Ontario Hospital Cost Distribution Methodology
By Patient Activity
ONTARIO COST DISTRIBUTION METHODOLOGY
VERSION: 1997/98 DATA

A Guide to Determine Hospital Specific Acute Inpatient, Newborn & Qualifying Same Day Surgery Cost per Weighted Case under the MIS Reporting Requirements
(Using 1997/98 Year End MIS Trial Balance and Supplementary Year end Reporting Information)

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for the Hospital Funding Committee of the JPPC
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AN ONTARIO MINISTRY OF HEALTH AND ONTARIO HOSPITAL ASSOCIATION PARTNERSHIP
Due to changes in the Ontario Cost Distribution Methodology, this guide has been modified to reflect the methodology applied to the 1997/98 spreadsheets.

All inquiries and questions pertaining to the methodology applied to determine your hospital actual cost per weighted case should be sent to Rob Forbes, Technical Planning Consultant, JPPC Secretariat. Fax: (416) 934-0711, or e-mail: rforbes@jppc.org.

Any concerns pertaining to the DATA used in the calculation should be directed to your Financial Representative in the Institutional Branch of the Ministry of Health.
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INTRODUCTION

The Ontario Cost Distribution Methodology (OCDM) preserves the fundamental principles applied in the Acute Equity Funding Formula, that was developed in the late 1980’s to support the allocation of transitional funding. The OCDM has been refined over the years through the ongoing support of JPPC committees and representatives of the hospital field. The methodology has been tested in hospitals and is widely accepted in the industry. OCDM based information has been used extensively in Ontario. In recent years, the OCDM has provided the basis for several funding announcements, and has been used by the Health Services Restructuring Commission in its analysis and recommendations for funding program transfers and amalgamations.

The primary objective of the methodology is to allocate a hospital’s costs across discrete and comparable patient activity categories or “buckets” at the facility level and at the departmental level. These patient activity categories are:

- Acute Inpatient, Newborn and Same Day Surgery
- Rehabilitation
- Palliative Care
- Chronic and Respite Care
- ELDCAp
- Hospital Outpatients
- Other Hospital or Community Outpatients

The allocation model is dependent on financial and statistical data provided in hospital MIS submissions. Financial details at the departmental level are differentiated into direct and indirect (or overhead) categories of cost. Toward the comparability of the results between facilities, exclusions of “accounting” costs and other one time costs are applied against these financial details. Available statistical details provide the basis for proxies that set up the allocation costs.
across the patient activity categories. MIS guidelines have continued to evolve toward greater financial and statistical specificity, which has allowed continued refinement of the allocation model. This document refers to the MIS Guidelines, Version 3, which applies to the reporting of fiscal 1997/98 and fiscal 1998/99 data. The Ontario Hospital Reporting System (OHRS) User Guide, Version 3 document, provides further standards for MIS reporting in Ontario.

The resulting total costs by patient activity category are used to calculate per diem costs by category for each hospital. Additional statistical information in the form of weighted cases is available for the “Acute, Newborn and Same Day Surgery” category. This information is used to calculate hospital specific Actual Cost per Weighted Case (ACPWC). Regression analysis incorporating several adjustment factors is then applied to the ACPWC to yield the Expected Cost per Weighted Case (ECPWC). (Refer to JPPC Reference Document #RD 7-12, Methodology Used to Calculate 1999/00 Adjustment Factors Funding Model) A comparison of the ACPWC with the ECPWC provides a relative indicator of efficiency on a hospital by hospital basis. It is this comparison of relative efficiency that has supported funding and related planning activities in Ontario.

The purpose of this document is to set out, in detail, the calculations made in the methodology. Specifically, a summary is provided for each of:

- financial exclusions and adjustments applied at the departmental and facility level
- the derivation of allocation proxies from statistical information
- the calculation of ACPWC and per diems by patient activity category

The OCDM changes slightly from year to year. This year’s methodology applies to 1997/98 year-end MIS Trial Balances and supplementary year-end information. Some changes have been made to last year’s methodology to ensure consistency with MIS reporting, and to more appropriately allocate costs. The Hospital Funding Committee of the JPPC put together a small Data Review Team to review the final output in order to ensure reliability and consistency of the funding model.
PART A: ADJUSTMENTS ALLOWED TO FINANCIAL & STATISTICAL ACCOUNTING DATA

Excluding changes which can be made via a complete re-submission of the year-end MIS Trial Balance, the only adjustments allowed to the financial and statistical data are those contained on YE Tables 14 through 17 of the Hospital Year End Supplementary Forms, 1997/1998.

