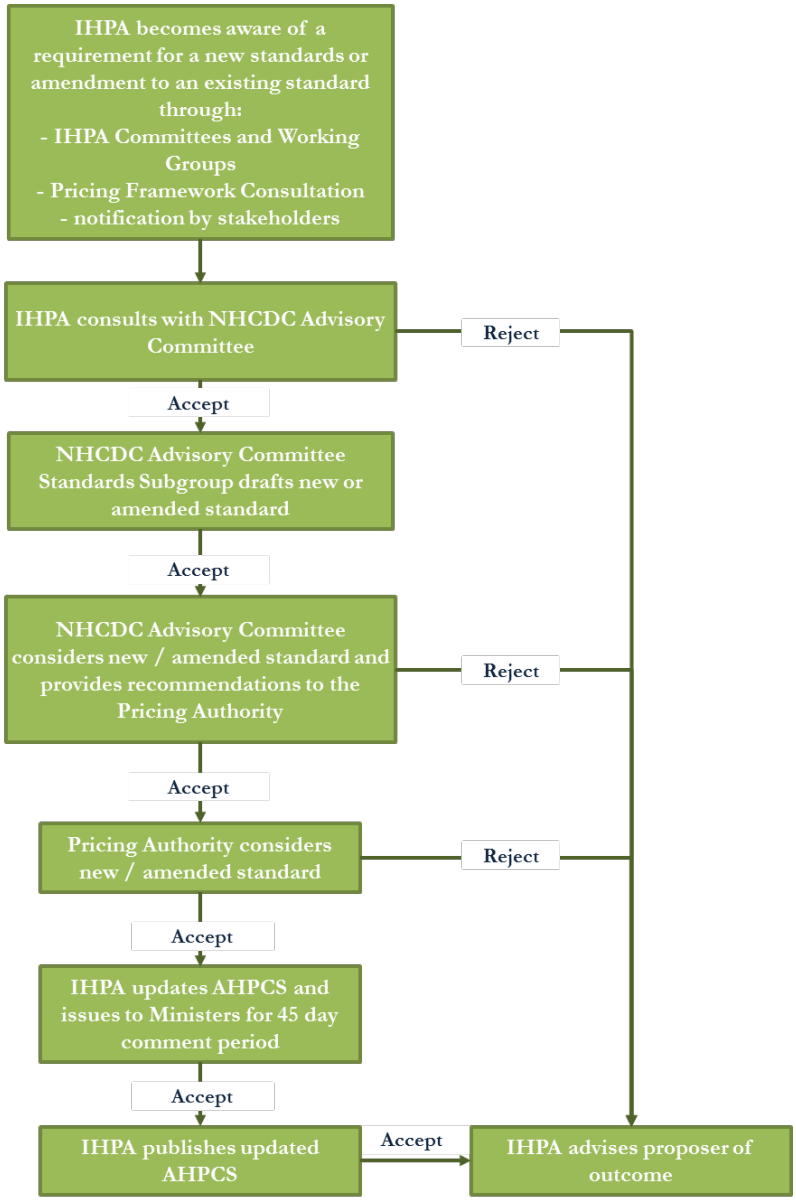
Figure 1: IHPA Committee structure



Standards development and approval process

The development and approval process for a new standard or for an amendment to an existing standard is illustrated in Figure 2.

Figure 2: Standards development and approval process



Feedback, comments and proposals relating the Standards

IHPA welcomes comments and feedback on the AHPCS, as well as submission for new and/or amended standards. Users can send comments to:

IHPA Hospital Costing
Independent Hospital Pricing Authority
Level 6, 1 Oxford Street
SYDNEY NSW 2000
Email: enquiries.ihpa@ihpa.gov.au

Overview of the product costing process

In simple terms hospital product costing is the process of identifying the inputs used in a hospital and attributing the costs of those inputs to the production of products (patient and non-patient). In practice this process is not simple and requires expertise in identifying inputs and outputs, guidance for allocating the costs, and considerable complex numerical processing, which can only realistically be done in purpose-built product costing software.

To assist with interpreting the Standards, it is considered useful to provide an overview of the product costing process. Figure 3 serves this purpose, illustrating at a high level, the process of transforming financial data from the general ledger and other relevant sources, together with data on the number and type of products produced, into a set of activity based costs for each end product class within each product category.

Broadly, the process of costing products consists of four steps. The first step is to manipulate the costs recorded in the general ledger to reflect the products that are being costed (this manipulation is best done inside the costing system, not the general ledger). This process involves identifying those costs incurred in the hospital, as well as those costs generated by the hospital that are necessary for producing the products to be costed (Standards SCP 1.004, SCP 2003, and SCP 3E.001). It then requires the alignment of the timing of incurring the costs and producing the products (GL 1.003). Once all in-scope costs have been identified, the costs reported in all cost centres are mapped to the standard line items (Standard GL 2.004), and the cost centres are partitioned into overhead and final costs centres (Standard GL 4.004).

The second step involves apportioning all costs in overhead cost centres to final costs centres (Standards SCP 3A.001, COST 1.002, COST 1A.002, COST 1B.002, COST 2.004, and DEP 1E.002). In performing this function it is important to ensure that the cost centres or parts of cost centres that are associated with non-patient products are allocated their fair share of overheads (if necessary, non-patient product costs centres may then be terminated, and only patient products costed to end-classes, typically individual patient service events).

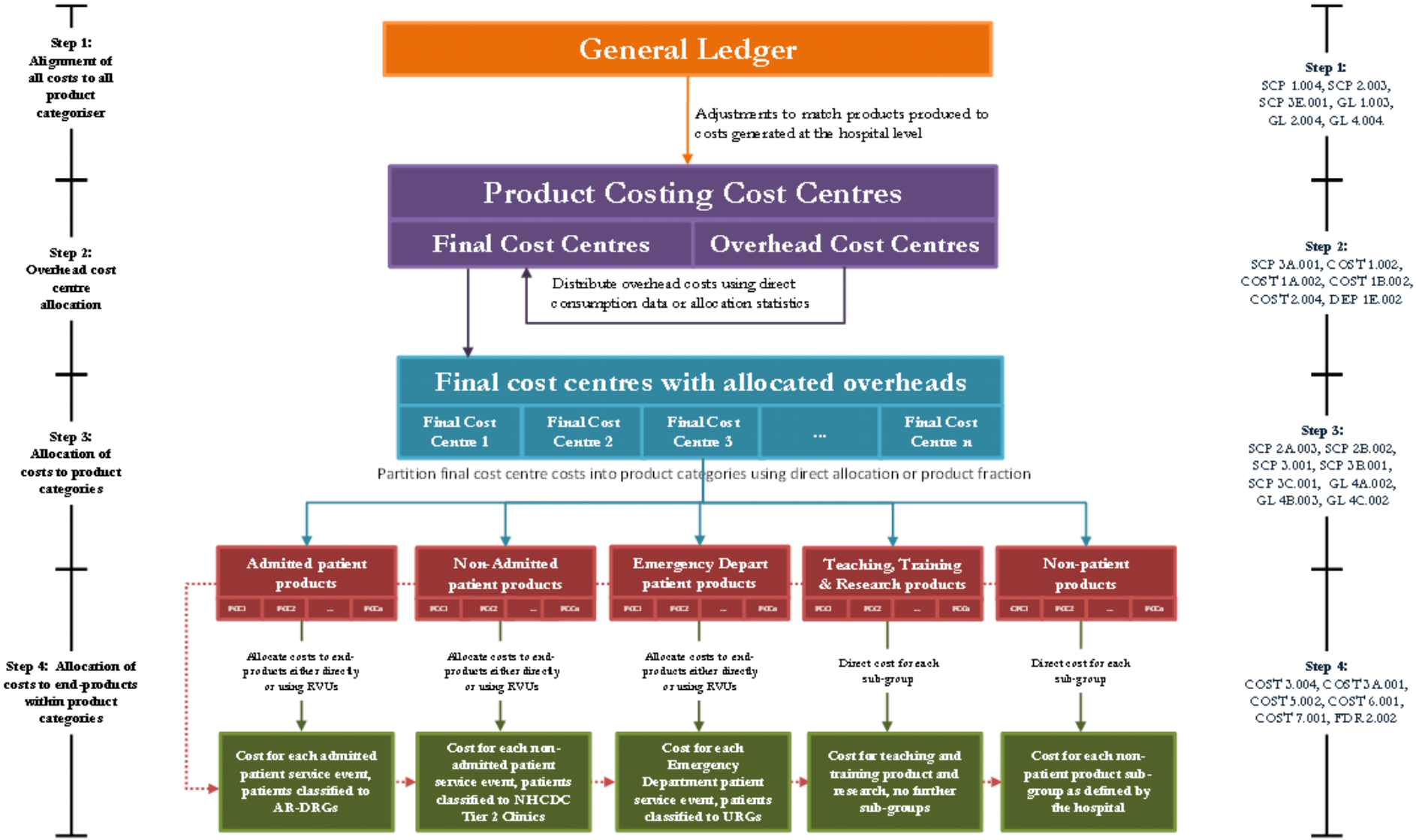
The third step involves partitioning the final costs centres into product categories. Ideally, a final cost centre will fit entirely within a product category. In practice this is often not the case and the costs in some final cost centres need to be apportioned across more than one product category (Standards SCP 3.001, GL 4A.002, GL 4B.003, and GL 4C.002). As the focus is on costing patient products it is important to clearly identify the costs associated with non-patient products (Standards SCP 2A.003, SCP 2B.002, SCP 3B.001, and SCP 3C.001). Ideally these costs should be carried in the costing process all the way through to producing final costs for non-patient products. Great care must be taken in this process, as errors here have significant impact on the final product costs.

The fourth step involves, within each product category, allocating the costs in final costs centres to end-classes within that category. Ideally for the patient products the end-classes are individual patient services events (i.e. an admitted patient episode, an outpatient service event, or an Emergency Department service event, reflecting patient level costing). The allocation processes are complex, and good allocation requires advanced knowledge of hospital operations (Standards COST 3.004, COST 3A.001, COST 5.002, COST 6.001, COST 7.001, FDR 2.002).

Those standards not directly referenced in this overview are still important. They set the context for performing the product costing and particularly the identification of the relevant

capital costs (Standards DEP 1.002, DEP 1A.002, DEP 1B.002, DEP 1C.002, DEP 1D.002). The other standards not identified with a specific step deal with issues relating to the costing process (Standards SCP 3D.001, COST 4.002) and the interpretation of the product costing results (Standard COST 8.001).

Figure 3: Overview of the product costing process



Layout of Australian Hospital Patient Costing Standards

Standards Description

Each standard in this document is described using the following attributes:

Categories used	Descriptions
Name	Title of Standard
Status	Candidate / Draft / Approved / Archived
Implementation Date	The date on which the standard was first implemented
Revision Date	Last date considered by Technical Working Group
Purpose	The reason for creating the standard, with reference to what it is intended to achieve
Standard	The standard which is to be met
Definitions	An explanation of terms in the standard which need to be defined
Guidelines	Advice and assistance for implementation of the standard
Sources	Reference to the source of definitions, classification systems or other material used in the description of the standard

Standard Numbering

Standards will be numbered with an alpha prefix as set out below:

- SCP – Scope
- GL – General Ledger
- COST – Costing process
- DEP – Depreciation
- FDR – Feeder system
- REP - Reporting

Following the prefix will be a number representing the number in the series, decimal point and a three digit number representing the version of the standard.

Versions with an alpha suffix to the main number in the series are subsidiary standards that provide guidance on the treatment of specific issues within the main standard.

Version numbers are only changed if the standard is altered. As stated above, the revised date indicates when the standard was last reviewed by the Technical Working Group. This may or may not result in a change in the version number, depending on whether the standard is altered.

Version Numbering

Minor amendments, additions or deletions to the version will result in a change to the version number after the decimal point. Where major amendments or additions to the standards occur, this will result in a change to the overall version number.

Master List

The following is a Master List of the standards contained in this version of the document:

Master List of Standards
• SCP 1.004 – Hospital Products in Scope
• SCP 2.003 – Product Costs in Scope
➢ SCP 2A.003 – Teaching and Training Costs
➢ SCP 2B.002 – Research Costs
• SCP 3.001 – Matching Production and Cost
➢ SCP 3A.001 – Matching Production and Cost – Overhead Cost Allocation
➢ SCP 3B.001 – Matching Production and Cost – Costing all Products
➢ SCP 3C.001 – Matching Production and Cost – Commercial Business Entities
➢ SCP 3D.001 – Matching Production and Cost – Negative Costs
➢ SCP 3E.001 – Matching Production and Cost – Offsets and Recoveries
➢ SCP 3F.001 – Matching Production and Cost – Order Request Point
➢ SCP 3G.001 – Matching Production and Cost – Reconciliation to Source Data
• GL 1.003 – Accrual Accounting
• GL 2.004 – Account Code Mapping to Line Items
• GL 4.004 – Cost Centre Mapping
➢ GL 4A.002 – Critical Care Definition
➢ GL 4B.003 – Emergency Department Definition
➢ GL 4C.002 – Operating Room and Specialised procedure Suite Definition
• COST 1.002 – Overhead Allocation Method
➢ COST 1A.002 – Overhead Allocation – Hotel Services
➢ COST 1B.002 – Overhead Allocation – Overhead Depreciation Costs
• COST 2.004 – Overhead Allocation Statistics
• COST 3.004 – Final Cost Allocation to patients and other products
➢ COST 3A.001 – Allocating clinical salary and wages to patients and other

Master List of Standards
products
➢ COST 3A.002 – Allocation of medical costs for private and public patients
➢ COST 4.002 – Costing Frequency
➢ COST 5.002 – Treatment of work in progress costs
• COST 6.001 – Intermediate Product/Service Matching Method
• COST 7.001 – Interpretation of Product Costs Data
• DEP 1.002 – Capital Expenditure
➢ DEP 1A.002 – Asset Recognition
➢ DEP 1B.002 – Revaluation of Assets
➢ DEP 1C.002 – Useful Life
➢ DEP 1D.002 – Classes of Assets
➢ DEP 1E.002 – Allocation of Depreciation and Amortisation
• FDR 2.002 – Relative Value Units
• REP 1.002 – Reporting of Patient and other product costs

Standards

SCP 1.004 – Hospital Products in Scope

Number	SCP 1.004
Name	Hospital Products in Scope
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure that all products produced by a hospital are costed in the product costing process.
Standard	Hospitals will allocate costs to all hospital products grouped into the categories: • Admitted patient products; • Non-Admitted patient products; • Emergency Department patient products; • Teaching, Training and Research products; and • Non-Patient products.
Definitions	**Patient service event**: refers to the end-classes in the product categories admitted patient, non-admitted patient and Emergency Department patient. Definitions for each hospital product category, the sub-product categories (where used), the end-classes within each sub-product category and the classification system into which patient service events are grouped are contained in Attachment A.
Guidelines	**Admitted patient products** are subdivided by care type (see Attachment A); and within each care type an appropriate classification system is used to sub-categorise admitted patient service events into clinical and resource homogenous categories (e.g. AR-DRGs for acute admitted patients, AN-SNAP for admitted rehabilitation patients, and so on). **Non-admitted patient products** are categorised into NHCDC Clinics (see Attachment A) that reflect the characteristics of the service delivered to the patient. NHCDC Clinics are used to classify all non-admitted patient service events including those that are provided on-campus (typically referred to as outpatients) and off-campus (typically

Number	SCP 1.004
	referred to as outreach and/or community based health services). **Emergency Department patient products** are categorised into URG classes (see Attachment A) that reflect the urgency (triage) category of the patient, the disposition (admitted or not-admitted) and diagnosis of the patient. Note that for emergency services (i.e. services that do not meet the definition of an Emergency Department) UDG classes that reflect only the urgency and disposition of the patient are used (see Attachment A). **Teaching, Training and Research (TTR) products** are subdivided into teaching and training; and research, pending completion of work on the feasibility of developing sub-categories for TTR products that can be used in the activity based funding of these services. **Non-patient products** are not formally further sub-divided. Hospitals may choose to use sub-categories of non-patient products that reflect the services they provide. Typical examples of non-patient products might include commercial business entities such as Car Parking, Florist, Gift Shop, Café, Leasing of Commercial Space (e.g. for retail, or for private medical suites). Other non-patient products might include general health information services provided to the community (i.e. not individual patients).
Sources	National Minimum Data Sets; NHCDC Hospital Reference Manual

SCP 2.003 – Product Costs in Scope

Number	**SCP 2.003**
Name	Product Costs in Scope
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure that all costs generated by a hospital in producing patient and non-patient products are identified in the product costing process.
Standard	Include, in the product costing process, all costs incurred by, or on behalf of the hospital, that are necessarily incurred in the production of patient and non-patient products, subject to the specific exclusion that the costs of time provided by medical specialists to treat private patients that are not directly met by the hospital, are not to be imputed.
Definitions	**Costs**: include all hospital expenditure as reflected in the general ledger, as well as non-cash expenses (e.g. depreciation) and costs incurred by third parties that are necessary for production of hospital products (e.g. insurances, corporate costs, shared services costs).
Guidelines	**A. Third Party Costs** The test that needs to be applied, at the hospital level, in deciding whether or not to include a cost incurred by a third party is that the hospital products could not be produced without the inputs provided as a result of the costs incurred by that third party (see below for the exception regarding medical specialists costs relating to private patients). **B. Corporate Costs** As a general rule corporate costs should not be included for more than one level above the management of the hospital (e.g., in the public sector, some LHN level costs may well be necessarily incurred to produce hospital products, but it is unlikely that State/Territory Health Authority level costs are directly related to generating hospital products). Similar principles should be applied to corporate office costs in the private sector. **C. Included third Party Costs** Examples of costs that may be incurred by third parties that are part of the day-to-day production of hospital products, and hence should be included in the costing process, comprise:

Number	SCP 2.003
	• Ambulance and patient transport (generated by the hospital); • Blood products; • Insurance – building insurance; • Insurance – equipment; • Insurance – medical indemnity; • Insurance – workers compensation; • Organ and tissue donation for transplantation and retrieval; • Shared services, e.g. human resources, payroll, finance, procurement unit, and information technology; and • Corporate costs (e.g. costs incurred at LHN or equivalent level) that is necessary for production of hospital products. **D. Exceptions to Third Party Costs** As the AHPCS advocate all-product costing (see SCP 3B.001), no costs incurred by the hospital should be excluded from the product costing process. The only exception to this standard relates to when these costs are the labour cost of medical specialists, where it is not directly met by the hospital (i.e. not paid for under salaried medical officer, visiting medical officer, or equivalent arrangements), and are incurred in providing services to private patients (admitted or non-admitted). These costs are significant, and they are incurred in both public and private hospitals, but they typically do not find their way into hospital accounts. For example (the hospital does not pay, in most cases the medical specialist is paid directly for his/her time through a mixture of Medicare Benefits Schedule (MBS) payments, private health insurance payments and patient co-payments. For this reason it is best to cost private patient products separate from public patient products and **not impute costs** for specialist medical services, pathology services, and diagnostic imaging services for private patient products, where these costs are not directly funded by the hospital. The exception does not apply to any hospital inputs of products, irrespective of whether the hospital obtains revenue for the input or product (for example. prostheses supplied to patients for whom revenue is received from private health insurers). Such inputs or products should

Number	SCP 2.003
	be included in the costing process at actual cost (not revenue). . Some costs that involve patients may be best allocated to non-patient product categories. Examples of such costs include: • Aerial retrieval and Royal Flying Doctor Services; • Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS); and • Capital planning.
References	COST 3A.002 – Allocation of Medical Costs for Private and Public Patients
Sources	NHCDC Hospital Reference Manual

SCP 2A.003 – Teaching and Training Costs

Number	SCP 2A.003
Name	Teaching and Training Costs
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure the consistent identification of costs allocated to the 'teaching and training' sub-product category within the 'teaching, training and research' product category.
Standard	All costs should be allocated to the 'teaching and training' sub-product where direct teaching and training is clearly the purpose of the cost centre. A portion of the costs of other costs centres should be allocated to the 'teaching and training' sub-product where there is a robust and justifiable method of identifying that part of the costs attributable to direct teaching and training activities.
Definitions	**Teaching and training:** any activity where the primary aim is to transfer clinical knowledge for ongoing professional development via a teacher or mentor to a student or candidate in a recognised program/course that will result in either: • Qualifications that may meet registration requirements; or • Admission to a specified discipline where the right to practise in that discipline requires completion of the program/course. Teaching and training activities may include: • Automated/self-directed learning where the teaching and training component is electronically provided; • Presentation and development of content; and • Supervision/participation in curriculum based research. **Direct teaching and training (included in teaching and training costs):** where the sole purpose of the activity is teaching and training (e.g. a medical specialist presenting a clinical case study to an audience of registrars, residents and interns who are all enrolled in a recognised program/course). **Indirect teaching and training (not included in teaching and training costs):** where teaching and training is produced jointly with

Number	SCP 2A.003
	another hospital product (e.g. when teaching and training occurs as part of a review of a patient's condition, as would typically happen in a ward round conducted by a medical specialist in conjunction with registrars, residents and interns). **Note:** Health Workforce Australia refers to teaching as clinical training, hence the use of the collective term teaching and training.
Guidelines	Indirect or by-product teaching and training are considered as normal patient care and should not be allocated to the teaching and training sub-product. Staff training and development, whether clinical or non-clinical, are considered a normal cost of maintaining a safe workplace and appropriate patient care and should not be allocated to the teaching and training sub-product. **Note:** This definition is interim pending further developments in the ABF work stream on Teaching, Training and Research
Sources	NHCDC Hospital Reference Manual

SCP 2B.002 – Research Costs

Number	SCP 2B.002
Name	Research Costs
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure the consistent identification of research costs allocated to the research sub-product category within the 'teaching, training and research' product.
Standard	All costs should be allocated to the 'research' sub-product where direct research is clearly the purpose of the cost centre. A portion of the costs of other costs centres should be allocated to the 'research' sub-product where there is a robust and justifiable method of identifying that part of the costs attributable to direct research activities.
Definitions	**Research:** an activity where the primary aim is the advancement of knowledge through: • Observation; data analysis and interpretation; or other techniques that are secondary to the primary purpose of providing patient care; or • Activities associated with patient care where additional components or tasks exist (for example, the addition of control group in a cohort study). This definition excludes curriculum-based research projects (included as teaching). **Direct research (included in research costs):** where the sole purpose of the activity is research (e.g. preparation of a paper for publication from the results of a clinical trial, or additional tests ordered for research purposes that are not required for normal patient care). **Indirect research (not included in research costs):** where research is produced jointly with another hospital product (e.g. when research occurs as part of the normal patient care provided to a patient on a clinical trial).
Guidelines	Indirect or by-product research is considered as normal patient care and should not be allocated to the research product.

Number	SCP 2B.002
	Note: This definition is interim pending further developments in the ABF work stream on Teaching, Training and Research.
Sources	NHCDC Hospital Reference Manual

SCP 3.001 – Matching Production and Cost

Number	SCP 3.001
Name	Matching Production and Cost
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure alignment between the production quantities measured in each product category and the costs attributed to that product category in the fiscal (costing) period.
Standard	For the purposes of product costing, the costs taken from the general ledger and other sources will be manipulated so as to achieve the best match of production to cost measures at the levels of the whole hospital, each product category, each cost centre within a product category, and each end-class within a product category.
Definitions	Nil
Guidelines	Matching production quantities to cost is the most difficult process in product costing. Imprecision in matching is generally far more material, in terms of the impact on the estimated costs of end-classes within product categories, than other sources of imprecision (e.g. using an externally developed RVU scale). Matching starts at the level of the whole hospital by determining the manipulations required to the general ledger entries to align the costs to be used in product costing with the quantities of products produced (application of SCP 1.004, SCP 2.003., SCP 3E.001, GL 1.003, GL 1.003, GL 2.004, GL 4.004). This manipulation process should generally occur within the product costing systems (not the general ledger), and should be done in such a way that there is a clear reconciliation of the costs reported in the product costing system to the hospital's general ledger. At the second level, it is important to allocate overhead cost centres to final costs centres using either direct consumption data (where it is available) or an appropriate allocation statistic (application of SCP 3A.001, COST 1.002, COST 1A.002, COST 1B.002, COST 2.004, DEP 1E.002). This process yields a set of final cost centres containing fully absorbed costs that can then be assigned to product categories. At the third level, it may be necessary to partition final cost centres into product categories (application of SCP 2A.003, SCP 2B.002, SCP

<table>
<tr><th>Number</th><th>SCP 3.001</th></tr>
<tr><td></td><td>
3B.001, SCP 3C.001, GL 4A.002, GL 4B.003, GL 4C.002). For example many cost centres will provide services across multiple product categories. The costs in these cost centres will need to be apportioned across product categories using data derived from one-off surveys (e.g. medical staff in the cost centre spend x% of their time on admitted patients, y% on non-admitted patients and z% on teaching, training and research), or using, where available, direct consumption data (e.g. x% of imaging examinations are for admitted patients, y% are for non-admitted patients, and z% are for Emergency Department patients).

At the fourth level, costs are allocated to end-classes in each product category (application of COST 3.004, COST 3A.001, COST 5.002, COST 7.001, FDR 2.002). For patient level costing, the end-classes in the patient product categories are the individual patient service events. The end-classes for non-patient products are, at this stage, much coarser. The allocation is made directly where possible (i.e. the cost of each interim product consumed in the patient service event is known). When direct allocation is not possible, costs are assigned indirectly using RVUs (i.e. the volume and type of interim product consumed is known and its cost is estimated using an RVU).

In practice this process requires a strong understanding of the hospital's production process and the data that are available. Each level of matching is dealt with by a number of standards:
<table>
<tr><th>Matching Level</th><th>Relevant standards</th></tr>
<tr><td>All hospital costs to all hospital production</td><td>SCP 1.004, SCP 2.003, SCP 3E.001, GL 1.003, GL 1.003, GL 2.004, GL 4.004;</td></tr>
<tr><td>Overhead to final costs centres</td><td>SCP 3A.001, COST 1.002, COST 1A.002, COST 1B.002, COST 2.004, DEP 1E.002</td></tr>
<tr><td>Final cost centres to product category</td><td>SCP 2A.003, SCP 2B.002, SCP 3B.001, SCP 3C.001, GL 4A.002, GL 4B.003, GL 4C.002</td></tr>
<tr><td>Product category to end-class</td><td>COST 3.004, COST 3A.001, COST 5.002, COST 7.001, FDR 2.002</td></tr>
</table>
As can be seen, matching is the key ingredient required for successful product costing. This standard, in association with Figure 3, presents the framework within which each of the standards that are relevant to matching operates.
</td></tr>
<tr><td>Sources</td><td>NHCDC Hospital Reference Manual</td></tr>
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SCP 3A.001 – Matching Production and Cost – Overhead Cost Allocation

Number	SCP 3A.001
Name	Matching Production and Cost – Overhead Cost Allocation
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure that all costs accumulated in overhead costs centres are allocated to the final cost centres before any partitioning of costs into product categories is attempted, ensuring each product category (patient and non-patient) attracts its fair share of overheads.
Standard	All costs accumulated in overhead costs centres should be allocated to final cost centres before any partitioning of costs into product categories is undertaken.
Definitions	**Overhead costs:** are accumulated in overhead costs centres, which as per GL 4.004, are defined as a cost centre that accumulates costs that have an incidental rather than a direct relationship to a specific product category. Overhead costs centres typically accumulate costs for services (e.g. payroll) that are provided to organisational units in the hospital rather than to producing end-products (e.g. patients). One of the aims of the costing process is to redistribute all overhead cost centre costs across the final cost centres.
Guidelines	Allocating overhead costs final cost centres (second level matching, see SCP 3.001) is essential to ensure that all hospital products receive the appropriate share of overhead cost allocation.
Sources	NHCDC Hospital Reference Manual

SCP 3B.001 – Matching Production and Cost – Costing all Products

Number	SCP 3B.001
Name	Matching Production and Cost – Costing all products
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure that all hospital costs are allocated across the full range of products produced by a hospital, thereby allowing reconciliation of costing results to hospital accounts.
Standard	All costs should be accounted for in the costing process and allocated, as appropriate, across all patient and non-patient products generated by the hospital in the costing (fiscal) period.
Definitions	Nil
Guidelines	The results of product costing needs to reflect both the volume of production of all hospital products (as per SCP 1.004) and all in-scope hospital costs (as per SCP 2.003). Including all relevant hospital costs in the product costing process reflects first and third level matching (see SCP 3.001) and has the advantage of simplifying the process of reconciling product costing output with reported (and audited) hospital expenditure.
Sources	NHCDC Hospital Reference Manual

SCP 3C.001 – Matching Production and Cost – Commercial Business Entities

Number	SCP 3C.001
Name	Matching Production and Cost – Commercial Business Entities
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure that all hospital costs are allocated across the full range of products produced by a hospital, thereby allowing reconciliation of costing results to hospital accounts.
Standard	Commercial business entities should be treated as non-patient products for the purposes of product costing.
Definitions	**Commercial business entities:** are organisational units within a hospital that generate non-patient products for which revenue is obtained from third parties (i.e. not exclusively from hospital patients and staff).
Guidelines	Many hospital commercial business entities do not generate products that are used in the production of the hospital's patient products. Examples of commercial business entities include the florist shop, car parking, child care centres, and leasing of retail (e.g. for the operation of on-site cafes) or commercial space (e.g. for on-site private medical suites). For such commercial business entities, to the extent that at least part of their costs are accumulated in the hospital's operating accounts, they should be included in the product costing process and treated as non-patient products. Where there is no part of the cost of operating these entities included in the hospitals operating accounts then there is no need to include them in the product costing process (hospitals can choose to do so if they wish, and treat them as non-patient products). Where commercial business entities produce products that are also used in generating patient products (e.g. meals that are prepared for patients but also sold to third parties, linen laundered in the hospital laundry for third parties, etc.), their costs must be included in the product costing process. The costs of these entities should be partitioned, (e.g. for meals, into costs of patient meals, and costs of meals sold to third parties). In the absence of any better measure, the revenue derived from the sale of products to third parties may be taken

Number	SCP 3C.001
	as a surrogate for the cost (i.e. the revenue is treated as a cost recovery against patient product costs).
Sources	NHCDC Hospital Reference Manual

SCP 3D.001 – Matching Production and Cost – Negative costs

Number	SCP 3D.001
Name	Matching Production and Cost – Negative Costs
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure that there no negative costs in the outputs of the product costing process at the end-class level within a product category (e.g. at the patient level for admitted patients).
Standard	Hospitals will make adjustments within the costing process to ensure that costing outputs do not contain negative costs at the end-class level in any product category.
Definitions	Nil
Guidelines	The data to be used for patient costing must be adjusted to ensure that the cost attributed to a patient service event, or any other end-class in a product category, in the costing process output is not negative. There are a number of scenarios where negative costs could legitimately occur in the costing process. Most of these scenarios arise as a result of recharging between cost centres or in accounting for cost recoveries (see SCP 3E.001). Where there are negative costs in the starting costs file, they need to be offset against positive costs that will be treated in the same manner for costing purposes (i.e., in order, against positive costs in a different expenditure line in the same overhead cost centre that will be allocated in the same way to final cost centres, against positive costs in another overhead cost centre that will be allocated in the same way to final costs centres). If, after overhead allocation, there are still negative costs in final cost centres, then use same process (i.e. first offset within the cost centre against an expenditure line that will be allocated in the same way to patient products, and then offset against another final cost centre that will be allocated in the same way to patient products). Application of these processes should result in no negative costs at the end-class level for each product category.
Sources	NHCDC Hospital Reference Manual

SCP 3E.001 – Matching Production and Cost – Offsets and Recoveries

Number	SCP 3E.001
Name	Matching Production and Cost – Offsets and Recoveries.
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure that offsets and recoveries are treated consistently for the purposes of product costing.
Standard	Hospitals will not offset revenue against costs but cost recoveries may be offset against cost where appropriate.
Definitions	**Offset**: refers to the process of entering revenue generated from end-classes in any product category as negative cost in the hospital accounts. Offsetting of revenue from patient products should not occur in product costing. Revenue should be reported separately in revenue accounts, which may be at cost centre level but distinct from cost accounts. **Cost Recovery:** an amount recovered for the provision of an interim product/service by a hospital to a third party (i.e. not a hospital patient or staff member). Costs recoveries generally occur when the hospital sells interim products to third parties (e.g. meals) or provides staff to another health service where the services provided by those staff members are recorded in the production volumes of the other health service. In return for this staff time, the hospital receives an amount that reflects re-imbursement of salary.
Guidelines	For costing purposes, revenue derived from production of end-classes in any product category should not be offset against cost. Specific areas where revenue is not to be offset are: • Revenue received from private patient charging; • High cost S100 and PBS drugs; and • Compensable and ineligible patient revenues. For costs recoveries, best practice is to estimate that proportion of the cost centre costs that was used to generate the products/services for which the cost recoveries were received and partition that amount into a non-patient product cost centre. Where this approach is not possible or practical, the cost recovery may be treated as an estimate of the cost of

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	generating the products/services for which the cost recovery is obtained, and offset against the costs in that cost centre. This process should typically not generate negative costs, as cost recoveries should only reflect a small part of the operation of cost centres where the principal purpose is to generate interim products for use in the patient product production process. In any circumstance where offsetting the cost recovery does result in a negative cost, the process outlined in GL 5D.002 should be followed.
Sources	NHCDC Hospital Reference Manual

SCP 3F.001 – Matching Production and Cost – Order Request Point

Number	SCP 3F.001
Name	Matching Production and Cost – Order Request Point
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To identify the order request point so as to allow intermediate products/services to be costed to the correct patient service event.
Standard	All hospitals will ensure that intermediate products/services ordered as part of patient service events are allocated to one of the following product categories: • Admitted Care • Non-Admitted Care • Emergency Department Care
Definitions	**Order Request Point:** The department/service (cost centre) that orders or prescribes an intermediate product/service.
Guidelines	It is important to capture the intermediate products/services that are provided to patients within each hospital product category. The intermediate products/services where it is particularly important to ensure correct allocation to the correct end-class in each product category include: • Pathology • Imaging • Pharmacy • Allied Health For the purpose of matching, order request point defines that part of the hospital where an intermediate product/service is ordered or prescribed. For example, for a patient under the care of the Emergency Department who has an imaging test, the cost of that test must be attributed to the ED service event even if the patient is subsequently admitted to a ward.
Sources	NHCDC Hospital Reference Manual

SCP 3G.001 – Matching Production and Cost – Reconciliation to Source Data

Number	SCP 3G.001
Name	Matching Production and Cost – Reconciliation to Source Data
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure that there is a transparent reconciliation of the activity and costs data generated through the product costing process to the activity and costs that were captured in the source data.
Standard	Hospitals will produce a statement that reconciles the activity and cost data outputs of the product costing process to the activity and costs that were captured in the source data.
Definitions	Nil
Guidelines	It is vital that there be a clear link from the outputs of the product costing process to the source data. It is only through the preparation of a clearly documented reconciliation statement that stakeholders (inside and outside the hospital) can be assured about the quality of the outputs of the product costing process and therefore use the data with confidence. The reconciliation statement should clearly identify all costs brought into the costing process from outside the hospital's operating accounts (i.e. costs incurred by a third party). It should also clearly identify any manipulation of general ledger costs that has taken place to create a better match between costs and activity in the fiscal (costing) period. The reconciliation should also clearly align the volume of products that have been costed in each product category to the activity levels that are captured in the hospital's source data. Again, any inclusion of exclusions of activity in a product category to create a better match between costs and activity should be clearly documented, with explanations, in the reconciliation statement.
Sources	NHCDC Hospital Reference Manual

GL 1.003 – Accrual Accounting

Number	GL 1.003
Name	Accrual Accounting
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure that the costs of human and material resources consumed in the production of hospital products, is matched to the fiscal period in which those products are produced.
Standard	Data used in the product costing process will be drawn from the general ledger and other financial systems that apply accrual accounting principles (in accordance with Australian Accounting Standards).
Definitions	**Accrual accounting:** a method that records the costs of resources when they are consumed in the production process irrespective of when payment is made. In contrast, cash accounting attributes the costs of resources to the period in which payment is made.
Guidelines	If a hospital is wholly (or partly) using cash accounting, adjustments will have to be made to ensure that reported costs reflect accrual accounting methods. Accrual accounting takes into account (for example) the following: Creditors – where accounts are received near the end of the fiscal period but are not paid until the next fiscal period; Inventory levels – where the acquisition of stock has resulted in a significant change in inventory levels from one fiscal period to the next, rather than reflecting resources consumed in the production process; Prepaid expenses – where expenses are paid near the end of one fiscal period, that relate wholly or in part to goods or services consumed in the next fiscal period (e.g. insurance payments can relate to two financial years); Accrued expenses – where expenses are recognised in the fiscal period in which the organisation incurs liability for them, even though the actual payment is made in the next or some future fiscal period (e.g. employee superannuation and long service leave); and

Number	GL 1.003
	Non–Cash items – such as depreciation. Best practice is to make accrual adjustments for each fiscal reporting period (usually four-weekly or monthly) rather than to wait until the end of a longer fiscal period (e.g. financial year).
Sources	NHCDC Hospital Reference Manual; Australian Accounting Standards Board Standard 101.