SECTION 1: Financial Adjustments to MIS Data

YE Table 14 identifies one time MoH-approved capital project expenses to be excluded from the calculation of the cost per weighted case, and the functional centres to which they were expensed in the current period.

YE Table 15 identifies recoveries for non-unit producing work performed in Diagnostic and Therapeutic (71 4 **) functional centres for other hospitals or outside agencies, to be netted against expenses used in the calculation of the cost per weighted case. For example, this may include costs associated to providing management or education services to other hospitals as part of a regional laboratory program.

YE Table 17 identifies one time expenses incurred by the facility during the course of restructuring to be excluded from the calculation of the cost per weighted case, that were either expensed in the current period or accrued for subsequent periods. For the purposes of MIS trial balance submissions, a specific functional centre (81970 Restructuring) has been created to isolate the expenses incurred during restructuring. This account is mandatory for 1997/1998 MIS trial balance submissions. Hospitals must provide restructuring expense details in both functional centre 81970 and the YE Table 17, which is a required signed auditors statement. To ensure the accuracy of adjustments made for restructuring, the amounts reported in YE Table 17 and 81970 are reconciled in Section 14.

SECTION 2: Statistical Adjustments to MIS Data

YE Table 16 is to link the appropriate OR number (identified by Health Records for Canadian Institute for Health Information (CIHI) Same Day Surgery Data) to the appropriate MIS functional centre code in the hospital. This table is used to identify the same day surgery costs within the various functional centres (see Section 3).
PART B: DETERMINATION OF NET EXPENSES\textsuperscript{2,3}  
(I.E., ACUTE INPATIENT, NEWBORN AND QUALIFYING SAME DAY SURGERY NET EXPENSE)

This section follows the structure of the 1997/1998 OCDM spreadsheet. The spreadsheet is organized in such a manner as to allow facilities to determine their acute inpatient, newborn and qualifying same day surgery cost per weighted case as well as to perform other types of analyses.

The first page of the spreadsheet provides selected data, and summarizes the major categories within the methodology and provides a facility’s cost per weighted case and per diem costs.

The rest of the spreadsheet is organized into sections that correspond to sections in this guide. Columns 1 & 2 in the spreadsheet identify the number and description of the functional centre. Column 3 identifies the total expenses reported for the listed functional centres. Column 4 provides the distribution of equipment depreciation/amortization that is undistributed to functional centres in the Trial Balance data. Columns 5 and 7 provide detail on external and inter-facility recoveries. Column 6 provides detail on one-time capital expenses reported in YE Table 14. Column 8 summarizes the total allowed offset revenues/recoveries or cost reductions (see Appendix 1 for detail). Column 9 identifies the resulting total net expenses to be distributed by patient activity and is equal to total expenses in Column 3 and Column 4 less the total allowed offset revenues/recoveries or cost reductions in Column 8.

The next seven columns identify the patient activities to which net expenses are allocated based upon the methodology detailed in this guide. The seven patient activities include:

- Acute Inpatient, Newborn and Qualifying Same Day Surgery
- Rehabilitation
- Palliative Care
- Chronic and Respite Care
- ELDCAp
- Hospital Outpatient
- Other Hospital or Community Outpatients.

The total of net expenses allocated by patient activity is provided as a summary line of each section.

The spreadsheet provides information at the MoH designated functional centre level (refer to the Glossary of Terms of the OHRS User Guide), and does not provide detail on the treatment of financial and statistical secondary accounts. Appendix 1 reviews the general approach to allocate expenses and revenues as well as to discuss the treatment of interdepartmental expenses and recoveries.
Appendices A, B, C, and D of the spreadsheet provide supplemental information on the number of weighted cases and selected data by patient grouping (see Section 15).

**SECTION 1: Nursing Inpatient Services (Excluding Inpatient Surgery)**

Total Nursing Inpatient costs is equal to the total net expenses for Inpatient Nursing functional centres 71 2 ***, excluding Operating Rooms and Post Anaesthetic Recovery Rooms 71 2 6* (see Section 3). Net expense is equal to the total expenses less allowable recoveries (see Appendix 1).

Given reliable statistical data, it would be more accurate to allocate Nursing net expense based on workload units than to allocate net expense based on the type of functional centre (acute inpatient, rehabilitation, chronic care, palliative, day surgery, outpatient, ELDCAP). However, since 1997/98 was the first year for mandatory Nursing workload reporting, there were inconsistencies found in the data and the JPPC Hospital Funding Committee recommended that the OCDM continue to allocate Nursing net expense based on the type of functional centre. However, all hospitals are required to continue to report workload. It is expected that hospitals have used this last year to refine and complete the process for the production of valid and reliable workload, and that next year’s OCDM will use workload to distribute Nursing net expense.