GL 2.004 – Account Code Mapping to Line Items

<table>
<tr><th>Number</th><th>GL 2.004</th></tr>
<tr><td>Name</td><td>Account Code Mapping to Line Items</td></tr>
<tr><td>Status</td><td>Approved</td></tr>
<tr><td>Implementation Date</td><td>1 July 2014</td></tr>
<tr><td>Revision Date</td><td>February 2014</td></tr>
<tr><td>Purpose</td><td>To ensure that hospitals use a standard set of line items in the product costing process thereby improving the consistency and comparability of the resultant costs data.</td></tr>
<tr><td>Standard</td><td>Hospitals will map all in-scope costs to the standard list of line items.</td></tr>
<tr><td>Definitions</td><td>Line items: typically groups of general ledger expenditure account codes that describe the input type (rather than function type), which define the resources being used by a cost centre.</td></tr>
<tr><td>Guidelines</td><td>More detailed definitions of the line items to be used for product costing purposes as set out below are at Attachment B.
<table>
<tr><th>Code</th><th>Line Item</th></tr>
<tr><td>SWNurs</td><td>Nursing, Salaries and Wages</td></tr>
<tr><td>SWMed</td><td>Medical, Salaries and Wages (non VMO)</td></tr>
<tr><td>SWVMO</td><td>Medical, Salaries and Wages (VMO)</td></tr>
<tr><td>SWAH</td><td>Allied Health, Salaries and Wages</td></tr>
<tr><td>SWOther</td><td>Other staff types, Salaries and Wages</td></tr>
<tr><td>OnCosts</td><td>Labour (staff) oncosts, all staff types</td></tr>
<tr><td>Path*</td><td>Pathology</td></tr>
<tr><td>Imag*</td><td>Imaging</td></tr>
<tr><td>Pharm*</td><td>Drugs</td></tr>
<tr><td>Pros</td><td>Prostheses</td></tr>
<tr><td>Blood</td><td>Blood Products</td></tr>
<tr><td>MS</td><td>All other medical and surgical supplies (excluding</td></tr>
</table>
</td></tr>
</table>

Number	GL 2.004
	<table><tr><td></td><td>prostheses and drugs)</td></tr><tr><td>Hotel*</td><td>Hotel</td></tr><tr><td>GS</td><td>All other Goods and Services</td></tr><tr><td>Lease</td><td>Leasing costs</td></tr><tr><td>Deprec</td><td>Depreciation</td></tr><tr><td>Corp</td><td>Corporate costs (from outside the hospital GL and not otherwise specified)</td></tr><tr><td>Cap</td><td>Capital works – not in scope</td></tr><tr><td>Exclude</td><td>Excluded costs – not in scope</td></tr></table> *Except for cost centres in a Group with the same name (see GL 4.004), this line item should include all costs (salaries and wages, medical/surgical supplies, and other goods and services) relating to the named intermediate product/service. It is important that all relevant line items are used in order to allow reconciliation to the general ledger. However, not all line items will be used in the process of product costing (in particular capital works and excluded costs will not be in scope of the costing process).
Sources	NHCDC Hospital Reference Manual

GL 4.004 – Cost Centre Mapping

Number	**GL 4.004**
Name	Cost Centre Mapping
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure that hospitals use a standard set of cost centres in the product costing process thereby improving the consistency and comparability of the resultant costs data.
Standard	For product costing purposes, all in-scope cost centres should be mapped to the standard list of cost centres at the most detailed level possible.
Definitions	**Hospital cost centre:** a production unit which creates a range of related products. Related products are those which involve use of similar mixes of staff and/or equipment, and technically similar production methods. Each cost centre represents an area of expense. Cost centre names and groupings will vary from hospital to hospital. There are ultimately two types of cost centre – final (or direct) and overhead (or indirect). **Final cost centre:** a final cost centre accumulates costs that are directly attributable or specific to a product category. For this reason it is also known as a direct product cost centre or patient care cost centre (when speaking of patient products). These three terms are interchangeable, but final cost centre is the preferred term and will be used for consistency throughout these standards. Final cost centres can either be directly related to treatment of patients (such as nursing care) or can be attributable to a patient episode as an input to the full treatment episode (such as pathology). **Overhead cost centre:** an overhead cost centre accumulates costs that have an incidental rather than a direct relationship to a specific product category. Overhead costs centres typically accumulate costs for services that are provided to organisational units in the hospital rather than to producing end-products (e.g. patients). One of the aims of the costing process is to redistribute all overhead cost centre costs across the final cost centres.
Guidelines	A list of the standard cost centres to be used in mapping hospital cost centres for product costing purposes is at Attachment C. The list also allocates each defined cost centre to a group (for standardised reporting

Number	GL 4.004
	purposes) and also indicates whether the cost centre should be treated as overhead or final in the product costing process. From Attachment C it can be seen that typical examples of cost centres that should be grouped as final are Renal Unit, Radiology and Anaesthetics. They give their services to patients rather than to other cost centres. For this reason doctors and nurses salaries will usually also be final costs. A typical example of a cost centre that should be grouped as overhead is the cleaning service. It does not care for patients, but provides services to other cost centres. Note that it is possible to use direct consumption data to allocate overhead costs (e.g. patient meals consumed). This does not imply that overhead cost centres can be allocated as direct costs. It should be noted that there may not be a direct one to one relationship to the cost centres listed in Attachment C and those used in each hospital. It may be necessary to move expenditure from one cost centre to another to ensure the best matching of costs to the products produced. It may be appropriate to seek clinical input where there is some uncertainty about the mapping requirements. Generic cost centres should only be used where it is not possible to allocate a more specific cost centre (e.g. Plain Radiology should be used in preference to General Imaging).
Sources	NHCDC Hospital Reference Manual

GL 4A.002 – Critical Care Definition

Number	GL 4A.002
Name	Critical Care Definition
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure that there is a consistent definition of the boundary between Critical Care Units and General wards.
Standard	For product costing purposes the following units will be included in critical care: Intensive Care, Coronary Care, Cardiothoracic Intensive Care, Psychiatric Intensive Care, Paediatric Intensive and Neonatal Intensive Care. High dependency, special care nurseries and other close observation units either located within general wards or stand alone will be costed as general wards.
Definitions	**Critical Care Unit:** separate and self-contained area of a hospital dedicated to the management of patients with life-threatening illnesses, injuries and complications, and monitoring of potentially life-threatening conditions. It provides special expertise and facilities for support of vital functions and uses the skills of medical, nursing and other personnel experienced in the management of these problems. (College of Intensive Care Medicine).
Guidelines	Where close observation units, costs are integrated with Critical Care Units, these will be treated as critical care, recognising the difficulty in disaggregating Critical Care services from High Dependency services in combined units. Special Care Nurseries (SCN) attached to either a Neonatal Intensive Care Unit or in another combined unit, will be treated as critical care. Where the SCN can be identified as a separate ward or cost centre will be treated as clinical care.
Sources	College of Intensive Care Medicine of Australia and New Zealand http://www.cicm.org.au/resources.php

GL 4B.003 – Emergency Department Definition

Number	GL 4B.003
Name	Emergency Department Definition
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure that there is a consistent definition of the boundary between Emergency Department care and General wards.
Standard	The Emergency Department does not include any associated or attached short stay admitted units.
Definitions	**Emergency Department**: a department that provides initial, typically unscheduled, treatment to patients with a broad spectrum of illnesses and injuries, some of which may be life threatening and require immediate attention.
Guidelines	This standard restricts the Emergency Department to that area of a hospital that provides emergency care. Any discrete areas of the hospital that may be attached to, or associated with, the Emergency Department in which admitted patients are managed are considered to be general ward areas for product costing purposes. Such services include Short Stay Admitted Units, Clinical Decision Units, Short Stay Medical Assessment Units, and Emergency Management Units. The key defining attribute is admission to a bed in a discrete area that is used only for admitted patients, in contrast to admitting a patient while he/she is occupying a trolley or examination bay in the Emergency Department that is also used to provide care to patients who are not admitted. For the purpose of product costing, the Emergency Department service event is considered to comprise all the services provided in the period from a patient's presentation to his/her departure from the ED including all ancillary services ordered for the patient during that period.
Sources	NHCDC Hospital Reference Manual

GL 4C.002 – Operating Room and Specialised Procedure Suite Definition

Number	GL 4C.002
Name	Operating Room and Specialised Procedure Suite (SPS) Definition
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure that there is a consistent definition of the boundary between operating rooms and specialised procedure suites.
Standard	Operating rooms should be separated from Specialised Procedure Suites for the purposes of product costing
Definitions	**Operating room:** a designated area of a hospital where significant surgical procedures are carried out under surgical conditions under the supervision of qualified medical practitioners. The operating room must be equipped to deliver general anaesthesia and conform to the College of Anaesthetists and the Faculty of Intensive Care standards. **Specialised Procedure Suite:** a designated area of a hospital where surgical and non-surgical procedures are performed by an appropriately qualified clinician (including medical scientists).
Guidelines	This standard restricts operating room costs to those areas of the hospital which would typically be found in the theatre suite. There are a number of other areas in hospitals where procedures are performed, which should not be included as operating rooms but classified as specialist procedure suites for product costing purposes including: • Angiography; • Cardiac Catheter Suites; • ECT Suites; • Endoscopic Suites; • General Procedure Suites; • Hyperbaric Chamber; • Lithotripsy Suites; • Lung function laboratories;

Number	GL 4C.002
	• Non–invasive Cardiac Laboratories (e.g. Echo Labs); • Physiology Laboratories; • Radiotherapy Suites; • Respiratory Laboratories; • Sleep Laboratories.
Sources	NHCDC Hospital Reference Manual

COST 1.002 – Overhead Allocation Method

Number	COST 1.002
Name	Overhead Allocation Method
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure that the product costing processes recognises that both overhead and final cost centres consume the outputs of overhead cost centres.
Standard	All hospital overheads will be allocated using an algorithm that reflects the fact that both overhead and final costs centres consume the outputs of overhead cost centres.
Definitions	Nil
Guidelines	The key to understanding overhead allocation process is to consider that the allocation process mimics the flow of costs that would be captured if all services were billed internally. This analogy makes it clear that overhead costs are also incurred by overhead cost centres including the cost centre itself (e.g. the finance department consumes the services of the finance department). The costing process should recognise that overhead costs are distributed to all cost centres that interact with the overhead cost centre being allocated. The ultimate aim is to pass the costs of all overhead cost centres to the final cost centres. In an appropriately functioning costing engine (software) this process occurs through the solution of a series of simultaneous equations. It does not occur through the use of 'step down' methods which, by their nature, cannot recognise that a cost centre consumes its own products/services.
Sources	NHCDC Hospital Reference Manual

COST 1A.002 – Overhead Allocation – Hotel Services

Number	COST 1A.002
Name	Overhead Allocation – Hotel Services
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure that hotel services costs remain visible after allocation to the relevant target departments (final cost centres).
Standard	All hotel service costs (salaries and wages, and goods and services) will be allocated to the line item “Hotel” at the final cost level.
Definitions	**Hotel Services:** services that principally support the accommodation functions of the hospital including: • Food services (for patients); • Linen and laundry services; • Porters and orderlies; • Cleaning services.
Guidelines	Hotel services costs should remain visible when allocated to final cost centres, (i.e. not merged with costs flowing in from other overhead costs centres). In particular, the allocation of staff costs in the hotel services areas of the hospital should be based on the role being carried out (not qualifications of the person doing it). In most cases these two things will be the same. For example, the costs of a person working in the Catering Department (i.e. doing no nursing) who may be paid under a nursing Award should be regarded as hotel costs, not as nursing salaries and wages.
Sources	NHCDC Hospital Reference Manual

COST 1B.002 – Overhead Allocation – Overhead Depreciation Costs

Number	COST 1B.002
Name	Overhead Allocation - Overhead Depreciation Costs
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure that depreciation costs remain visible after allocation to the relevant target departments (final cost centres).
Standard	All depreciation overhead costs will be allocated to the line item called depreciation at the final cost centre level.
Definitions	Nil
Guidelines	Depreciation costs should remain visible when allocated to final cost centres, i.e. not merged with costs flowing in from other overhead costs centres.
Sources	NHCDC Hospital Reference Manual

COST 2.004 – Overhead Allocation Statistics

Number	COST 2.004
Name	Overhead Allocation Statistics
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Applicability	All hospitals
Purpose	To ensure that hospitals use the most appropriate statistic to allocate overhead costs, thereby improving the quality and comparability of the product costing results.
Standard	All hospital overhead costs will be allocated using one of an alternative order of allocation statistic.
Definitions	**Allocation statistics**: are relative values used to distribute overhead costs to the appropriate cost centres. These values measure the relative consumption of products/services produced by overhead cost centres by hospital organisational units and/or end-product classes. There are two basic types of overhead allocation statistics: • **Financial allocation statistic:** the use of a statistic such as nurse salaries to allocate the cost of nursing management overhead costs to all relevant cost centres; and • **Non-Financial allocation statistic:** the use of a statistic such as the number of meals, metres of floor space, or bed days to allocate an overhead cost to all relevant cost centres.
Guidelines	Overhead costs generally comprise a significant proportion of a hospital's operating costs and must be allocated correctly to produce the best estimate of the costs of patient and non-patient products. It is critical that the most appropriate allocation statistic is used to allocate overhead costs to the relevant final cost centres or end-product classes. In the product costing process, all costs accumulated in overhead costs centres must be allocated to the final cost centres before any partitioning of costs into product categories, and subsequently into end-classes within product categories is attempted, to ensure that each product category (patient and non-patient) attracts its fair share of overheads. Overhead costs can be distributed to final cost centres or, in some

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	circumstances, directly to end-product classes. The ideal situation is where there is an allocation statistic that enables either all or part of the costs in an overhead cost centre to be directly attributed to the end-product class (e.g. patient meals consumed in the admitted patient service event). Note that any part of the overhead cost centre costs that cannot be allocated directly to end-product classes will need to be distributed to final cost centres as described below (e.g. catering for doctors meetings). In practice, most overhead costs need to be distributed to final cost centres. In this situation the actual cost to the final cost centre cost, where available, is always the alternative allocation statistic. Actual cost centre cost is known in situations where there is internal or external billing for the products/services produced by overhead costs centres. Where the actual costs centre costs is not known, the tables in Attachment D provide hospitals with the alternate order of allocation statistics to be used for each cost centre. Hospitals will need to document the allocation statistic used for each overhead cost centre as part of the product costing process.
Sources	NHCDC Hospital Reference Manual

COST 3.004 – Final Cost Allocation to patients and other products

Number	Cost 3.004
Name	Final Cost Allocation to patients and other products
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure the most appropriate method is used to allocate final cost centre expenses to patients and other products, thereby improving the quality and comparability of the product costing results.
Standard	All final costs will be allocated to patients and other products using methods prescribed in this standard.
Definitions	**Final Costs** refers to all the expenses and overhead expenses allocated to a direct patient care or other product identified cost centre **Internal RVUs** are those relative value units derived within an LHN/hospital. **External RVUs** are those relative value units derived by a source outside of the LHN/hospital. **Conditional service weights** are qualified relativities for varying casemix classes where the consumption of a product/service is known. The costs are allocated on the basis of service weights, but only to those patients who actually consumed the product/service (eg: MRI services - Each patient who received MRI services will be allocated an equal share of the costs, and those patients who received no MRI services will be allocated no cost. Therefore data must be obtained on how many patients in each DRG were recipients of MRI services). **Unconditional service weights** are relativities based on predetermined average costs for each casemix class. Every patient will receive a share of the costs, regardless of whether they actually consumed the product/service. Therefore use must be made of data on how many patients there were in each casemix class.
Guidelines	This standard requires the application of a method which is considered reliable, and will improve the consistency and comparability of the product costing results across hospital services. Attachment E provides sites with the alternative options for allocating final costs. It should be noted that the preferred method of allocation is actual cost.

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	Where the purchase of intermediate products/services either internally or externally, • can link the consumption to a patient within a relevant product category or other product, • and the actual costs are known can therefore be used in product costing. In practice, where intermediate products/services are produced in-house, it is most common for the units of consumption of the intermediate/product service to be known but not the unit production cost. In this situation, the most accurate allocation of costs to end-classes within product categories (e.g. patient service events) is achieved through the use of relative value unit (RVU) scales. RVUs allow the determination of the weighted quantity (using relative cost) of intermediate products/services consumed by each end-class (across all product categories) and thus the total weighted quantity consumed in the hospital. These two data elements together with the cost in the final cost centre that produces the intermediate products/services can be used to allocate a quantum of cost that reflects actual consumption multiplied by relative cost to each end-class in each product category. **Use of service weights** The use of service weights (particularly unconditional service weights) should always be considered as the last option. Service weights are the relative costs of a service for each type of patient care product. For example, the relative costs of imaging or nursing across all AN-DRGs. If the imaging service cost weight for DRG 1 were 0.9, and the weight for DRG 2 were 1.8, this would mean that patients in DRG 2 cost twice as much in imaging, on average. Where no RVU scale is available for the intermediate product/service, costs can be allocated using relativities at the level of a casemix class (eg: DRG, URG). These relativities are known as service weights. Service weights have been developed from detailed costing studies, are expensive to develop and thus can be based on quite old data. These weights are often available in two forms: conditional and unconditional. When the consumption of an intermediate product/service is known or a surrogate indicator is available (eg: bed days on a ward for the nursing service or ICD-10-AM procedure codes for physiotherapy) then a conditional service weight can be used to provide relativities between cases using their casemix class.

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	If there is no indication of intermediate product/service use available then an unconditional service weight can be used. These weights have had two factors considered within their derivation ie: the average cost of the service for each casemix class and the propensity for cases in that class to use the service. It is expected that the practice of using service weights (particularly unconditional service weights) to allocate costs to patients will decline as costing systems and processes are further developed.
Sources	Product costing in Australian hospitals, A background guide to national costing work, Don Hindle 1999

COST 3A.001 – Allocating Clinical Salary and Wages to patients and other products

Number	COST 3A.001
Name	Allocating Clinical Salary and Wages to patients and other products
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure clinical salary and wage expenses held in departmental cost centres are distributed to the relevant product categories and final cost centres, before allocating them to patients in each product category.
Standard	Clinical salary and wage expenses held in departmental cost centres should be allocated to product categories of admitted and non-admitted patients including Critical Care, Emergency, Operating Rooms and Specialised Procedure Suites and any Consultation liaisons, before being allocated to the patients in those product categories.
Definitions	**Consultation Liaison** is when a patient is under the care of one physician who holds the medical governance/ bed card and another clinician or team provide a consultation service for the patient or a liaison service to the treating team providing care to the patient. Examples include a 'second opinion', advice on a particular problem, a case review, a one-off assessment or therapy session. Consultation liaison applies to inpatient (admitted) episodes and patients within an emergency setting or non-admitted setting. Adapted from Australian Rehabilitator Outcomes Centre AROC, General Definitions for AROC V4 Online Data Dictionaries, January 2014 **NOTE:** This definition is interim pending further developments in the ABF work streams.
Guidelines	The costs of clinical labour are often recorded within a single cost centre for each department type (e.g. Medicine, Surgery, Obstetrics and Gynaecology, Respiratory, Allied Health etc.) with the granularity of the classification of departments being a function of the hospital size and complexity. The issues with clinical labour costs are: • Clinical staffs normally work across a range of product categories of the hospital, and each component of clinical work may require a different feeder system to appropriately allocate the costs to the end-classes in

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	the relevant product category. • Identification of time spent providing a consultation liaison to other clinical units and emergency patients may need to be determined as a feeder extract may be difficult to obtain. o Where cost centres are predominately identified as a consultation liaison service then the use of a specific feeder is recommended or one developed in consultation with the consultation liaison department which would identify time spent with each patient. Otherwise these costs will be absorbed into the allocation. o Where consultation liaison is one part of a cost centres service then those costs will be absorbed into the allocation of the other services. • There are rarely all-encompassing feeder systems for the recording of clinical activity associated with the patients or other products in product categories. • Cost centres that accumulate clinical costs normally need to be apportioned across various product categories. • Clinical staff of various qualification levels (staff specialists, VMOs, registrars, residents, interns, allied health professionals etc.) will require a different consideration in the cost allocation process. • Clinical staff will usually work across all types of patients without any discrimination, so their costs need to be allocated across all patient products, where appropriate. • This standard and its guidelines should be considered in combination with standard Cost 3A.002 – Allocation of Medical Costs for Private and Public Patients It is important that clinical staff costs are correctly allocated to areas such as ED, ICU and OR. If this allocation is not performed clinical costs are inappropriately measured. Costs of clinical services provided to third parties, where the associated products are reported by the third party are to be excluded from clinical costs at the host hospital (see SCP 3E.001).
Sources	Australian Rehabilitator Outcomes Centre AROC, General Definitions for AROC V4 Online Data Dictionaries, January 2014 – (http://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@aroc/documents/doc/uow164855.pdf)

COST 3A.002 – Allocation of Medical Costs for Private and Public Patients

Number	COST 3A.002
Name	Allocation of Medical Costs for Private and Public Patients
Status	Draft
Implementation Date	1 July 2014
Revision Date	
Purpose	To ensure that all patients regardless of funding source receive the correct proportion of costs and that the patient costs are not adjusted or offset with any revenue streams received for that patient. Any costs that are paid for outside of the Hospitals operational accounts such as business units and special purpose accounts must be allocated to the patient
Standard	All costs that relate to patients are allocated based on consumption regardless which cost centres contain the medical salaries expenses.
Definitions	**Operational accounts** relate to expenses incurred in carrying out an organisation day-to-day activities. **Non-operational accounts** are expenses that are not part of the business functions of an organisation but occur in order for the company to carry out business practices such as pathology. These include business units, special purpose accounts and private practice trust accounts. The following are defined in METeOR as: **Public patient:** A person, eligible for Medicare, who receives or elects to receive a public hospital service free of charge. Includes: patients in public psychiatric hospitals who do not have the choice to be treated as a private patient. Also includes overseas visitors who are covered by a reciprocal health care agreement, and who elect to be treated as public patients. **Private patient** for the purposes of these Standards the following is considered to be <u>included</u> as private patients. • A person who elects to be treated as a private patient and elects to be responsible for paying fees for an amount charged for public hospital services. This can include Medicare Benefits Scheme, private health insurance, self-funding, or a combination.

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	• All patients in private hospitals (other than those receiving public hospital services and electing to be treated as a public patient) are private patients. **Other funded patients** are patients who are neither public or private, as defined above, but receive a sources of funding through the following : • Health service budget (due to eligibility for Reciprocal Health Care Agreement) • Department of Veterans' Affairs • Department of Defence • Correctional facility • Other hospital or public authority (contracted care) • Worker's compensation • Motor vehicle third party personal claim • Other compensation (e.g. public liability, common law, medical negligence) • Other funding source
Guidelines	Costing feeder system extracts include all patients and therefore any cost relating to patients should be identified and allocated to the matching activity. A guide for allocating medical salary costs: **Finding all expenses:** • Determine the Hospital's salary arrangements for specialist and general practice medical officers, registrars, residents. • Determine which General Ledger cost centres contain the expenses for each category of medical salary. Where those cost centres are outside the Hospitals operational accounts, those salary expenses will need to be incorporated into the costing process for allocation to patients. **Allocation to patients** • Identify the specific public and private activity which those salary arrangements cover. Apportion the relevant cost to that activity based on a preferred allocation methodology as in Attachment E. • Where medical practitioners bill private patients directly, the cost is absorbed by the patient or their payor and should therefore be considered out-of-scope for the purposes of clinical costing. Where a facility fee is paid for use of public hospital resources, e.g. use of theatre or outpatient rooms, the revenue for the facility fee should be excluded and not used to offset the costs. This standard and its guidelines should be considered in combination with standard Cost 3A.001 – Allocating Clinical Salary and Wages to

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	patients and other products
References	SCP 2.003 – Product Costs in Scope
Sources	Clinical Costing Standards of Australia Ltd. CCS9 Episode of admitted patient care—patient election status, code N (http//meteor.aihw.gov.au/content/index.phtml/itemId/326619) Episode of care—source of funding, patient funding source code NN (http://meteor.aihw.gov.au/content/index.phtml/itemId/553314)

COST 4.002 – Costing Frequency

Number	COST 4.002
Name	Costing Frequency
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To encourage hospitals to conduct activity based costing at regular intervals so as to improve the quality of product costing data, and hence its usefulness to hospital clinicians and managers.
Standard	Hospitals should undertake regular product costing, review the results for reasonableness, and use them to refine the costing methods applied for subsequent costing periods.
Definitions	Nil
Guidelines	Final product costing is typically done after the end of the financial year to which it relates, when all source data are final and any adjustments indicated by the quarterly costing results have been made. Any product costing done during the financial year should be considered interim, and used to refine the costing methods applied to generate the end of financial year results. An ideal scenario would be to conduct quarterly product costing, with the results for one quarter being available prior to completion of the next quarter. As activity based funding becomes the predominant method of payment for patient products in public and private hospitals, it is likely that hospital managers and clinicians will want to accelerate their product costing activities to allow timely comparison of cost and revenue data for end-classes in each patient product category.
Sources	Nil

COST 5.002 – Treatment of Work-In-Progress Costs

Number	COST 5.002
Name	Treatment of Work-In-Progress Costs
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure that all patient costs are allocated to the patient in the reporting period in which the service is delivered, regardless of whether the episode has been completed and that all costs for the reporting period are reconciled against the hospital total costs.
Standard	Each patient is allocated their proportion of costs in the reporting period regardless of whether the service event is completed or commenced and that the cost and activity is reported in each period.
Definitions	**Patient service event** (for the purposes of this standard) refers to any admission (Admitted episode) or visit (Emergency or Non Admitted episode) that has commenced consuming services and/or treatment. **Work in Progress (WIP)** where service events are not commenced in the reporting period but are completed (that is the patient was admitted in the previous financial year), all costs are to be allocated and reported. Service events that commence but are not completed in the reporting period (that is the patient has not been discharged in the reporting period), will be reported in the reconciliation. **Consumptions** are discreet goods and services used in the provision of services and/or treatment for a patient or product.
Guidelines	That each patient is allocated their proportion of costs within the reporting period regardless of whether the service event is completed or commenced. **Work-in-Progress** Patients that have not been discharged in the financial year are considered Work-In-Progress These patients should not be reported to IHPA. However they must be included in the reconciliation and carried forward for reporting in the following financial year.

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	Care Type Changes Where an admitted patient's care type changes in the course of a continuous hospital stay, the first episode of care ceases and a second episode commences (see SCP1.004). The discrete service events must be separately costed, and where that service event is identified as Work-In-Progress then those rules should be applied only if the distinct service event spans the reporting period.
References	REP-1.002 Reporting of Patient and Other Product Costs
Sources	Nil

COST 6.001 – Intermediate Product/Service Matching Method

Number	COST 6.001
Name	Intermediate Product/Service Matching Method
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure that the cost of all intermediate products/services prescribed or ordered during an admitted patient, Emergency Department or non-admitted patient service event are captured and attributed to that service event.
Standard	Intermediate products/services will be costed to the patient service event in which they are ordered or prescribed. Where there are multiple possibilities for cost attribution, the point of referral or an explicit preference order encounter matching method must be used.
Definitions	Nil
Guidelines	The successful matching of intermediate products/services to patient service events is integral to the activity based costing process. The ideal is that intermediate products/services are matched to the service event in which they have been ordered. However the process of recording data in the Departmental systems used to manage the delivery of intermediate products/services ('feeder systems') can sometimes cause issues that need to be resolved by relaxing the matching rules that require the date/time of order to be strictly within the time period from the start to the finish of the service event. The risk in relaxing the rules is that inappropriate matches can occur. These matches are often referred to as 'false positives'. This standard seeks to minimise unmatched intermediate products/services while simultaneously minimising the false positive matches. In some instances there will be a proportion of intermediate products/service which cannot be matched without a high risk of false positives. In other instances, some intermediate products/services are end-classes in their own right. For example, the only contact a patient has with the hospital is for a nuclear medicine scan (the process of ordering the scan and interpreting the result is done in medical specialist rooms outside the hospital). In this case the end-class is a non-admitted patient service event classified to the NHCDC Tier 2 Clinic 30.04 Nuclear Medicine. Matching this intermediate product to another patient

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	service event would create a false positive. Where there is a good date/time capture and patient identifier, the risk of false positives is low. In practice, hospitals will need to develop and apply rules that fit with local service models, which put 'time windows' around admitted patient, Emergency Department patient and non-admitted patient service events. Intermediate products/services that are ordered or delivered within these time windows are then considered to match. In developing and applying rules for matching intermediate products/services, there are several issues to be considered: • The intermediate product/service should be linked to the correct patient product (e.g. prostheses from the operating room feeder system should only go to patient product categories). • Where there are multiple possibilities, make a consistent decision (correct date, but no time stamp). For example, radiology for a patient presenting at the Emergency Department who is subsequently admitted could always be matched to the Emergency Department service event rather than the resultant admitted patient service event. • Where the recorded date/time of the ordering/delivering the intermediate product/service is not contained within the 'time window' of a service event for the same patient, some flexibility may be required to allow matching of the intermediate product/service to that service event. • If multiple matches are possible for the same intermediate product/service the default hierarchy is admitted, Emergency Department, and non-admitted patient service events (in that order). Several issues need to be considered when applying the rules: • The preference order of selection if multiple possibilities will not take precedence over the days of flexibility (e.g. if a radiology test occurs within four days of an admitted patient service event and within two days of an non-admitted patient service event, the non-admitted service event will be considered the best match). • In the event that the date recorded for the intermediate product/service is ambiguous (e.g. the pharmacy system only records the date of script), then extend the match to incorporate the ambiguity, taking care to minimise false positive encounter matches. • The date/time for nursing acuity systems, where used, may have a

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	patient admitted in the early morning (i.e. after midnight) for whom there may be an entry for the previous day due to these systems being based on start of shift. • Some of the matching rules will rely on the product category boundary specification for the costing study (e.g. if a planned Emergency Department attendance is considered a non-admitted patient then the non-admitted costing rules will need to be applied). If after applying the matching rules, no reasonably matched patient service event can be found, the intermediate product/service should be costed as a non-admitted patient service event in its own right.
Sources	Nil

COST 7.001 – Interpretation of Product Costs Data

Number	COST 7.001
Name	Interpretation of Product Costs Data
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To facilitate the analysis of interpretation of data generated by the product costing process by suggesting the level of granularity of the data produced for each end-class within a product category.
Standard	Hospitals should generate product costs data for each end-class within each product category that identifies the contribution to the costs made by each line item within each final cost centre.
Definitions	Nil
Guidelines	Product costs data are more valuable when they can be analysed for the purposes of benchmarking costs, and for comparing production costs with revenue generated at the level of each end-class within each product category. For example, when the end-class is an admitted patient service event, it will be valuable to know how the costs of that patient service event were constructed, and how those costs compare to other patient service events with similar characteristics (e.g. all admitted patients in the costing period, all admitted patients classified into the same AR-DRG, all admitted patients treated by doctors within the same department, and so on). Having the costs available by line item within final costs centres, will allow comparison of important aspects of the patient pathway (e.g. the use of high dependency wards, or the use of intermediate products such as microbiology, CT and pharmacy). It will also allow direct comparison of costs to revenue, (e.g. how did the cost compare with the efficient price for that patient or to the benefits paid by the health insurer for that patient, and what were the key sources of variation). All of these analyses will make the product costing data much more valuable for clinical and financial management purposes at the hospital. It will also result in downstream improvements to the product costing process, by highlighting opportunities to refine the costing methodology.
Sources	Nil

DEP 1.002 – Capital Expenditure

Number	DEP 1.002
Name	Capital Expenditure
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure that all assets used in the production of hospital products are reflected accurately in the Fixed Asset Register and included in product costing.
Standard	Hospital product costing should include costs in relation to: All purchased and leased assets used in producing hospital products including improvements to those assets; and All donated assets (regardless of whether the assets are purchased with donated funds, donated physical assets or funds granted by the Commonwealth) used in producing hospital products including improvements to those assets. Hospital patient product costing must exclude costs in relation to: • Buildings surplus to requirements for operating a hospital; • Buildings exclusively used for teaching, training, and research purposes (included in the costs of the TTR product); • Buildings used exclusively for producing non-patient products (included in the costs of non-patient products); and • Intangible assets with infinite useful lives. Hospital patient product costing must include: • lease costs • depreciation and amortisation (based on actual cost for purchased assets and fair value for donated assets); • any loss or profit on the sale of assets; • any revaluation increments or decrements that are recognised in the profit and loss; and • any actual interest expense associated with financing asset

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	purchases.
Definitions	**Improvements:** Improvements extend the useful life of an asset, increase its service capacity, increase income-earning capacity or reduces operating costs. These costs are capitalised and so will be included in the depreciated value of an asset. **Fair value:** The amount for which an asset could be exchanged between knowledgeable, willing parties in an arm's length transaction. **Donated assets:** Assets donated to a hospital (where the physical asset has been donated) must be recorded in the balance sheet and Fixed Asset Register at fair value in accordance with accounting standards.
Guidelines	Hospitals cannot apply this standard retrospectively without affecting audited financial statements. Discussions with auditors must be held before any decision is made to recognise a donated asset on the balance sheet and asset register if the asset was obtained in a prior year.
Sources	AASB 116 Property, Plant and Equipment AASB 1004 Contributions

DEP 1A.002 – Asset Recognition

Number	DEP 1A.002
Name	Asset Recognition
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To improve the consistency of asset recognition policies across all States and Territories to ensure comparability of product costing data.
Standard	The asset acquisition or improvement recognition threshold for all hospital property, plant and equipment should be no greater than $10,000.
Definitions	**Asset recognition threshold:** The amount selected as appropriate for recognising assets, taking into consideration materiality and practicalities of maintaining the asset on an asset register. Amounts below this threshold are expensed at the time of purchase.
Guidelines	There is some subjectivity about whether subsequent expenditure is classified as maintenance or improvement. Generally, the decision whether to capitalise or expense subsequent expenditure on an asset is based on whether the expenditure maintains the asset's original service potential or whether it improves it. The accounting standards provide guidance only and the decision remains subjective. As such, each subsequent amount over the $10,000 threshold will need to be considered on a case-by-case basis.
Sources	AASB 116 Property, Plant and Equipment AASB 138 Intangible Assets

DEP 1B.002 – Revaluation of Assets

Number	DEP 1B.002
Name	Revaluations of Assets
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To ensure that all assets requiring revaluation are on the same valuation cycle to ensure comparability amongst States/Territories.
Standard	All assets subject to the revaluation method of accounting for property, plant and equipment should be independently valued at 30th June 2012 and then at least every three years following this date. Revaluation increments and decrements that are recognised in the profit and loss should be allocated to products using the same allocation methods as for depreciation and amortisation.
Definitions	**Revaluation method:** After recognition as an asset, an item of property, plant and equipment whose fair value can be measured reliably shall be carried at a re-valued amount, being its fair value at the date of the revaluation less any subsequent accumulated depreciation and subsequent accumulated impairment losses. **Independent Valuation:** A valuation undertaken by a professionally qualified expert, such as a qualified valuer or quantity surveyor, who is independent to the Department of Health in the relevant State/Territory for the public sector or the hospital owners/operators in the private sector. The Valuer General in the relevant State/Territory is considered to be an independent party.
Guidelines	It is important to appreciate that this standard prescribes the timing rather than the methods for revaluations. Revaluation methodology must still be in line with guidance from the relevant State/Territory government authorities and/or consistent with commercial practice. In line with AASB 116, if a fully written down asset is re-valued, then all property, plant and equipment in the same class must be re-valued at the same time. Given the large number of assets in each class, this requirement is likely to be impractical. Instead adjustments to the useful life on individual assets should be made prior to an asset being fully depreciated. Refer to DEP 1C.002 for guidance on determining the useful life of assets.