**1.1 Acute Inpatient Nursing**

The Acute Inpatient Nursing functional centres include:

- Medical Inpatient Services (71 2 10 **)
- Surgical Inpatient Services (71 2 20 **)
- Combined Medical/Surgical (71 2 30)
- Hospital in the Home (71 2 35)
- Intensive Care (71 2 40 **)
- Obstetrics (71 2 50 **)
- Pediatric (71 2 70)
- Psychiatry (71 2 75 **)
- Nursing Inpatient Services - Temp. Functional Ctr (71 2 99)

Expenses for these functional centres are charged to the Acute Inpatient, Newborn and Qualifying Same Day Surgery patient activity.
1.2 Rehabilitation, Palliative & Long Term Inpatient Nursing

The Rehabilitation, Palliative & Long-Term Inpatient Nursing functional centres include:

- Rehabilitation (71 2 80 **)
- Palliative Care (71 2 90)
- Chronic Care (71 2 95 20)
- Respite Care (71 2 95 40)
- Intermediate Care (ELDCAP) (71 2 95 60)

The net expenses of these functional centres are charged to the appropriate patient activity.

1.3 Small Hospital Reporting

To simplify reporting for small hospitals where the costs for several patient activities are typically captured under a single cost centre, all Nursing Inpatient expenses may be reported in functional centre 71 2 30 Combined Medical/Surgical. If this option is exercised, and patient days are identified in the MIS trial balance submission for more than one patient activity, net expenses are allocated in the ratio of patient days. If expenses are recorded in at least one other Nursing Inpatient functional centre, net expenses are allocated as per 1.1 and 1.2 above.

SECTION 2: Ambulatory Care Services (Excluding Selected Day Surgery)

Total Ambulatory Care cost is equal to the total net expenses for Ambulatory Care functional centres 71 3 **. Net expense is equal to total expenses less allowable recoveries (see Appendix 1).

In order to simplify the formula, the net expense for qualifying same day surgery will not be allocated from Emergency (71 3 10 **) or Clinics (71 3 50 **) to the Acute Inpatient, Newborn, and Qualifying Same Day Surgery patient activity. Accordingly, weighted cases for qualifying same day surgery completed in these areas will not be considered in the methodology. However, it is important to note that these weighted cases are included when determining a hospital’s Day Surgery Incentive Adjustment (see Section 15).
2.1 Emergency

Emergency (71 3 10 **) functional centre net expense is allocated between acute inpatients and outpatients. There are two types of emergency care received by inpatients. The first is where a patient is admitted as an inpatient but is held in emergency while awaiting an available ward bed. In some hospitals, this can represent significant resources and may result in inpatient days collected in emergency. The second type of inpatient activity relates to inpatients receiving minor treatments or off-hours emergency care. This would also result in recording inpatient visits in emergency.

Inpatient Days in Emergency

In many facilities the emergency area is used as a holding area for patients awaiting placement in an inpatient bed which may result in the reporting of patient days in emergency. The cost of the patient days are removed at a rate of $143 per patient day (i.e., (typical ward hours/patient day) * average hourly rate = 5.5 paid hours/day *$26/hour) and allocated to the acute patient activity.

Inpatient Visits to Emergency

Net expense associated with inpatient visits to emergency is also allocated to the acute inpatient grouping. This is accomplished by first removing expenses attributed to inpatient days in emergency from the total emergency expenses. The remaining net expense is then allocated between the acute and outpatient patient activities based on the relative number of inpatient and outpatient visits. If visits are not reported the remaining net expense is allocated 100% to the acute patient activity.

2.2 Poison Information

The net expense of the Poison Information Centre (71 3 20) is assumed to be related to outpatients as the centre serves patients from emergency, as well as families and physicians in the community. The net expense is allocated 100% to the outpatient patient activity.