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	Revaluation decrements recorded in the profit and loss of a hospital in accordance with accounting standards should be costed using the same methodology as the depreciation for the asset to which the decrement relates. Revaluation increments recorded in the profit and loss of a hospital in accordance with accounting standards should be offset against the depreciation for the asset to which the increment relates, prior to depreciation being costed in respect of that asset.
Sources	AASB 116 Property, Plant and Equipment

DEP 1C.002 – Useful Life

Number	DEP 1C.002
Name	Useful Life
Status	Approved
Implementation Date	1 July 2014
Revision Date	May 2011
Purpose	To ensure that all assets used in the production of hospital products are consistently reflected in the Fixed Asset Register
Standard	All hospitals will assign useful lives to assets based on the minimum useful lives provided in this standard.
Definitions	**Useful life:** The period over which an asset is expected to be available for use by an entity.
Guidelines	The list of useful lives to be used is provided in Attachment F. These periods are the minimum useful lives to be assigned to classes of assets. Hospitals may select a longer useful life if this better reflects the service capacity of the asset. These minimum useful lives apply to asset purchases from 1st July 2011 onwards. Reassessment of useful life is permitted where an asset has serviceability longer than its remaining useful life. A hospital can choose to depreciate an asset's written down value over the adjusted remaining years of serviceability. The reassessment must be performed in accordance with accounting standards. The reassessment of useful life cannot be performed on assets that are fully written down without revaluing all assets in that class (see DEP 1B.002).
Sources	AASB 116 Property, Plant and Equipment Taxation Ruling TR 2010/2 - Income tax: effective life of depreciating assets (applicable from 1st July 2010) – to be updated annually

DEP 1D.002 – Classes of Assets

Number	DEP 1D.002
Name	Classes of Assets
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To provide for assets to be grouped into classes that will assist with the allocation of capital expenditure-related costs to final cost centres.
Standard	For the purposes of cost attribution, assets will be categorised into the following classes: • Medical equipment • Plant and non-medical equipment • Buildings and improvements • Intangibles
Definitions	**Intangible Asset:** An intangible asset is an identifiable non-monetary asset without physical substance.
Guidelines	Nil
Sources	Nil

DEP 1E.002 – Allocation of Depreciation and Amortisation

Number	DEP 1E.002
Name	Allocation of depreciation and amortisation
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	To set out a consistent method for allocating capital costs, thereby improving the quality and consistency of product costing results.
Standard	The allocation methods for capital costs will apply the same allocation principles established by the other costing standards for the allocation of direct and overhead costs. In that context, the allocation of capital costs to end-classes in each product category should occur in three-stages: 1. Allocation of capital costs held in central cost centres to final or overhead cost centres (based on an appropriate allocation statistic). 2. Allocation of capital costs in overhead cost centres to final cost centres (using the same allocation statistic for capital costs as for other costs in the overhead cost centre). 3. Allocation of capital costs in final cost centres to end-classes in each product category (using an appropriate allocation statistic for direct capital costs and for overhead capital costs, the same allocation statistic as for other overhead costs in that cost centre)
Definitions	**Capital costs:** are the expenses incurred in acquiring, producing or enhancing non-current (or fixed) assets. The associated expenses (that is, impacts on the profit and loss account) that are covered by this standard are: • Depreciation and amortisation – the annual charge that spreads the cost of an asset over its useful life (subject to variations for residual value and revaluations); • Any loss (or profit) on the sale of assets; and • Revaluation decrements and increments – revaluations only affect the profit and loss in very specific circumstances and so the impact of revaluations is most commonly recorded in a revaluation reserve (leaving the profit and loss account unaffected).

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Guidelines	**Stage 1 - Allocation of capital costs held in central cost centres to final or overhead cost centres:** Capital costs, in central cost centres or held at an organisation-level, should be allocated to final and overhead cost centres based on an appropriate allocation statistic (which includes allocations to a specific cost centre where an asset is used by a single cost centre only). Attachment G provides further guidance on the overhead allocation statistics on suitable allocation statistics for asset classes. Where capital costs are already allocated directly to a cost centre and this attribution accurately reflects use of the asset, there is no need to identify and apply alternative allocation methods. **Stage 2 – Allocation of capital costs in overhead cost centres to final cost centres:** The capital costs attributed to overhead cost centres should be allocated to final cost centres in the same way as all other costs in that overhead cost centre. **Stage 3 – Final cost allocation:** capital costs should be allocated to end-classes in the patient product categories from final cost centres using one of the allocation methods set out in Attachment G.
Sources	Nil

FDR 2.002 – Relative Value Units

Number	FDR 2.002
Name	Relative Value Units
Status	Approved
Implementation Date	1 July 2014
Revision Date	February 2014
Purpose	Where direct cost allocation is not possible, intermediate product/services costs should be allocated using validated Relative Value Units (RVUs).
Standard	Costs of intermediate products/services should be assigned using an RVU scale that reflects their relative costs of production.
Definitions	**Intermediate products/services:** are department specific and may represent either a product (e.g., catheter, medication) or a service (e.g., nursing care, x-ray) or a combination of products and services used in patient care. Examples of intermediate products include the medications provided by the pharmacy or a hospital gown from central supplier. Examples of intermediate services include cardiopulmonary resuscitation in the Emergency Department or nursing care in the intensive care unit. Examples of intermediate products/services that have a product and service component include a coronary angioplasty in the cardiac catheterisation laboratory or a chest x-ray in the radiology department. **Relative Value Unit:** a set of (usually) normalised index numbers that reflects the relative costs of production of one product/service against another, across the full range of products/services produced within the same department.
Guidelines	In determining which RVUs to use, a series of factors should be considered, including whether it: • Has been through a validation process which should include expert review; • Is comprehensive and complete; • Uses actual minutes where labour costs are involved; • Is routinely used for management purposes; and

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	• Reflects current practice. RVUs should be updated if there are changes in the purchase price; changes in clinical practice and technology and changes in the way the department is operated. Review of RVUs should be undertaken in conjunction with the staff involved in the department to which the RVUs are being applied. The product costing documentation should clearly set out which RVUs are used to distribute the costs of which intermediate products/services; particularly when external (i.e. not developed within the hospital) RVUs are used.
Sources	Clinical Costing Standards Association of Australia Number 10

REP 1.002 – Reporting of Patient and Other Product Costs

Number	REP 1.002
Name	Reporting of Patient Costs
Status	Approved
Effective Date	1 July 2011
Revised Date	February 2014
Applicability	All hospitals
Principle	Hospitals will report costed episodes at a level of granularity that allows aggregation into different meaningful categories for benchmarking and informing price-setting.
Standard	Hospitals will report the total cost of episodes that are completed within the reporting period by line item, cost centre and order request point.
Definitions	**Total cost** - represents the accumulation of a patient's costs from the start to the end of their stay. **Work In Progress (WIP)** - where service events are commenced in any prior year but not completed in the reporting period (ie the patient was admitted in the previous financial year) or service events are commenced but not completed in the reporting period (ie the patient has not been discharged in the reporting period)
Guidelines	**Work in Progress** The following patients' total costs (including all prior year(s) (from start of treatment to end) should be reported to IHPA: 1. Patients that are admitted and discharged in the financial period, and 2. Patients who were discharged in the financial year and admitted in prior year(s). Patients that have not been discharged in the financial year should not be reported to IHPA. However they must be included in the reconciliation and carried forward for the following financial year.
Related Standards	GL 2.004 – Account Code Mapping to Line Items GL 4.004 - Cost Centre Mapping SCP 3F.001 – Matching Production and Cost - Order Request Point
References	Cost 5.002 – Treatment of Work In Progress Costs
Sources	NHCDC Hospital Reference Manual

Glossary of Terms

Term	Explanation
Accrual accounting	A method that records the costs of resources when they are consumed in the production process irrespective of when payment is made.
Admitted patient	A patient who has been formally admitted to a hospital. Sub–categories of overnight stay and same–day are defined, as is the care type.
Allocation Statistics	Allocation statistics are relative values used to distribute overhead costs to the appropriate cost centres. These values measure the relative consumption of products/services produced by overhead cost centres by hospital organisational units and/or end-product classes.
Amortisation	The systematic allocation of the depreciable amount of an asset over its useful life.
Average cost	In the costing context, the total cost of production divided by the number of products in a period. Also known as full average cost.
Capital costs	Capital costs are the expenses incurred in acquiring, producing or enhancing non-current (or fixed) assets. They include costs associated with land, buildings, and equipment.
Casemix	The term Casemix refers to both the number and types of patients treated and the mix of bundles of treatments, procedures and so on, provided to patients. In general, Casemix is the use of resources in treating patients which is the key to understanding Casemix as a measure of hospital output and activities.
Cash accounting	Cash accounting attributes the costs of resources to the period in which payment is made.
Commercial Business Entities	Commercial business entities are organisational units within a hospital that generate non-patient products for which revenue is obtained from third parties (i.e. not exclusively from hospital patients and staff).
Consumption	Consumption are discreet goods and services used in the provision of services and/or treatment for a patient or product
Consultation Liaison	Consultation Liaison is when the inpatient is under the care of one physician who holds the medical governance/ bed card and another clinician or team provide a one-off consultation service for the patient. Examples: a ‘second opinion’, advice on a particular

Term	Explanation
	problem, a case review, a one-off assessment or therapy session. Consultation liaison applies to inpatient (admitted) episodes and patients within an emergency setting. Joint care in other settings is classified as shared care. Adapted from Australian Rehabilitator Outcomes Centre AROC, General Definitions for AROC V4 Online Data Dictionaries, January 2014
Corporate Costs	Costs incurred at LHN or equivalent level that are necessary for production of hospital products.
Cost centre	An accounting entity where all costs associated with a particular type of activity and/or production process can be recorded. Sometimes abbreviated to CC.
Cost group	A high level aggregation of the cost centres. Examples of Cost Groups relate to Allied Health, Operating Rooms, Radiology, etc.
Cost weight	A measure of the average cost of an AR–DRG, compared with the average cost of a reference AR–DRG. Usually the average cost across all AR–DRGs is chosen as the reference value, and given a weight of 1.
Critical Care Unit	Critical care unit is a separate and self-contained area of a hospital dedicated to the management of patients with life-threatening illnesses, injuries and complications, and monitoring of potentially life-threatening conditions. It provides special expertise and facilities for support of vital functions and uses the skills of medical, nursing and other personnel experienced in the management of these problems. (College of Intensive Care Medicine).
Depreciation	Depreciation is a non-cash expense which represents the decline in value of an asset over an estimate of how long the asset will effectively last.
Direct costs	Used to designate costs which are relatively easily related to products. In the standard product costing method, costs which are passed directly to end-product classes from either overhead or final costs centres (rather than allocated via overhead cost centres).
Direct product	In product costing, a product which emerges from the end of the production line. In the health setting this is the completed patient service event. It could be an acute admitted patient service event involving diagnostic imaging, pathology tests, drug therapies, surgical procedures, nursing care, physiotherapy, and so on. It could also be a non-admitted patient service event, or a non-

Term	Explanation
	patient product such as teaching.
Direct Product Cost Centre	Direct cost centres are organisation units (e.g., radiology, operating room) that produce end products (patient and non-patient). In the product costing context, cost centres are generally classified as either overhead or final product. The latter type is also known as 'Final Cost Centres' and 'Patient Care Cost Centres'. Other final products include teaching, training and research.
Direct Teaching	Direct teaching is where the sole purpose of the activity is teaching (e.g. a medical specialist presenting a clinical case study to an audience of registrars, residents and interns who are all enrolled in a recognised program/course).
End-class	End-class is the term used to refer to the final activity unit that is costed in a product category. In patient level costing the end-classes for the patient product categories will typically be admitted patient service events, non-admitted patient service events, and Emergency Department service events. Where patient level costing is not possible, the end-classes for admitted patient products may be, for example, AR-DRG classes.
Episode of care	A phase of treatment from admission to separation. An admission may be 'statistical' in that the patient changed from one type of admitted patient category to another (between any two of acute, rehabilitation, palliation, or non–acute) without being separated from the hospital. It follows that there must be a 'statistical separation' before every statistical admission.
Feeder Systems	Information systems used throughout a given hospital to provide data on the services used by patients.
Final Cost Centre	A final cost centre accumulates costs that are directly attributable or specific to a product category. For this reason it is also known as a direct product cost centre or patient care cost centre (when speaking of patient products). These three terms are interchangeable, but final cost centre is the preferred term and will be used for consistency throughout these standards. Final cost centres can either be directly related to treatment of patients (such as nursing care) or can be attributable to an intermediate product/service as an input to the full admitted patient service event (such as pathology).
Full/Final cost	The total cost of producing a service (product). It consists of the direct cost of producing a service, together with a share of the indirect (overhead) costs

Term	Explanation
General Ledger	A central repository of the accounting information of an organisation in which the services of all financial transactions during an accounting period are recorded.
Hospital	A health care institution providing patient treatment and care with specialised staff and equipment.
IFRAC	See Inpatient fractions
Indirect costs	Indirect cost centres are hospital overhead departments (e.g., administration, housekeeping), and the costs incurred by these departments are called indirect costs.
Indirect teaching	Indirect teaching is where teaching is produced jointly with another hospital product (e.g. when teaching occurs as part of a review of a patient's condition, as would typically happen in a ward round conducted by a medical specialist in conjunction with registrars, residents and interns).
Inpatient	A patient who has been formally admitted to a hospital. Sub–categories of overnight stay and same–day are defined, as is the care type.
Inpatient Fractions (IFRAC)	The proportion of costs of a patient care cost centre which relate to inpatient rather than other kinds of products.
Intangible Asset	An intangible asset is an identifiable non-monetary asset without physical substance.
Intensive Care Unit (ICU)	An Intensive Care Unit (also called Critical Care Unit) is a designated patient care area in a hospital which is staffed with experienced clinicians skilled in the care of high acuity patients requiring intensive treatment, invasive monitoring and/or life support. Critical Care Units include adult, paediatric and neonatal intensive care; and coronary care.
Intermediate products/services	Intermediate products/services are department specific and may represent either a product (e.g., catheter, medication) or a service (e.g., nursing care, x-ray) or a combination of products and services used in patient care. Examples of intermediate products include the medications provided by the pharmacy or a hospital gown from central supplier. Examples of intermediate services include cardiopulmonary resuscitation in the Emergency Department or nursing care in the intensive care unit. Examples of intermediate products/services that have a product and service component include a coronary angioplasty in the cardiac catheterisation laboratory or a chest x-ray in the radiology

Term	Explanation
	department.
Length of stay (LOS)	The number of days an inpatient spends in hospital (i.e. the total number of days– usually measured in multiples of a 24-hr day that a patient occupies a hospital bed). The most common methodology for deriving length of stay involves subtracting the admission date from the discharge date minus the leave days.
Line item	Line items are typically groups of general ledger expenditure account codes that describe the input type (rather than function type), which define the resources being used by a cost centre. For example, they might be drugs, prostheses, or nursing salaries.
LOS or ALOS	See length of stay. ALOS is the acronym for “average length of stay”.
Non-Operational Accounts	Non-operational accounts are expenses that are not part of the business functions of an organisation but occur in order for the company to carry out business practices such as pathology. These include business units, special purpose accounts and private practice trust accounts.
Occupied bed day (OBD)	A term used in Australia to describe an admitted patient day of stay (also termed bed–day).
Offsetting Costs	Offsetting means the reduction in the cost of providing a service by revenue or recoveries generated
Operating Accounts	Operating Accounts relate to expenses incurred in carrying out an organisations day-to-day activities
Operating Room (OR)	A designated patient care area in a hospital which is staffed with experienced clinicians skilled in the care of patients requiring operations
Order Request Point	The department/service (costs centre) that orders or prescribes an intermediate product/service.
Other funded patients	**Other funded patients** are patients who are neither public or private, as defined above, but receive a sources of funding through the following : • Health service budget (due to eligibility for Reciprocal Health Care Agreement) • Department of Veterans' Affairs • Department of Defence • Correctional facility • Other hospital or public authority (contracted care)

Term	Explanation
	• Worker's compensation • Motor vehicle third party personal claim • Other compensation (e.g. public liability, common law, medical negligence) • Other funding source
Overhead Cost Centre	An overhead cost centre accumulates costs that have an incidental rather than a direct relationship to a specific product category. Overhead costs centres typically accumulate costs for services that are provided to organisational units in the hospital rather than to producing end-products (e.g. patients). One of the aims of the costing process is to redistribute all overhead cost centre costs across the final cost centres.
Patient Service Event	Patient Service Event refers to any admission (Admitted episode) or visit (Emergency or Non Admitted episode) that has commenced consuming services and/or treatment
PFRACS	See Program fractions
Product Category	A classification of the final products that emerge from the end of the production line. For the purposes of the AHPCS, the product categories are admitted patients, non-admitted patients, Emergency Department patients, teaching training and research, and non-patient products. There may be sub-product categories within a product category (e.g. admitted patients may be divided into acute admitted, sub-acute, same-day and so on). And there are end-classes within a product category (e.g. admitted patient service events for the admitted patient product category).
Program Fractions (PFRACS)	The proportion of costs of a patient care cost centre which relate to the various programs associated with that patient care ie: admitted, non-admitted, emergency, teaching and training etc
Private Patient	**Private patient** for the purposes of these Standards the following is considered to be <u>included</u> as private patients. • A person who elects to be treated as a private patient and elects to be responsible for paying fees for an amount charged for public hospital services. This can include Medicare Benefits Scheme, private health insurance, self-funding, or a combination. • All patients in private hospitals (other than those receiving public hospital services and electing to be treated as a public patient) are private patients.

Term	Explanation
Public Patient	A person, eligible for Medicare, who receives or elects to receive a public hospital service free of charge. Includes: patients in public psychiatric hospitals who do not have the choice to be treated as a private patient. Also includes overseas visitors who are covered by a reciprocal health care agreement, and who elect to be treated as public patients.
Relative Value Units	The weighting of one product against another within a department/service to reflect the intensity of resource use. These can be either: Internal - are those relative value units derived within an LHN/hospital. External - those relative value units derived by a source outside of the LHN/hospital.
Research	For the purposes of costing, research is an activity where the primary aim is the advancement of knowledge through: • Observation; data analysis and interpretation; or other techniques that are secondary to the primary purpose of providing patient care; or • Activities associated with patient care where additional components or tasks exist (for example, the addition of control group in a cohort study). This definition excludes curriculum-based research projects (included as teaching).
Service Weight	Service weights is a relative measure of resource use for each episode of care in a classification (DRG, URG, Tier2 etc) and are derived specifically for a department/service products. These can be either: Conditional are qualified relativities for varying casemix classes where the consumption of a product/service is known. The costs are allocated on the basis of service weights, but only to those patients who actually consumed the product/service (eg: MRI services - Each patient who received MRI services will be allocated an equal share of the costs, and those patients who received no MRI services will be allocated no cost. Therefore data must be obtained on how many patients in each DRG were recipients of MRI services). Unconditional are relativities based on predetermined average

Term	Explanation
	costs for each casemix class. Every patient will receive a share of the costs, regardless of whether they actually consumed the product/service. Therefore use must be made of data on how many patients there were in each casemix class.
Teaching and Training	Teaching is any activity where the primary aim is to transfer clinical knowledge for ongoing professional development via a teacher or mentor to a student or candidate in a recognised program/course that will result in either: • Qualifications that may meet registration requirements; or • Admission to a specified discipline where the right to practise in that discipline requires completion of the program/course. Teaching activities may include: • Automated/self-directed learning where the teaching component is electronically provided; • Presentation and development of content; and • Supervision/participation in curriculum based research.
Total cost	The total cost of producing a service (product). It consists of the direct cost of producing a service, together with a share of the indirect (overhead) costs.
Work In Progress (WIP)	Work in progress is where service events are not commenced in the reporting period but are completed (ie the patient was admitted in the previous financial year); all costs are to be allocated and reported. Service events that commence but are not completed in the reporting period (ie the patient has not been discharged in the reporting period), will be reported in the reconciliation.

ATTACHMENT A: Classifications for Product Categories

Admitted Patients

Definitions relating to admitted patients and admitted acute care can be found on the IHPA website (http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/admitted-acute).

A definition and code for each service care type, including subacute and non-acute care, can be found in METeOR (http://meteor.aihw.gov.au/content/index.phtml/itemId/270174).

Non-Admitted Patients

The classification system for non-admitted care is known as Tier 2 Non-Admitted Care Services. The IHPA website defines the non-admitted patient setting and provides links to the Tier 2 Non-Admitted Services Definitions Manual, the Tier 2 Non-Admitted Services National Index and the Tier 2 Non-Admitted Services Compendium. (http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/non-admitted-care)

Emergency Department Patients

Patient presentations to emergency services are classified using Urgency Disposition Groups (UDGs), whereas patient presentations to emergency departments are classified using Urgency Related Groups (URGs). The most current URG and UDG code descriptions can be found on the IHPA website (http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/emergency-care).

Definitions of emergency services for ABF purposes are outlined on the IHPA website (http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/ihpa-three-year-plan.html~appendix-A).

Teaching, Training and Research

Teaching, Training and Research (TTR) products are subdivided into teaching and training; and research. As part of the *National Health Reform Agreement 2011* IHPA will provide advice to the Standing Council on Health on the feasibility of transitioning funding for TTR to an activity based funding (ABF) system by 30 June 2018. The IHPA website will be updated to reflect the progression of the TTR classification between now and 2018 (http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/teaching-training-and-research).

Mental Health

IHPA is currently in the process of developing a new classification for mental health, known as the Australian Mental Health Care classification (AMHCC). From 1 July 2013, IHPA has priced these services using a modified AR-DRG approach, with major refinements to be undertaken in 2014-15. Further information relating to the mental health care classification can be found on the IHPA website (http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/mental-health).

Non-Patient Products

Non-Patient products are not formally further sub-divided. Hospitals may choose to use sub-categories of non-patient products that reflect the services they provide. Typical examples of non-patient products might include commercial business entities such as Car Parking,

Florist, Gift Shop, Café, Leasing of Commercial Space (e.g. for retail, or for private metical suites). Other non-patient products might include general health information services provided to the community (i.e. not individual patients).

Subacute & Non-Acute Care

The Australian National Subacute and Non-Acute Patient (AN-SNAP) classification system was selected by IHPA as the ABF classification system to be used for subacute and non-acute care. The IHPA website provides the scope and definition of subacute and non-acute care, the AN-SNAP casemix classification and the AIHW hospital service care type codes and definitions. (http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/subacute-care)

ATTACHMENT B: Line Items Definitions

Salary and Wages

Salary and wages are the main forms of payments made to an employee. Generally, they are considered payments made:

a) to an individual;

b) as remuneration for services; and

c) provided under a contract of service (employment contract).

Salaries and wages include: ordinary hours worked, penalty rates, overtime, leave loading, professional development, and allowances (e.g. district/remote, on-call, living out, uniform & laundry) and excludes on-costs.

All Salary and Wages need to be allocated to one of the following five categories.

Nursing, Salaries and Wages

Nursing Salary and Wages includes the following categories of staff:

- Registered Nurses;
- Enrolled Nurses;
- Establishment Based Student Nurses; and
- Trainee/pupil nurse.

Medical, Salaries and Wages (non VMO)

Medical Salary and Wages includes the following categories of staff:

- Specialist and General Practice Medical Officers;
- Registrar;
- Residents; and
- Interns.

Medical, Salaries and Wages (VMO)

Visiting Medical Officers are defined as:

- A medical practitioner appointed by the hospital to provide medical services for hospital (public) patients in an honorary, sessionally paid or fee-for-service basis.
- VMOs are entitled to on-call and call-back allowance and public holiday allowance on top of their ‘contracted’ services payments.

Allied Health, Salaries and Wages

Allied Health Salary and Wages includes qualified staff (other than qualified medical and nursing staff) engaged in duties of a diagnostic, professional or technical nature (but also including diagnostic and health professionals whose duties are primarily or partly of an administrative nature). This category includes all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff).

Staff must be registered or working towards registration and must have current practicing certificate with an applicable registered body or training towards registration under the direct supervision of the relevant diagnostic or allied health professional.

Allied health is a collective term for a wide range of tertiary qualified health professionals, other than medical and nursing, including but not limited to:

- Art /Music Therapists
- Optometrists
- Audiologists
- Orthoptists
- Chiropractors
- Orthotists/Prosthetists
- Clinical Psychologists
- Osteopaths
- Dentists
- Pharmacists (Community/Hospitals)
- Dieticians/Nutritionists
- Physiotherapists
- Medical Scientists
- Podiatrists
- Medical Imaging Technologists/Radiographers
- Radiation Therapists
- Medical Physicists
- Social Workers
- Nuclear Medicine Technologists
- Sonographers
- Occupational Therapists
- Speech Pathologists

Other staff types, Salaries and Wages

Salaries and wages for other staff types should fit into the two categories below.

Other Personal Care staff

Staff engaged primarily in the provision of personal care to patients or residents, who are not formally qualified or undergoing training in nursing or allied health professions and are not allocated as an overhead cost. This category includes attendants, assistants or home assistants, home companions, family aides, ward helpers, ward assistants, assistants in nursing and Aboriginal Health Workers.

Other Administrative, Maintenance and Clerical Staff

Other administrative, maintenance and clerical staff costs includes staff engaged in administrative, maintenance and clerical duties, including ward clerks, health information managers and administrative staff. Medical staff, nursing staff, diagnostic and health professionals and laundry and hotel staff are excluded.

Labour (staff) on costs, all staff types

On costs are long service leave, superannuation, payroll tax, FBT workers compensation payments (excluding premiums that are a goods and services cost) and redundancy payments.

Pathology

Pathology costs are goods and services used in the provision of a pathology service and consumables (including reagents, stains and calibration products, etc.) or the actual cost as billed by a provider and is defined as the following.

- Animal Testing
- Autopsy
- Blood Products
- Clinical Biochemistry
- Clinical Chemistry
- Cytogenetics
- Cytology
- Forensic
- General Pathology
- Genetics
- Haematology (Laboratory)
- Histopathology
- Immunology (Laboratory)
- Microbiology
- Mortuary
- Pharmacology
- Specimen collection services
- Toxicology
- Transfusion services (incl. blood bank/Autologist services)
- Other Pathology (please specify)

Imaging

Imaging costs are goods and services used in the provision of an imaging service (including film, contrast, etc.) or the actual cost as billed by a provider and is defined as the following:

- Angiography
- Computed Tomography (CT)
- General Imaging
- Echo Cardiogram
- Mammography
- Magnetic Resonance Imaging (MRI)
- Nuclear Medicine
- Positron Emission Tomography (PET)
- Plain X ray (including films and contrasts)
- Ultrasound
- New Technologies
- Other Imaging

Pharmaceuticals

Pharmacy costs are goods and services used in the provision of a pharmaceutical service and consumables or the actual cost as billed by a provider. They include the purchase, production, distribution, supply and storage of drug products and clinical pharmacy services of both PBS reimbursed pharmaceuticals and PBS non–reimbursed pharmaceuticals.

Prostheses

The term '*Prostheses,*' includes surgically implanted prostheses, human tissue and other medical devices.

Implanted prostheses include cardiac pacemakers and defibrillators, cardiac stents, hip and knee replacements and intraocular lenses, as well as human tissues such as human heart valves, corneas, bones (part and whole) and muscle tissue.

Criteria for listing on the Prostheses List

Products meeting all of the following criteria are eligible for consideration for inclusion on the Prostheses List:

1. The product must be included or being considered for inclusion on the Australian Register of Therapeutic Goods; and
2. The product must be provided to a person as part of an episode of hospital treatment or hospital-substitute treatment; and

3. A Medicare benefit must be payable in respect of the professional service associated with the provision of the product (or the provision of the product is associated with podiatric treatment by an accredited podiatrist); and

4. The product should:

(a) be surgically implanted in the patient and be purposely designed in order to:

(i) replace an anatomical body part; or

(ii) combat a pathological process; or

(iii) modulate a physiological process; or

(b) be essential to and specifically designed as an integral single-use aid for implanting a product, described in (a) (i), (ii) or (iii) above, which is only suitable for use with the patient in whom that product is implanted; or

(c) be critical to the continuing function of the surgically implanted product to achieve (i), (ii) or (iii) above and which is only suitable for use by the patient in whom that product is implanted; and

5. The product has been compared to alternate products on the Prostheses List or alternate treatments and:

(a) assessed as being, at least, of similar clinical effectiveness; and

(b) the cost of the product is relative to its clinical effectiveness.

Blood Products and Services

Defined as the following:

(a) products *(*blood products) that are used or intended for use for human therapeutic or diagnostic purposes and that:

(i) consist of human blood or components of human blood; or

(ii) are derived from human blood; or

(b) products (blood-related products) that are used or intended for use for human therapeutic or diagnostic purposes and that:

(i) are alternative, analogue or complementary to the use of blood products; and

(ii) are regarded as blood-related products for the National Blood Agreement; or

(c) services, equipment or procedures that are regarded as blood-related services for the National Blood Agreement and that:

(i) are used in the collection, supply or use of blood products or blood-related products; or

(ii) are alternatives to the use of blood products or blood-related products; or

(iii) reduce the need for blood products or blood-related products; or

(iv) otherwise affect the demand or supply of blood products or blood-related products.

All other medical and surgical supplies

Medical and surgical supplies, includes medical and surgical equipment, medical instruments and medical aides.

Medical surgical supplies are items that:

- are usually disposable in nature; and/or
- cannot withstand repeated use by more than one individual; and/or
- are primarily and customarily used to serve a clinical purpose; and/or
- generally are not useful to a person in the absence of illness and injury; and/or
- may be ordered and used by clinical staff.

Medical and surgical supplies include external prosthetics such as prosthetic legs, external breast prostheses, prosthetic eyes, wigs and other such devices.

It also includes dressings, minor surgical instruments, medical gases, disposable medical supplies, medical and surgical appliances such as splints, crutches and wheelchairs.

In addition, includes items of medical equipment, surgical instruments and patient appliances which have a life of less than one year.

Supplies that cannot be classified under these definitions should be classified under goods and services.

Hotel

Hotel includes:

- cleaning products and services;
- linen and laundry services;
- food services (patients); and
- general hotel services.

All Other Goods and Services

Goods: items of merchandise, finished products, supplies, or raw materials. Sometimes the term is extended to cover all inventory items or assets such as cash, supplies, and fixed assets.

Services: labour performed by an individual or organisation on behalf of others. Payments made for provision of services by a client.

Goods and Services also include:

Repairs and Maintenance: The costs incurred to bring an asset back to an earlier condition or to keep the asset operating at its present condition**.** Costs incurred on existing non-current assets that maintain the usefulness of an asset are repairs and maintenance expenses. Costs incurred on repairs and maintenance of assets is to be expensed in the Operating Statement when incurred.

Lease costs

An agreement whereby the lessor conveys to the lessee, in return for a payment or series of payments, the right to use an asset for an agreed period of time.

Depreciation

The systematic allocation of the depreciable amount of an asset (building or equipment), over its useful life. Building depreciation includes fixed fit-out such as items fitted to the building e.g. lights, partitions etc. Equipment depreciation includes non-fixed building fit-out such as theatre tables, moveable furniture, and chemotherapy chairs etc.

Corporate costs (from outside the hospital GL and not otherwise specified)

For the purposes of product costing corporate overheads costs comprise expenditures related to the provision of health care services, but occurring outside the hospital cost centre structure. Examples of these costs include:

- Finance costs – accounts receivable and accounts payable;
- HR costs;
- IT costs;
- Major leases;
- Corporate expenditure such as planning, projects and directorate; and
- Medical indemnity, public liability and building and contents insurance (productivity commission).

Capital works – not in scope

- Capital works - Non-recurrent expenditure;

Excluded costs – not in scope

- Non-operating costs e.g. trust fund;
- Trust Funds - Special payment funds e.g. Private Practice Fund; and
- Any items on the non-operating ledger e.g. research.

ATTACHMENT C: Cost Centre Definitions

Table C.1: List of Standard Cost Centres

Cost centre name	Code	Group	Final / Overhead
Audiology	Audio	Allied	Final
Diabetes Educator	Diab	Allied	Final
General Allied Health	GenAllied	Allied	Final
Occupational Therapy	OccupatTher	Allied	Final
Nutrition / Dietetics	Dietetics	Allied	Final
Optometry	Optometry	Allied	Final
Other Allied Health (please specify)	OtherAllied	Allied	Final
Orthoptics	Orthoptics	Allied	Final
Orthotics	Orthotics	Allied	Final
Physiotherapy	Physiotherapy	Allied	Final
Podiatry	Podiatry	Allied	Final
Prosthetics	Prosthetics	Allied	Final
Psychology	Psychology	Allied	Final
Social work	SocialWork	Allied	Final
Speech Pathology	Speech	Allied	Final
Acupuncture	Acup	Clinical	Final
Adolescent Medicine	AdolMed	Clinical	Final
Aged Care	AgedCare	Clinical	Final
Allergy	Allergy	Clinical	Final
Anti – Coagulant Service	AntiCo	Clinical	Final
Assisted Reproduction Technology	AssTech	Clinical	Final
Asthma Service	Asthma	Clinical	Final
Birthing Centre	BirthCentre	Clinical	Final
Breast Services	Breast	Clinical	Final

Cost centre name	Code	Group	Final / Overhead
Burns	Burns	Clinical	Final
Bone Marrow Transplant	BoneMar	Clinical	Final
Cardiology	Cardio	Clinical	Final
Cardiac Surgery	CardiacSurg	Clinical	Final
Cardio–thoracic Surgery	CardioThor	Clinical	Final
Clinical Decision Units	ClinDec	Clinical	Final
Clinical Haematology	ClinHaem	Clinical	Final
Clinical Immunology & Allergy	ClinImmun	Clinical	Final
Clinical Measurement	ClinMeas	Clinical	Final
Clinical Pharmacology	ClinPharm	Clinical	Final
Clinical Care Trials	ClinTrial	Clinical	Final
Colorectal	Colorectal	Clinical	Final
Community Medicine	CommMed	Clinical	Final
Consultation Liaison	ConsLias	Clinical	Final
Continence	Cont	Clinical	Final
Coronary Care Units	CCU	Critical	Final
Craniofacial	Craniofacial	Clinical	Final
Day Surgery Ward	DaySurgWard	Clinical	Final
Delivery ward	DelivWard	Clinical	Final
Dementia	Dementia	Clinical	Final
Dental	Dental	Clinical	Final
Dermatology	Dermat	Clinical	Final
Dev Disabled Service	DevDisSer	Clinical	Final
Diabetes	Diabetes	Clinical	Final
Drug & Alcohol Service	DrugAlch	Clinical	Final
Dysplasia and colposcopy	DysCol	Clinical	Final

Cost centre name	Code	Group	Final / Overhead
Electrodiagnosis - neurology	ElecNeur	Clinical	Final
Emergency Management Units	EDmu	Clinical	Final
Endocrinology	Endocrin	Clinical	Final
ENT Services	ENT	Clinical	Final
Epilepsy	Epilepsy	Clinical	Final
Falls Clinic	Falls	Clinical	Final
Family Planning	FamPlan	Clinical	Final
Fracture Service	Fracture	Clinical	Final
Gait Laboratory - paediatric	GaitLab	Clinical	Final
Gastroenterology	Gastro	Clinical	Final
General Medicine	GenMed	Clinical	Final
General Surgery	GenSurg	Clinical	Final
General Ward	GenWard	Clinical	Final
Genetics	Genetics	Clinical	Final
Geriatrics	Geriatrics	Clinical	Final
Geriatric evaluation and maintenance (care type 4.0)	GEM	Clinical	Final
Gynaecology	Gynaecology	Clinical	Final
Head Injury	HeadInjury	Clinical	Final
Heart and Chest	HeaChest	Clinical	Final
Heart Transplant Services	HeartTrans	Clinical	Final
Hepatobiliary	Hepatobiliary	Clinical	Final
High Dependency Unit	HDU	Clinical	Final
Hospital in the Home	HITH	Clinical	Final
Hospital Boarder (care type 10.0)	Boarder	Clinical	Final
Hypertension	Hypertension	Clinical	Final
Infectious diseases	Infectious	Clinical	Final

Cost centre name	Code	Group	Final / Overhead
Lithotripsy	Litho	Clinical	Final
Liver transplant	LiverTrans	Clinical	Final
Lung transplant	LungTrans	Clinical	Final
Maintenance care (care type 6.0)	Maintenance	Clinical	Final
Maternal foetal monitoring	MatMon	Clinical	Final
Medihotel	MedHot	Clinical	Final
Medical oncology	MedOncology	Clinical	Final
Metabolic bone	MetBone	Clinical	Final
Midwifery (including breast feeding support)	Midwif	Clinical	Final
Neonatology	Neonat	Clinical	Final
Nephrology	Nephrology	Clinical	Final
Neurology / Stroke	NeuroStroke	Clinical	Final
Neurosurgery	Neurosurg	Clinical	Final
Newborn care (care type 7.0)	Newborn	Clinical	Final
Non Acute Inpatients	NonAcute	Clinical	Final
Non-admitted patients (clinic)	Outpat	Clinical	Final
Non-admitted patients (other)	OutpatOther	Clinical	Final
Observations beds	ObsBed	Clinical	Final
Obstetrics, Gynaecology – General	ObsGynaeGen	Clinical	Final
Obstetrics	Obstet	Clinical	Final
Occupational Medicine	OccupatMed	Clinical	Final
Oncology	Oncology	Clinical	Final
Ophthalmology	Ophthalm	Clinical	Final
OralMaxillofacial surgery	OralMaxillofac	Clinical	Final
Organ Procurement (care type 9.0)	OrganProc	Clinical	Final
Orthopaedic appliances	OrthApp	Clinical	Final

Cost centre name	Code	Group	Final / Overhead
Orthopaedics	Orthpaed	Clinical	Final
Other admitted patient care (care type 8.0)	Othadmpatcar	Clinical	Final
Other Clinical Service (please specify)	OtherClinServ	Clinical	Final
Outreach / Community	OutComm	Clinical	Final
Paediatric General	PaedGen	Clinical	Final
Paediatric General Medicine	PaedGenMed	Clinical	Final
Paediatric General Surgery	PaedGenSur	Clinical	Final
Pain Management	PainMgt	Clinical	Final
Palliative Care/Hospice	PalCare	Clinical	Final
Plastic surgery	PlasticSurg	Clinical	Final
Pre admission service	PreAdmit	Clinical	Final
Pre anaesthesia service	PreAnaes	Clinical	Final
Psychiatry	Psychiatry	Clinical	Final
Psychogeriatric care (care type 5.0)	Psychgeriatric	Clinical	Final
Public Health	PubHlth	Clinical	Final
Pulmonary Medicine	PulmMed	Clinical	Final
Radiation Medicine	RadMed	Clinical	Final
Radiation Oncology	RadOnc	Clinical	Final
Rehabilitation	Rehab	Clinical	Final
Renal Dialysis	Renal	Clinical	Final
Renal Medicine	RenalMed	Clinical	Final
Renal transplant	RenalTransp	Clinical	Final
Respiratory Medicine	Resp	Clinical	Final
Respite Services	ResSer	Clinical	Final
Rheumatology	Rheumat	Clinical	Final
Sexual Health	SexHealth	Clinical	Final