2.3 Day/Night Care

See Section 3 for the allocation of Surgical/Procedural (OR/PARR Excluded) (71 3 40 20 **), Surgical/Procedural (OR/PARR Included) (71 3 40 25 **) and Endoscopy (71 3 40 55).
The other Day/Night Care functional centres include:

- General Day/Night Care (71 3 40 05)
- Medical (71 3 40 10 **)
- Cardiac (71 3 40 35 **)
- Diabetes (71 3 40 50)
- Geriatric (71 3 40 60 **)
- Metabolic (71 3 40 65)
- Oncology (71 3 40 70)
- Palliative (71 3 40 75)
- Psychiatry (71 3 40 80 **)
- Renal Dialysis (71 3 40 85 **)
- Rehabilitation (71 3 40 90)

The allocation of Day/Night Care net expense takes into account the costs of the acute inpatients and the outpatients treated in the Day/Night Care functional centres. In order to do this, the total net Day/Night Care expense is allocated to the acute and outpatient patient activities based on the relative number of inpatient and outpatient visits. If visits are not reported the total Day/Night Care expense is allocated 100% to the acute patient activity.

2.4 Clinics

The Clinic functional centres include:

- Medical Clinics (71 3 50 10 **)
- Surgical Clinics (71 3 50 15 **)
- Combined Clinics (71 3 50 17 **)
- Cardiac Clinics (71 3 50 20 **)
- Family Practice Clinics (71 3 50 25)
- Geriatric Clinics (71 3 50 30 **)
- Gynecology Clinics (71 3 50 35 **)
- Metabolic Clinics (71 3 50 40 **)
- Endocrinology Clinics (71 3 50 43)
- Neurology Clinics (71 3 50 45 **)
- Obstetrics Clinics (71 3 50 50 **)
- Oncology Clinics (71 3 50 55 **)
- Ophthalmology Clinics (71 3 50 60 **)
- Orthopedic Clinics (71 3 50 65 **)
• Pediatric Clinics (71 3 50 70 **)
• Plastics Clinics (71 3 50 75 **)
• Psychiatry Clinics (71 3 50 80 **)
• Rehabilitation Clinics (71 3 50 85 **)
• Rheumatology Clinics (71 3 50 95 **)

The Clinic net expense takes into account the costs of the acute inpatients and the outpatients treated in the Clinic functional centres. This is handled by allocating the total Clinic functional centre net expense to the acute and outpatient patient activities based on the number of inpatient and outpatient visits. If visits are not reported, then net expenses are allocated 100% to the acute patient activity.

It is assumed that the net expenses of Clinic Administration (71 3 50 05) relate to the Clinic functional centres, and are allocated to the acute and outpatient activities in the ratio of the total Clinic expenses above.

It is assumed that the net expenses of Private Clinics (71 3 55), Home Care (71 3 60 **) and Community Health Services (71 3 70 **) relate to outpatient activity only and therefore, the expenses of these functional centres are allocated 100% to the outpatient activity. The total net expense reported for Ambulatory Care Services - Temporary Functional Centre (71 3 99) is allocated to the patient activity based on the number of inpatient and outpatient visits.

SECTION 3: Inpatient Surgery And Selected Day Surgery Activity & Total Direct Nursing Costs

3.1 Activity in Inpatient O.R and P.A.R.R.

The total net expenses for the Operating Rooms (71 2 6*) and the Day/Night Surgical/Procedural (OR/PARR Excluded) functional centre (71 3 40 20) are totaled on the summary line All Activity in OR/PARRs. The non-qualifying outpatient activity is removed from the acute patient activity category and allocated to the outpatient category. In order to do this the following steps are taken:
1. **Determine Total Cases:** The total number of cases reported in the secondary account 437** are summed for the Operating Rooms (71 2 6*) and the Day/Night Surgical/Procedural (OR/PARR Excluded) functional centre (71 3 40 20).

2. **Determine Total Qualifying Cases:** The number of qualifying same day surgery cases reported in Appendix A of the spreadsheet is totaled. This is added to the total number of inpatient cases to yield total qualifying cases.

3. **Calculate Total Non-Qualifying Cases:**
   \[
   (\text{Total Non-Qualifying Cases}) = (\text{Total Cases}) - (\text{Total Qualifying Cases}).
   \]

4. **Calculate Cost for Non-Qualifying Cases:** The total number of non-qualifying cases allocated to the outpatient patient activity is then equal to $50 \times$ the total number of cases (identified in step 1) less the total number of qualifying cases (identified in step 2). The remaining dollars are allocated to the acute patient activity.

\[
\text{Non-Qualifying Same Day Surgery Costs} = (\text{Total Cases} – \text{Qualifying Cases}) \times 50
\]

5. **Calculate Functional Centre Allocation:** The net expenses are then allocated back up to the functional centres based upon the relative net expense reported in each functional centre.