Cost centre name	Code	Group	Final / Overhead
Short Stay Assessment	ESSU	Clinical	Final
Special Medical	SpecMed	Clinical	Final
Special Surgical	SpecSurg	Clinical	Final
Speciality Ward	Specialty	Clinical	Final
Special Care Nursery (not attached to Neonatal ICU)	SpecCN	Clinical	Final
Spinal Injury	Spinal	Clinical	Final
Stroke	Stroke	Clinical	Final
Stomal Therapy	StomTher	Clinical	Final
Surgical High Dependency Unit	SurgHDU	Clinical	Final
Thoracic medicine	ThoracicMed	Clinical	Final
Thoracic surgery	ThoracicSur	Clinical	Final
Transit Lounge	TranLoun	Clinical	Final
Transplants	Transplant	Clinical	Final
Trauma Centre	TraumCentre	Clinical	Final
Urology	Urology	Clinical	Final
Vascular Services	Vascular	Clinical	Final
Wound Management	Wound	Clinical	Final
Adult Intensive Care Unit	AICU	Critical	Final
Cardiothoracic Intensive Care	CTICU	Critical	Final
General Critical Care	GenCritCare	Critical	Final
High Dependency Unit (attached to ICU)	HDICU	Critical	Final
Neonatal Intensive Care Units	NICU	Critical	Final
Other Critical Care (please specify)	OtherCritCare	Critical	Final
Paediatric Intensive Care Units	PaedICU	Critical	Final
Psychiatric Intensive Care	PsychICU	Critical	Final
Special Care Nursery (attached to NICU)	SCNICU	Critical	Final

Cost centre name	Code	Group	Final / Overhead
Emergency Department / Emergency Medicine	EmergMed	ED	Final
Other Emergency Departments (please specify)	OtherEMed	ED	Final
Trauma	EmergTrauma	ED	Final
Angiography	AngioImag	Imag	Final
Computed Tomography (CT)	CT	Imag	Final
Echo CardioGram	EchoCardio	Imag	Final
General Imaging	GenImag	Imag	Final
Mammography	Mammo	Imag	Final
Magnetic Resonance Imaging (MRI)	MRI	Imag	Final
Medical Illustration (including medical photography)	MedIll	Imag	Final
Nuclear Medicine	Nuclmed	Imag	Final
Positron Emission Tomography (PET)	PET	Imag	Final
Plain radiology	PlainRad	Imag	Final
Ultrasound	Ultrasound	Imag	Final
Other Imaging (please specify)	OtherImag	Imag	Final
Anaesthesia	Anaesth	OR	Final
General Day Surgery Suite	DaySurg	OR	Final
General Operating Rooms	GenOr	OR	Final
Operating Theatre Suite	OR	OR	Final
Other Operating Rooms (please specify)	OtherOR	OR	Final
Patient Induction / Anaesthesia area	Anaesthesia, Area	OR	Final
Recovery Rooms	RecoverRooms	OR	Final
Animal House	AnimHou	Path	Final
Autopsy	Autopsy	Path	Final
Blood Products	Blood	Path	Final

Cost centre name	Code	Group	Final / Overhead
Clinical Biochemistry	ClinBio	Path	Final
Clinical Chemistry	ClinChem	Path	Final
Cytogenetics	Cytogen	Path	Final
Cytology	Cytology	Path	Final
Forensic	Forensic	Path	Final
General Pathology	GenPath	Path	Final
Genetics	Genet	Path	Final
Haematology (Laboratory)	Haemat	Path	Final
Histopathology	Histopath	Path	Final
Immunology (Laboratory)	Immunology	Path	Final
Microbiology	Microbio	Path	Final
Mortuary	Morgue	Path	Final
Pharmacology	Pharmac	Path	Final
Specimen collection services	Specimen	Path	Final
Toxicology	Toxic	Path	Final
Transfusion services (incl. blood bank/autologist services)	Transfusion	Path	Final
Other Pathology (please specify)	OtherPath	Path	Final
Cytotoxic drugs	Cytoxic	Pharm	Final
Dispensing costs of drugs	Dispense	Pharm	Final
General Pharmacy	GenPharm	Pharm	Final
High Cost drugs	HighDrugs	Pharm	Final
Imprest (Ward)	Imprest	Pharm	Final
Manufacturing	MfedDrugs	Pharm	Final
Other Pharmacy (please specify)	OtherPharm	Pharm	Final
Parenteral / Enteral Nutrition (goods & services only)	TPN	Pharm	Final

Cost centre name	Code	Group	Final / Overhead
Other Services (e.g. business & commercial)	OtherServ	OtherServ	Final
Research	Research	OtherServ	Final
Teaching	Teaching	OtherServ	Final
Angiography	AngioSPS	SPS	Final
Cardiac Catheter Suites	CardCath	SPS	Final
ECT Suites	ECT	SPS	Final
Endoscopic Suites	Endoscopic	SPS	Final
General Procedure Suites	GenProcSuites	SPS	Final
Hyperbaric Chamber	Hyperbaric	SPS	Final
Lithotripsy Suites	Lithotrip	SPS	Final
Lung function laboratories	LungFunc	SPS	Final
Non–invasive Cardiac Laboratories (e.g.Echo Labs)	NoninvasiveCar	SPS	Final
Other Procedure Suites	OthProcSuite	SPS	Final
Physiology Laboratories	PhysioLabs	SPS	Final
Radiotherapy Suites	Radiotherapy	SPS	Final
Respiratory Laboratories	RespiratLabs	SPS	Final
Sleep Laboratories	SleepLabs	SPS	Final
Allied Health Administration	AHAdmin	Overhead	OtherOhds
Biomedical Engineering	BiomedEng	Overhead	OtherOhds
Central Sterilising and Supply Department	CSSD	Overhead	OtherOhds
Chaplaincy	Chap	Overhead	OtherOhds
Cleaning Services	Floorfrq	Overhead	HotelOhds
Clinical Information	ClinInfo	Overhead	OtherOhds
Computing	Comp	Overhead	OtherOhds
Corporate Management Fees	CorpMan	Overhead	OtherOhds
Document Transmission & Storage	DocXmit	Overhead	OtherOhds

Cost centre name	Code	Group	Final / Overhead
Energy Supplies	EneSupp	Overhead	OtherOhds
Executive Services (Management)	ExecServ	Overhead	OtherOhds
Financial Administration	FinAdmin	Overhead	OtherOhds
Financing Costs (including interest)	FinCosts	Overhead	OtherOhds
Food Services (patients)	PatFood	Overhead	HotelOhds
Fringe Benefits Tax	FBT	Overhead	OtherOhds
Grounds and Gardens	Grounds	Overhead	OtherOhds
Health Information Management	HIM	Overhead	OtherOhds
Hospital Management and Administration	AdminCost	Overhead	OtherOhds
Hospital Staff Catering	StaffCat	Overhead	OtherOhds
Human Resource Management	HRM	Overhead	OtherOhds
Infection Control	InfectCtrl	Overhead	OtherOhds
Insurance	Insur	Overhead	OtherOhds
Interpreter Services	Interp	Overhead	OtherOhds
Legal Services	Legal	Overhead	OtherOhds
Library Services	Library	Overhead	OtherOhds
Linen & Laundry Services	Linen	Overhead	HotelOhds
Maintenance, Engineering & Repairs	MaintEngReprs	Overhead	OtherOhds
Medical Management & Admin	MedAdmin	Overhead	OtherOhds
Medical Records	MedRecord	Overhead	OtherOhds
Nursing Management & Admin	NurseAdmin	Overhead	OtherOhds
Occupational Health and Safety	OHS	Overhead	OtherOhds
Other Administrative Services	OtherAdmin	Overhead	OtherOhds
Other Hotel Services	OHSvrs	Overhead	HotelOhds
Other Overheads	OtherOhds	Overhead	OtherOhds
Patient Administration	PatAdmin	Overhead	OtherOhds

Cost centre name	Code	Group	Final / Overhead
Patient Residential Accommodation	ResAcc	Overhead	OtherOhds
Patient Transport	PatTransport	Overhead	OtherOhds
Payroll	Payroll	Overhead	OtherOhds
Payroll Tax	PayrollTax	Overhead	OtherOhds
Porters & Orderlies	PortOrd	Overhead	HotelOhds
Printing, Postage and Stationery	PrintPost	Overhead	OtherOhds
Property Services	PropServ	Overhead	OtherOhds
Public Relations & Marketing	PubRel	Overhead	OtherOhds
Quality Assurance	QualAssur	Overhead	OtherOhds
Redundancy Payments	Reday	Overhead	OtherOhds
Sales Tax	SalesTax	Overhead	OtherOhds
Security	Security	Overhead	OtherOhds
Staff Accommodation	StaffAccom	Overhead	OtherOhds
Staff Development	StaffDev	Overhead	OtherOhds
Stores / Supplies & Transport costs	Stores	Overhead	OtherOhds
Telecommunications	Telecommun	Overhead	OtherOhds
Transport of Personnel	StaffTransport	Overhead	OtherOhds
Volunteer Services	Volt	Overhead	OtherOhds
Water	Water	Overhead	OtherOhds

ATTACHMENT D: Overhead Allocation Statistics

Table D.1: List of Allocation Statistics

Code for Statistic	Description of overhead allocation statistic
ActualPatsCost	Actual cost of service directly allocated to a patient either externally or internally billed e.g. patient meals, transport cost.
ActualCostCentreCost	Actual cost of service directly allocated to a cost centre either externally or internally billed (e.g. biomedical service, payroll services, CSSD).
ActualPatUnits	Actual units of service directly allocated to a patient either externally or internally billed e.g. patient meals, transport, interpreter services.
ActualCostCentreUnits	Actual units of service directly allocated to a cost centre either externally or internally billed e.g. patient meals.
Allpats	All episodes (admitted and weighted non-admitted).
ExpAll	General ledger total expenses for total hospital or specific service e.g. medical.
ExpG&S	Goods and services expenses from general ledger for total hospital or specific service e.g. surgical.
ExpSalwageAll	Salary and wages per cost area for all staff applied to the total hospital or a specific service.
ExpSalwageMed	Salary and wages per cost area for medical staff applied to the total hospital or a specific service.
ExpSalwageNurs	Salary and wages per cost area for nursing staff applied to the total hospital or a specific service.
Floor	Floor space (sq. metres).
Floorfrq	Floor space * frequency of cleaning.
FteTotalALL	Full time equivalents for all staff applied across the total hospital or a specific service.
Ftemed	Total full time equivalent for medical staff applied across the total hospital or a specific service.
Ftenurs	Total full time equivalent for nursing staff applied across the total hospital or a specific service.
HeadCountAll	Total staff head count applied across the total hospital or a specific service.
HeadCountMed	Medical staff head count applied across the total hospital or a specific

Code for Statistic	Description of overhead allocation statistic
	service.
HeadCountNurs	Nursing staff head count applied across the total hospital or a specific service.
InpatAll	Number of inpatient discharges or admissions.
InpatSS	Number of inpatient separations or admissions for a specific service
MedAss	Medical equipment assets.
Medrec	Time taken to code medical record (admitted and non-admitted).
Nopc	Number of computers.
Obd	Occupied bed days (admitted).
ObdEquiv	Occupied bed day equivalents (i.e. use of an equivalence ratio between admitted and non-admitted service to produce overall service volume).
OutpatOcc	Outpatient occasion of service.
Phones	Number of telephone lines connected.
Stores	Stores issued.
Totass	Total assets.
TransGL	Total number of transactions by Cost Centre.
WardAdm	Ward admissions to take account for ward transfers.

Table D.2: Suggested Allocation Statistics and Code

Type of overhead cost centre	Order of Alternatives		
	1st	2nd	3rd
Allied Health Administration	ActualPatUnits (allied health time by patient)	Allpat	InpatAll
Biomedical Engineering	MedAss	Totass	ObdEquiv
Central Sterilising and Supply Department	InpatSS (surgical activity)	InpatAll	Allpats
Chaplaincy	ObdEquiv	InpatAll	Allpats
Cleaning Services	Floorfrq	Floor	FteTotalAll
Clinical Information	Allpat	InpatAll	ExpG&S
Computing	Nopc	FteTotalAll	HeadCountAll
Corporate Management Fees	ExpAll	FteTotalAll	HeadCountAll
Document Transmission & Storage	ExpAll	ExpSalwageAll	FteTotalAll
Energy Supplies	Floor	ExpAll	ExpSalwageAll
Executive Services (Management)	ExpAll	FteTotalAll	HeadCountAll
Financial Administration	TransGL	ExpAll	FteTotalAll
Financing Costs (including interest)	ExpAll	Totass	ExpG&S
Food Services (patients)	ActualPatUnits	ActualCostCentreUnits	Obd
Fringe Benefits Tax	ExpSalwageAll	FteTotalAll	HeadCountAll
Grounds and Gardens	ExpSalwageAll	HeadCountAll	ExpAll
Health Information Management	Allpats	InpatAll	ExpG&S
Hospital Management & Administration	HeadCountAll	FteTotalAll	ExpAll
Hospital Specific Service Management & Administration	HeadCountAll	FteTotalAll	ExpAll

Type of overhead cost centre	Order of Alternatives		
	1st	2nd	3rd
Hospital Staff Catering	HeadCountAll	FteTotalAll	ExpSalwageAll
Human Resource Management	HeadCountAll	FteTotalAll	ExpSalwageAll
Infection Control	Ftemed	Ftenurs	ObdEquiv
Insurance - Property	Totass	ExpG&S	ExpAll
Insurance – Professional Indemnity	FteMed	ExpSalwageMed	ExpAll
Interpreter Services	ActualPatUnits	ActualCostCentreUnits	ObdEquiv
Legal Services	InpatAll	HeadCountAll	FteTotalAll
Library Services	HeadCountAll	FteTotalAll	ExpSalwageAll
Linen & Laundry Services	ActualCostCentreUnits	ObdEquiv	Obd
Maintenance, Engineering & Repairs	Totass	MedAss	Floor
Medical Management & Admin.	HeadCountMed	Ftemed	ExpSalwageMed
Medical Management & Admin Specific Service	HeadCountMed	Ftemed	ExpSalwageMed
Medical Records	Allpat	InpatAll	ObdEquiv
Nursing Management & Admin	HeadCountNurs	Ftenurs	ExpSalwageNurs
Nursing Management & Admin Specific Service	HeadCountNurs	Ftenurs	ExpSalwageNurs
Occupational Health and Safety	HeadCountAll	FteTotalAll	ExpSalwageAll
Other Administrative Services	HeadCountAll	FteTotalAll	ExpSalwageAll
Other Hotel Services	ObdEquiv	InpatAll	Floor
Other Overheads	ExpAll	InpatAll	ExpSalwageAll
Patient Administration	Allpat	InpatAll	ObdEquiv
Patient Residential Accommodation	HeadCountAll	InpatAll	ObdEquiv

Type of overhead cost centre	Order of Alternatives		
	1st	2nd	3rd
Patient Transport - Admitted	InpatAll	Allpats	Obd
Patient Transport – Non Admitted	OutPatOcc	Allpat	ObdEqiv
Payroll	HeadCountAll	FteTotalAll	ExpSalwageAll
Payroll Tax	ExpSalwageAll	FteTotalAll	HeadCountAll
Porters and Orderlies	WardAdm	InpatAll	Allpats
Printing, Postage and Stationery	ExpAll	ExpSalwageAll	ObdEquiv
Property Services	ExpSalwageAll	HeadCountAll	ExpAll
Public Relations & Marketing	InpatAll	ExpAll	ObdEquiv
Quality Assurance	InpatAll	ExpAll	ExpSalwageAll
Redundancy Payments	ExpSalwageAll	FteTotalAll	HeadCountAll
Sales Tax	ExpG&S	ExpAll	FteTotalAll
Security - Other	HeadCountAll	FteTotalAll	ExpG&S
Security - Patient	InpatAll	Obd	ObdEqiv
Staff Accommodation	HeadCountAll	FteTotalAll	ExpSalwageAll
Staff Development	HeadCountAll	FteTotalAll	ExpSalwageAll
Stores/Supplies & Transport costs	Stores	ExpG&S	ExpAll
Telecommunications	Phones	HeadCountAll	FteTotalAll
Transport of Personnel	HeadCountAll	FteTotalAll	ExpSalwageAll
Volunteer Services	ObdEquiv	InpatAll	ExpSalwageNurs
Water	Floor	ExpAll	ExpSalwageAll

ATTACHMENT E: Final Allocation Statistics

The allocation of costs from final cost centres to point of delivery is described as a matrix including:

- Admitted patients (with separate advice for wards/medical units, critical care, theatres and procedure suites),
- Emergency Department patients and non-admitted patients), and
- Line items, (medical S&W, nursing S&W, allied health S&W, other S&W, prosthetics, other goods and services, medical supplies and consumables, pharmacy, pathology, imaging, oncosts, hotel and depreciation.

When describing the alternative order for final allocation statistics to be used from the matrix, there is effectively a continuum of precision from the first to the last alternative. It is possible that, depending on available data, there will be different alternatives used within the same point of delivery.

E.G. allocation of nursing S&W in the operating room:

alternative1 - “Actual time with patient” is the allocation of procedure time,
alternative2 - Planned/rostered time by OBD is the known planned or rostered time for an occupied bed day.
alternative3 “Internally derived RVUs by service event” is used to determine the setup and clean-up costs in the service event.

Table E.1: List of Final Allocation Methods

Allocation Method	Description
Actual Cost	The purchase cost (from the feeder system) or the actual production cost (unlikely to be known) of the individual products/services consumed by the patient.
Actual Time	The actual time spent by clinical or other professionals (from the feeder system) to provide services to the individual patient (for allocating the costs of clinician time, this number will be multiplied by the average cost of a time unit (i.e. hourly rate)).
Actual utilisation with externally derived RVUs	The actual number of units consumed (from the feeder system), with an RVU developed from external data applied to reflect the relative cost of each product/service consumed in the end-product class (e.g. use of MBS prices as cost relativities for imaging services). These RVUs may be calculated on several bases depending on the service setting, including occupied bed days (OBDs), theatre sessions, Emergency Department and non-admitted patient products.
Actual utilisation with internally derived RVUs	The actual number of units consumed (from the feeder system), with an RVU developed from internal data (preferably with local clinical involvement) applied to reflect the relative cost of each product/service consumed in the end-product class. These RVUs may be calculated on several bases depending on the service setting, including OBDs, theatre sessions, Emergency Department and non-admitted patient products.