*Note: The Day/Night Surgical/Procedural (OR/PARR Excluded) functional centre (71 3 40 20) provides pre and post operative care only and utilizes operating room and recovery room facilities that serve inpatients. Therefore, no qualifying same day surgery cases should be reported in this functional centre.*

### 3.2 Selected Outpatient Activity

Day/Night Surgical/Procedural (OR/PARR Included) (71 3 40 25 **) and Endoscopy (71 3 40 55) net expenses are totaled on the summary line ‘OTHER OR/PARR COSTS’. The non-qualifying activity is removed from the ‘OTHER OR/PARR COSTS’ and allocated to the outpatient category. In order to do this the following steps are taken:

1. **Determine Total Cases:** The total number of cases reported in the secondary accounts 416** and 418** are summed for Day/Night Surgical/Procedural (OR/PARR Included) (71 3 40 25 **) and Endoscopy (71 3 40 55).
2. **Determine Total Qualifying Cases:** The number of qualifying same day surgery cases reported in Appendix A of the spreadsheet is totaled.

3. **Calculate Total Non-Qualifying Cases:**

\[
\text{(Total Non-Qualifying Cases)} = (\text{Total Cases}) - (\text{Total Qualifying Cases}).
\]

4. **Calculate Cost for Non-Qualifying Cases:** The total number of non-qualifying cases allocated to the outpatient patient activity is then equal to $50 \times \text{the total number of cases (identified in step 1) less the total number of qualifying same day surgery cases (identified in step 2). The remaining dollars are allocated to the acute patient activity.}

\[
\text{Non-Qualifying Same Day Surgery Costs} = (\text{Total Cases} – \text{Qualifying Cases}) \times $50
\]

5. **Calculate Functional Centre Allocation:** The net expenses are then allocated back up to the functional centres based upon the relative net expense reported in each functional centre.

*Note: The Day/Night Surgical/Procedural (OR/PARR Included) functional centre (71 3 40 25) pertains to units with self-contained operating room(s) and post anaesthetic recovery room(s).*

### 3.3 Total Direct Nursing Costs

Expenses allocated by patient activity for Nursing Inpatient Services (Section 1), Ambulatory Care (Section 2), and Inpatient Surgery and Selected Day Surgery (Section 3) are totaled on the summary line ‘**TOTAL DIRECT NURSING COSTS**’.

**SECTION 4: Nursing Administration & Total Nursing Costs**

4.1 **Inpatient Nursing Administration**

Nursing Administration (71 2 05 **), Program Management (71 2 06), and Medical Resources (71 2 07) functional centre costs are charged to the respective patient activity based on the relative total net expenses for Nursing Inpatient and Inpatient Surgery and
Qualifying Same Day Surgery functional centres.

4.2 Ambulatory Care Nursing Administration

Ambulatory Care Administration (71 3 05), Program Management (71306), and Medical Resources (71 3 07) functional centre costs are charged to the respective patient activity based on the relative total net expenses for Ambulatory Care functional centres.

Expenses allocated by patient activity for Nursing Inpatient Services (Section 1), Ambulatory Care (Section 2), Inpatient Surgery and Selected Day Surgery (Section 3), and Nursing Administration are totaled on the summary line ‘TOTAL NURSING COSTS’.

Note: If a hospital reports only the Nursing Administration Functional Center (71205**), then costs are allocated to all patient activity categories based on the distribution of Direct Nursing Costs. Thus when hospitals report both Nursing Inpatient and Ambulatory Care Administration, items 4.1 and 4.2 above will apply.

SECTION 5: Total Diagnostic And Therapeutic Services

Total Diagnostic and Therapeutic costs are equal to the total Diagnostic and Therapeutic (71 4 **) functional centre net expense by patient activity.

Net expense is equal to total expenses less allowable recoveries and recoveries per YE Table 15 (see Appendix 1). YE Table 15 allows a hospital to identify recoveries for non-unit producing work done in a Diagnostic & Therapeutic functional centre for other hospitals or outside agencies. The line item termed Recovery per Table 2 has been included in each Diagnostic & Therapeutic section and identifies those recoveries for non-unit producing work done in the functional centre for outside facilities. (Table 2 refers to the table created in the Lotus OCDM spreadsheet file, and summarizes the recoveries from YE Table 15)

The methodology allocates the net expense at the minimum reporting level (designated in OHRS as MoH). However, if a hospital is only reporting at Level 3 then the net expenses are allocated at this level for Clinical Laboratory and Diagnostic Imaging.

In general, Diagnostic & Therapeutic functional centre net expense is prorated across the patient activity based on in-house workload units or in-house procedures. If a hospital does not report workload units or procedures in their MIS Trial Balance submission, then the net expense is
prorated 100% to the acute patient activity. For Diagnostic functional centers where referred out expenses have been identified using financial secondary accounts (84 * **), and the reporting of referred out procedures is mandatory, the related portion of net expense is prorated across the patient activity based on referred out procedures. This approach recognizes that in-house and referred out activity may be differentially distributed across patient activities.

To simplify the formula, the net expense for qualifying same day surgery will not be allocated from Diagnostic Imaging (71 4 15 **) to the acute inpatient and same day surgery patient category for cardiac catheters. The workload reported should allocate the net expenses adequately. Accordingly, weighted cases for qualifying same day surgery completed in these areas will not be considered in the methodology. However, it is important that these weighted cases are included when determining a hospital’s Day Surgery Incentive Adjustment (see Section 15).

The following table outlines the use of secondary statistical accounts in identifying Diagnostic and Therapeutic costs.
**USING STATISTICAL INFORMATION TO IDENTIFY COSTS**

The secondary statistical accounts used for allocating Diagnostic and Therapeutic expenses are:

- in-house workload (115** to 150**)
- in-house procedures (458** to 459**)
- referred out procedures (461** to 462**)

All secondary statistical information must be linked to the functional centre incurring the cost of the activity.

The type of statistical account used for cost identification will be dependent on the specific functional centre and the information currently available. Minimum MIS reporting requirements for in-house activity include workload, procedures, and attendance days. Workload is the preferred in-house statistic for distributing in-house costs since it provides a better reflection of resource consumption. Minimum reporting requirements for referred out statistics are limited to procedures.

For distributing in-house expenses, statistical information is used in the following order:

- MIS in-house workload
- MIS in-house procedures or attendance days, if workload not available
- inpatient 100%, if no information is provided by the facility

For distributing referred out expenses, statistical information is used in the following order:

- MIS referred out procedures
- MIS in-house workload or attendance days, if referred out procedures are not available
- MIS in-house procedures, if workload is not available
- inpatient 100%, if no information is provided by the facility
The specific approach to cost distribution is described within each functional centre but the general approach regardless of the statistic used is:

A. In-house Cost per workload unit = \((\text{Total costs} - \text{Approved Recoveries} - \text{Referred Out Expense}) / \text{Total In-house Workload Units}\)

B. In-house Cost per procedure = \((\text{Total Costs} - \text{Approved Recoveries} - \text{Referred Out Expense}) / \text{Total In-house Procedures}\)

C. Referred Out Cost per procedure = \(\text{Referred Out Expense} / \text{Total Referred Out Procedures}\)

D. Referred Out Cost per workload unit = \(\text{Referred Out Expense} / \text{Total In-house Workload Units}\)

\[\text{Acute Cost} = ([A \times \text{Acute In-house Workload}) \text{ or } (B \times \text{Acute In-house Procedures})] + [(C \times \text{Acute Referred-Out Procedures}) \text{ or } (D \times \text{Acute In-house Workload})]\]

### 5.1 Clinical Laboratory

The Clinical Laboratory functional centres include:

- Clinical Laboratory (71 4 10) (used if reporting at Level 3)
- Clinical Lab - Administration (71 4 10 10)
- Clinical Lab - Support Services (71 4 10 15 **)
- Specimen Procurement, Dispatch (71 4 10 20 **)
- Clinical Chemistry (71 4 10 25 **)
- Hematology (71 4 10 30 **)
- Immunohematology (71 4 10 35 **)
- Anatomical Pathology (71 4 10 40 **)
- Microbiology (71 4 10 45 **)
- Immunology (71 4 10 50)
- Cytogenetics (71 4 10 55)
- Tissue Typing (71 4 10 60)
- Stat Laboratory (71 4 10 65)
- Molecular Diagnostics (71 4 10 75)
- Clinical Laboratory - Combined Functions (71 4 10 99)
In-house expenses (net expenses, excluding referred out expenses) of the Clinical Lab functional centres (71 4 10 and 71 4 10 25 ** to 71 4 10 99) are allocated based on the relative number of in-house workload units (115**) by patient activity. If workload units are not available then the allocation is based on the relative number of in-house procedures (458**) by patient activity. If neither in-house workload units nor in-house procedures are available, then the Clinical Lab in-house expense is prorated 100% to the acute patient activity. Referred out expenses of the Clinical Lab functional centres are allocated based on the relative number of referred out procedures (461**). If referred out procedures are not available, then referred out expenses are allocated in the same ratio as the in-house portion of expenses.