Allocation Method	Description
Externally derived RVUs	The modelled number of units consumed combined with the modelled relative costs developed from external (outside of the LHN/hospital) data applied to reflect the relative cost of each product/service consumed in the end-product class (e.g. the use of the national service weights). These RVUs may be calculated on several bases depending on the service setting, Emergency Department and non-admitted patient products.
Externally derived RVUs by OBD	These are externally derived RVUs calculated on the bases of an Occupied Bed Day.
Externally derived RVUs by patient service event	These are externally derived RVUs calculated on the bases of a patient service event.
Externally derived RVUs by procedure	These are externally derived RVUs calculated on the bases of a procedure.
Internally derived RVUs	The modelled number of units consumed combined with the modelled relative costs developed from internal (within the LHN/Hospital) data (preferably with local clinical involvement) applied to reflect the relative cost of each product/service consumed in the end-product class (often referred to as internally derived service weights). These RVUs may be calculated on several bases depending on the service setting, including Emergency Department and non-admitted patient products.
Internally derived RVUs by OBD	These are internally derived RVUs calculated on the bases of an Occupied Bed Day.
Internally derived RVUs by patient service event	These are internally derived RVUs calculated on the bases of a patient service event.
Internally derived RVUs by procedure	These are internally derived RVUs calculated on the bases of a procedure.
Planned or rostered time	The time that it is planned or rostered for a clinician to spend on each end-product class (or an aggregation of end-product classes). Where the time is specific to one end-product class, the number will be multiplied by the average cost of a time unit (i.e. hourly rate)). Where the time is for multiple end-product classes, the time for individual end-product classes may be allocated equally or using an RVU (e.g. nurse dependency for nursing S&W) across all relevant end-product classes, then multiplied by the average cost of a time unit (e.g. hourly rate). These RVUs may be calculated on several bases depending on the service setting, including Emergency Department and non-admitted patient products.
Planned/rostered time by OBD	These are planned or roster times calculated on the bases of an Occupied Bed Day.
Planned/rostered time by procedure	These are planned or roster times calculated on the bases of a procedure.
As per relevant Salaries & Wages line item	The total of each type of salary and wages identified in the General Ledger for each final cost centre relevant to a patient's end-class.

The alternatives reflected in Table E.2 follows the broad logic that in descending order:

- actual cost allocation (where actual cost is known it is always preferred);
- actual time with patient (for allocating the costs of clinician time, this number will be multiplied by the average cost of a time unit (i.e. hourly rate));
- planned/rostered time with patients (for allocating the costs of clinician time, this number will be distributed across all relevant patients (equally or with RVU) then multiplied by the average cost of a time unit (i.e. hourly rate));
- actual utilisation with internally derived and validated RVUs that measure relative costs of intermediate products/services;
- actual utilisation with externally derived and validated RVUs that measure relative costs of intermediate products/services;
- internally derived and validated RVUs that measure relative costs and relative utilisation of intermediate products/services (often referred to as service weights);
- externally derived and validated RVUs that measure relative costs and relative utilisation of intermediate products/services (often referred to as service weights);

When determining what allocation methods need to be used to cost a particular service, additional emphasis needs to be placed on what sub-components of the costing should be recognised. For example it would be considered less reliable to have a single RVU for all of Imaging, when it is possible to have an RVU for each type of Imaging (Plain radiology, CT, MRI, ultrasound, etc.)

The selection of allocation method will rarely be a clear choice of one approach, and there will be hybrid models used to determine the most effective cost allocation to patient products in the given circumstances. For example, with medical salaried and wages, consideration should be given to how the costs of internal consultation time (i.e. consultation liaison time) are allocated. This item is not normally recorded in the hospital information systems (e.g. psychiatrists often consult to other medical specialists, emergency physicians often request consultations from the other medical specialists (refer to Standard COST 3A.001 – Allocating Clinical Salary and Wages to patients and other products).

In allocating medical costs associated with the operating room, it needs to be recognised that there will be multiple doctors in the operating room. Whether using actual, planned or rostered time, the allocations will need to reflect all medical staff (anaesthetist, surgeon, surgeon assistant, etc.) It is also likely that planned or actual setup/clean up time must be included in any of the options.

Table E.2: Suggested Allocation Method

		Admitted patients			Non-Admitted patients	
Line Item/ Point of Delivery	**Alternatives**	**Wards/ Medical Units**	**Critical Care**	**Theatre and Procedure Suites**	**ED**	**Non Admitted**
Medical Salaries & Wages (Both VMO and salaried medical officers)	**1.**	Actual time	Actual time	Actual time	Actual time	Actual time
	2.	Planned/ rostered time by OBD	Planned/ rostered time by OBD	Planned/ rostered time by procedure	Planned/ rostered time	Planned/ rostered time
	3.	Internally derived RVUs by OBD	Internally derived RVUs by OBD	Internally derived RVUs by procedure	Internally derived RVUs by patient service event	Internally derived RVUs by patient service event
	4.	Externally derived RVUs by OBD	Externally derived RVUs by OBD	Externally derived RVUs by procedure	Externally derived RVUs by patient service event	Externally derived RVUs by patient service event
Nurse Salaries & Wages	**1.**	Actual time	Actual time	Actual time	Actual time	Actual time
	2.	Planned/rostered time by OBD	Planned/rostered time by OBD	Planned/rostered time by procedure	Planned/rostered time	Planned/rostered time
	3.	Internally derived RVUs by OBD	Internally derived RVUs by OBD	Internally derived RVUs by procedure	Internally derived RVUs by patient service event	Internally derived RVUs by patient service event
	4.	Externally derived RVUs by OBD	Externally derived RVUs by OBD	Externally derived RVUs by procedure	Externally derived RVUs by patient service event	Externally derived RVUs by patient service event
Allied Health Salaries & Wages	**1.**	Actual time	Actual time	Actual time	Actual time	Actual time
	2.	Planned/ rostered time by OBD	Planned/ rostered time by OBD	Planned/ rostered time by procedure	Planned/ rostered time	Planned/ rostered time
	3.	Internally derived RVUs by OBD	Internally derived RVUs by OBD	Internally derived RVUs by procedure	Internally derived RVUs by patient service event	Internally derived RVUs by patient service event

		Admitted patients			Non-Admitted patients	
Line Item/ Point of Delivery	**Alternatives**	**Wards/ Medical Units**	**Critical Care**	**Theatre and Procedure Suites**	**ED**	**Non Admitted**
	4.	Externally derived RVUs by OBD	Externally derived RVUs by OBD	Externally derived RVUs by procedure	Externally derived RVUs by patient service event	Externally derived RVUs by patient service event
Other Salaries & Wages	**1.**	Actual time	Actual time	Actual time	Actual time	Actual time
	2.	Planned/rostered time by OBD	Planned/rostered time by OBD	Planned/rostered time by procedure	Planned/rostered time	Planned/rostered time
	3.	Internally derived RVUs by OBD	Internally derived RVUs by OBD	Internally derived RVUs by procedure	Internally derived RVUs by patient service event	Internally derived RVUs by patient service event
	4.	Externally derived RVUs by OBD	Externally derived RVUs by OBD	Externally derived RVUs by procedure	Externally derived RVUs by patient service event	Externally derived RVUs by patient service event
Prosthe-tics	**1.**	Actual cost	Actual cost	Actual cost	Actual cost	Actual cost
	2.	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs
	3.	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs
	4.	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs
Other Goods and Services	**1.**	Actual cost	Actual cost	Actual cost	Actual cost	Actual cost
	2.	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs

		Admitted patients			Non-Admitted patients	
Line Item/ Point of Delivery	**Alternatives**	**Wards/ Medical Units**	**Critical Care**	**Theatre and Procedure Suites**	**ED**	**Non Admitted**
	3.	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs
	4.	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs
Medical Supplies/ Consumables	**1.**	Actual cost	Actual cost	Actual cost	Actual cost	Actual cost
	2.	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs
	3.	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs
	4.	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs
Pharmacy	**1.**	Actual cost	Actual cost	Actual cost	Actual cost	Actual cost
	2.	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs
	3.	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs
	4.	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs
Pathology	**1.**	Actual cost	Actual cost	Actual cost	Actual cost	Actual cost
	2.	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs

		Admitted patients			Non-Admitted patients	
Line Item/ Point of Delivery	**Alternatives**	**Wards/ Medical Units**	**Critical Care**	**Theatre and Procedure Suites**	**ED**	**Non Admitted**
	3.	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs
	4	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs
Imaging	**1.**	Actual cost	Actual cost	Actual cost	Actual cost	Actual cost
	2.	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs
	3.	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs
	4.	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs
On-costs	**1.**	As per relevant Salaries & Wages line item.	As per relevant Salaries & Wages line item.	As per relevant Salaries & Wages line item.	As per relevant Salaries & Wages line item.	As per relevant Salaries & Wages line item.
Hotel Services	**1.**	Actual cost	Actual cost	Actual cost	Actual cost	Actual cost
	2.	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs
	3.	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs
	4	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs

		Admitted patients			Non-Admitted patients	
Line Item/ Point of Delivery	**Alternatives**	**Wards/ Medical Units**	**Critical Care**	**Theatre and Procedure Suites**	**ED**	**Non Admitted**
Depreciation	**1.**	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs	Actual utilisation with internally derived RVUs
	2.	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs	Actual utilisation with externally derived RVUs
	3.	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs	Externally derived RVUs

Legend: OBD – Occupied bed days; RVUs – Relative value units

ATTACHMENT F: List of Minimum Useful Lives for Asset Classes

Table F.1: Full ATO list of useful lives as at 1st July 2010

Asset	Life (years)
Anaesthesia machines	10
Angiography assets:	
Image acquisition system (incorporating computer with digital subtraction capability, digital camera, monitor and integrated software)	4
Image intensifier	7
Patient gantry or table, patient monitoring assets, positioning assets, and pressure injectors	10
Cell savers and cell separators	7
Colposcopes	10
Defibrillators	10
Diathermy and cautery machines/electrosurgical generators	10
Endoscopic surgery assets (excluding disposable accessories):	
Arthroscopic fluid management systems	7
Endoscopes (flexible and rigid) and endoscopic surgical instruments	4
Endoscopic camera systems:	
Beam splitters and light sources	10
Printers, video cameras, video camera adaptors, couplers and heads, video image capture systems and video processors	5
Still cameras	7
Video monitors and video recorders	7
Endoscopic electrosurgical generators	10
Endoscopic lasers	10
Endoscopic ultrasound systems (incorporating scanner, transducers/probes, integrated computer and integrated software)	5
Haemodialysis machines	7

Asset	Life (years)
Head lights	7
Beds:	
Electronic	7
Mechanical	10
Bedside cabinets/lockers, carts and poles, blanket warming cabinets, blood warming cabinets, medical refrigerators, and overbed tables	10
Infusion pumps:	
General, pain management and rapid	8
Syringe driven	6
Insufflators	10
Lithotriptors used for extra-corporeal shock wave lithotripsy	7
Mechanical assist assets:	
Calf and cuff compression devices	8
Cardiac bypass and heart lung machines	8
Intra-aortic balloon pumps	8
Ventricular assist heart pumps	8
Natal care assets (including incubators, infant warmers and mobile infant warmers)	7
Operating tables and attachments:	
Electronic	10
Mechanical	13
Operating theatre lights	8
Pan flushers	10
Patient hoists and lifters	10
Patient monitoring assets:	
Bedside monitoring systems	7
Cardiac monitors	7

Asset	Life (years)
ECG (electrocardiographs)	7
Foetal monitors	7
Pulse oximeters	7
Vital signs monitors	7
Patient warming assets (excluding disposable accessories):	
Fluid warmers	10
Forced air patient warmers	10
Smoke evacuators	8
Sterilisation and autoclave processing assets:	
Drying cabinets	10
Endoscope sterilisers and disinfectors	5
Flash sterilisers	10
Instrument washers	10
Pre-vacuum sterilisers	10
Ultrasonic cleaners and baths	7
Surgical instruments:	
Hand held manually operated instruments	8
Powered instruments (including drills, saws, shavers, non-disposable instrument accessories and power sources)	7
Ultrasonic aspirators	10
Ultrasonic scalpels	10
Surgical lasers (excluding ophthalmic surgical lasers)	10
Surgical microscopes	10
Ultrasonic bladder scanners	10
Ultrasonic needle guides	10
Ultrasound systems (incorporating scanner, transducers, integrated computer and integrated software) used by cardiologists, obstetricians and vascular surgeons	5

Asset	Life (years)
Ventilators:	
Fixed	7
Portable	5
Wheelchairs	10

ATTACHMENT G: Preferred Methods for Allocating Capital Costs

Table G.1: List of capital cost allocation methods – Stage 1

Code for Statistic	Description of statistic
Actual usage	Ideally, a piece of equipment will be able to be assigned to a single cost centre (either final or overhead). Where equipment is shared across cost centres, data from the feeder system may provide the number of units consumed by product categories to create a suitable cost allocation statistic.
Floor	Floor space (square metres)
OBD	Occupied bed day equivalents (admitted and non-admitted)

Table G.2: Suggested allocation Statistics and Code – Stage 1

Type of capital cost	Statistic	
	1st preference	2nd preference
Medical equipment	Actual usage or relevant allocation statistic	OBD
Plant and non-medical equipment	Relevant allocation statistic	OBD
Buildings and improvements	Floor area	Floor area
Intangibles	Actual usage or relevant allocation statistic	OBD

Table G.3: List of final allocation methods – Stage 3

Code for Statistic	Description of allocation method
Actual with RVU	Where data from the feeder system may provide the number of units consumed by patient products with a RVU applied to the feeder data to create a suitable cost allocation method.
Frac BD Spec	Fractional Bed Days - ward specific (bed day equivalents may be used for Non-admitted patients and other products).
OBD Spec	Occupied Bed Days - ward specific (bed day equivalents may be used for Non-admitted patients and other products).

Table G.4: Suggested allocation method – Stage 3

Type of Capital Cost	Place of Delivery	Allocation method	
		1st preference	2nd preference
Medical equipment	All locations	Actual with RVU	Frac BD Spec
All other depreciation	All locations	Frac BD Spec	OBD Spec

ATTACHMENT H: Cost Bucket Matrix

Cost centres	Line Items																					
	SW Nurs	SW Med	SW AH	SW Other	SW VMO	Oncsts	GS	MS	Pros	Path	Blood	Imag	Phrm NPBS	Phrm PBS	Hotel	Corp	Dprc B	Dprc E	Lease	Cap	Excld	PayTax
Allied	Allied	Allied	Allied	Allied	Allied	Oncsts	Allied	Allied	Pros	Path	Path	Imag	Phrm	Phrm	Hotel	Allied	Dprc	Dprc	Dprc	Excld	Excld	PayTax
Clinical	Ward Nurs	Ward Med	Allied	Non Clncl	Ward Med	Oncsts	Ward Spls	Ward Spls	Pros	Path	Path	Imag	Phrm	Phrm	Hotel	Ward Spls	Dprc	Dprc	Dprc	Excld	Excld	PayTax
Crtcl	Crtcl	Crtcl	Crtcl	Crtcl	Crtcl	Oncsts	Crtcl	Crtcl	Pros	Crtcl	Crtcl	Crtcl	Crtcl	Crtcl	Hotel	Crtcl	Dprc	Dprc	Dprc	Excld	Excld	PayTax
Imag	Imag	Imag	Imag	Imag	Imag	Oncsts	Imag	Imag	Pros	Path	Path	Imag	Imag	Imag	Hotel	Imag	Dprc	Dprc	Dprc	Excld	Excld	PayTax
Path	Path	Path	Path	Path	Path	Oncsts	Path	Path	Pros	Path	Path	Imag	Path	Path	Hotel	Path	Dprc	Dprc	Dprc	Excld	Excld	PayTax
OR	OR	OR	OR	OR	OR	Oncsts	OR	OR	Pros	OR	OR	OR	OR	OR	Hotel	OR	Dprc	Dprc	Dprc	Excld	Excld	PayTax
Phrm	Phrm	Phrm	Phrm	Phrm	Phrm	Oncsts	Phrm	Phrm	Pros	Phrm	Phrm	Phrm	Phrm	Phrm	Hotel	Phrm	Dprc	Dprc	Dprc	Excld	Excld	PayTax
ED	ED	ED	ED	ED	ED	Oncsts	ED	ED	Pros	ED	ED	ED	ED	ED	Hotel	ED	Dprc	Dprc	Dprc	Excld	Excld	PayTax
SPS	SPS	SPS	SPS	SPS	SPS	Oncsts	SPS	SPS	Pros	SPS	SPS	SPS	SPS	SPS	Hotel	SPS	Dprc	Dprc	Dprc	Excld	Excld	PayTax
Other Serv	Non Clncl	Non Clncl	Non Clncl	Non Clncl	Non Clncl	Oncsts	Non Clncl	Non Clncl	Pros	Non Clncl	Non Clncl	Non Clncl	Non Clncl	Non Clncl	Hotel	Non Clncl	Dprc	Dprc	Dprc	Excld	Excld	PayTax
Hotel Final	Hotel	Hotel	Hotel	Hotel	Hotel	Hotel	Hotel	Hotel	Pros	Hotel	Hotel	Hotel	Hotel	Hotel	Hotel	Hotel	Dprc	Dprc	Dprc	Excld	Excld	PayTax
PayTax	PayTax	PayTax	PayTax	PayTax	PayTax	PayTax	PayTax	PayTax	Pros	PayTax	PayTax	PayTax	PayTax	PayTax	Hotel	PayTax	Dprc	Dprc	Dprc	Excld	Excld	PayTax

Line Items

SW Nurs	Nursing, Salaries and Wages
SW Med	Medical, Salaries and Wages (Non-VMO)
SW AH	Allied Health, Salaries and Wages
SW Other	Other staff types, Salaries and Wages
SW VMO	Medical, Salaries and Wages (VMO)
Oncsts	Labour (staff) oncosts, all staff types
GS	Goods & services - Non medical & surgical sup
MS	Medical and surgical supplies
Pros	Prostheses (surgically implanted)
Path	Pathology
Blood	Blood Products
Imag	Imaging
Phrm NI	Drugs Non PBS
Phrm PI	Drugs PBS (eg high cost and S100)
Hotel	Hotel goods and services
Corp	Corporate costs, outside the hospital GL
Dprc B	Building depreciation
Dprc E	Equipment depreciation
Lease	Lease costs
Cap	Capital works - not in scope
Excld	Excluded costs - not in scope
PayTax	Payroll Tax

Cost centres (group)

Allied	Allied Health Services
Clinical	Clinical Services
Crtcl	Citical Care Areas
Imag	Imaging Department
Path	Pathology Department
OR	Operating Theatres
Phrm	Pharmacy Department
ED	Emergency Department
SPS	Special Procedure Suits
Other	Other Services
Hotel	Hotel Services
PayTax	Payroll Tax

Other Matrix Fields

Ward Nurs	General Ward areas - Nursing
Ward med	General Ward areas - Medical
Ward Spls	General Ward areas - Supplies
Phr	Pharmacy costs
Dprc	Depreciation costs
Non	Non-clinical costs