The allocation of Clinical Lab – General Administration (71 4 10 10), Clinical Lab - Support Services (71 4 10 15 **), and Specimen Procurement, Dispatch (71 4 10 20 **) functional centres is based on the relative lab expense assigned to each patient activity for the respective Clinical Lab functional centres (71 4 10 and 71 4 10 25 ** to 71 4 10 99).

### 5.2 Diagnostic Imaging

The Diagnostic Imaging functional centres include:

- Diagnostic Imaging (71 4 15) (used if reporting at Level 3)
- Diagnostic Imaging - Administration (71 4 15 10)
- General X-Ray (71 4 15 15 10)
- Mammography (71 4 15 15 20)
- Lithotripsy (71 4 15 15 30)
- Computed Tomography (71 4 15 25)
- Diagnostic Ultrasound (71 4 15 30 **)
- Nuclear Medicine (71 4 15 40)
- Cardiac Catheterization Lab (71 4 15 50)
- Thermography (71 4 15 60)
- Magnetic Resonance Imaging (71 4 15 70)
- Diagnostic Imaging - Combined Functions (71 4 15 99)
- Radiation Oncology (71 4 20)

In-house expenses (net expense excluding referred out expenses) for Diagnostic Imaging functional centres are allocated based on the relative number of in-house workload units (115**; 120**; 125**; 130**) by patient activity. If in-house workload units are not available then the allocation is based on the relative number of in-house procedures.
(458**) by patient activity. If neither in-house workload units nor in-house procedures is available, then the Diagnostic Imaging in-house expense is prorated 100% to acute inpatient. Referred out expenses for Diagnostic Imaging functional centres are allocated based on the relative number of referred out procedures (461**, 462**). If referred out procedures are not available, then referred out expenses are allocated in the same ratio as the in-house portion of expenses.

Exceptions to the above methodology include:
Nuclear Medicine uses statistical secondary 116** for in-house workload units where applicable
Radiation Oncology uses statistical secondary 459** for in-house procedures where applicable

The allocation of Diagnostic Imaging - Administration (71 4 15 10) is based on the relative diagnostic net expense assigned to each patient grouping for the respective Diagnostic Imaging functional centres (71 4 15 ** to 71 4 20).

5.3 Electrodiagnosis, Other Diagnostic Labs & Respiratory Therapy
Electrodiagnosis (71 4 25 **) and Other Diagnostic Labs (71 4 30 **) functional centre in-house expenses (net expense excluding referred out expenses) are allocated based on the relative number of in-house workload units (115**) by functional centre by patient activity. If in-house workload units are not available then the allocation is based on the relative number of in-house procedures (458**) by patient activity. If neither in-house workload units nor in-house procedures is available then the in-house expenses are prorated 100% to acute inpatient. Referred out expenses are allocated based on the relative number of referred out procedures (461**, 462**). If referred out procedures are not available, then referred out expenses are allocated in the same ratio as the in-house portion of expenses.

Respiratory Therapy (71 4 35 **) in-house expenses (net expense excluding referred out expenses) are allocated based on the relative number of in-house workload units (115**). If in-house workload units are not available then the allocation is based on the relative number of in-house procedures (458**, 459**). If neither in-house workload units nor in-house procedures is available, then the in-house expenses are prorated 100% to acute inpatient. Referred out expenses are allocated based on the relative number of referred out procedures (461**, 462**). If referred out procedures are not available, then referred out expenses are allocated in the same ratio as the in-house portion of expenses.
5.4 **Pharmacy**

5.4.1 *Pharmacy Costs (excluding drugs)*

The net expense of the Pharmacy (71 4 40 **) functional centre (excluding drugs) is prorated based on Pharmacy workload units by patient activity. Pharmacy costs are prorated to the patient activities based on the proportion of Pharmacy workload by patient type divided by the total Pharmacy workload.

5.4.2 *Inpatient Pharmacy Drug Expenses*

According to the OHRS User Guide (Version 3) hospitals have the option to distribute drug expenses to each consuming functional centre, or to distribute outpatient drug expenses to the Ambulatory Care functional centres with the balance charged to the Pharmacy functional centre. Therefore, any drug costs left in the Pharmacy functional centre are 100% acute inpatient costs (see Section 1), after netting for material recoveries.

5.4.3 *Chronic/Rehab Drug Per Diem Floor*

In order to allocate drug expenses left in Pharmacy to the appropriate patient activity, the following methodology was used:

A drug cost of $3.18 per chronic and rehab patient day reported by patient activity is used to allocate dollars to the chronic and rehab patient activities. Therefore, if a hospital allocated less than $3.18 per patient day to chronic and rehabilitation, then the difference is removed from the acute inpatient, newborn and qualifying same day surgery category, and reallocated to chronic or rehabilitation, respectively. The $3.18 per diem floor is based on the lowest quartile of drug per diem costs for Free Standing Chronic Care Hospitals, calculated from 1997/98 data.

5.5 **Clinical Nutrition**

The Clinical Nutrition (71 4 45) functional centre net expense is allocated based on the relative number of workload units (116**) by patient activity. If workload units are not available then the allocation is based on the relative number of attendance days (483**) by patient activity. If statistical information is not provided then the net expense will be allocated 100% to acute inpatients.
5.6 Physiotherapy, Occupational Therapy, and Audiology & Speech Language Pathology

Physiotherapy (71 4 50) and Occupational Therapy (71 4 55 **) functional centre net expense is allocated based on the relative number of weighted workload units (direct 145** and indirect 150** patient care), or the relative number of workload units (116**) by patient activity. If workload units are not available then the allocation of net expense is based on the relative number of attendance days (483**) by patient activity. If statistical information is not provided then the net expense will be allocated 100% to acute inpatients.

Audiology & Speech/Language Pathology (71 4 60 **) functional centre net expense is allocated based on the relative number of workload units (116**) by patient activity. If workload units are not available then the allocation is based on the relative number of attendance days (483**) by patient activity. If statistical information is not provided then the net expense will be allocated 100% to acute inpatients.

The allocation of Rehabilitation Services - Administration (71 4 49) is based on the relative net expense assigned to each patient grouping for the respective Physiotherapy (71 4 50), Occupational Therapy (71 4 55 **), and Audiology & Speech/Language Pathology (71 4 60 **) functional centres.

5.7 Rehabilitation Engineering, Social Work, Psychology, Recreation & Child Life

Rehabilitation Engineering (71 4 65 **), Social Work (71 4 70 **), Psychology (71 4 75 **), Recreation (71 4 85) and Child Life (71 4 90) functional centre net expense is allocated based on the relative number of workload units (116**) by patient activity. If workload units are not available then the allocation is based on the relative number of attendance days (483**) by patient activity. If statistical information is not provided then the net expense will be allocated 100% to acute inpatients.

5.8 Pastoral Care

In OHRS Version 3, the Pastoral Care functional centre was moved from an administration and support services functional centre to a direct patient care functional
As a result, hospitals were not required to report Pastoral Care workload for 1997/98. Pastoral Care (71 4 80) net expense is allocated based on the relative number of patient days by patient activity. If statistical information is not provided then the net expense will be allocated 100% to acute inpatients.

5.9 Diagnostic & Therapeutic Services - Temporary Functional Centres

Diagnostic & Therapeutic Services - Temporary functional centres (71 4 95; 71 4 96) net expense is allocated based on the relative number of workload units (116**) by patient activity. If workload units are not available then the allocation is based on the relative number of attendance days (483**) by patient activity. If statistical information is not provided then the net expense will be allocated 100% to acute inpatients.

SECTION 6: Food Services & Total Direct Costs

Total Direct Costs is equal to the total net expense for Nursing Inpatient, Ambulatory Care, Operating Rooms, Diagnostic and Therapeutic Services, and Food Services (see Sections 1-6).

6.1 Food Services

The cost of Patient Food Services (71 1 95 **) and Non-Patient Food Services (71 9 10 **) are combined and reduced by the respective recovery accounts (120**; 121**). The two functional centres are combined as most hospitals have a significant number of interdepartmental charges and recoveries between the functional centres. Therefore, the real cost is not available for each centre individually. The net expense is then prorated to the patient activity groups (acute, chronic, rehab, outpatient) using the ratio of patient meals days. Where meal days have not been recorded for patient activities and patient days were recorded, expenses are distributed to inpatient activities (acute, chronic, and rehab) in the ratio of patient days.
6.2 Total Direct Costs

Expenses allocated by patient activity for Total Nursing Costs (Sections 1 to 4), Diagnostic & Therapeutic Services (Section 5), and Food Services (Section 6) are totaled on the summary line ‘TOTAL DIRECT COSTS’.

SECTION 7: Total Education

Net expenses of the Education (71 8 **) functional centre are allocated based on the ratio of total direct (absorbing) cost by patient activity. Net expense is equal to total costs less all allowable recoveries (see Appendix 1). It is important to note that the net expense is limited to a minimum value of zero.

SECTION 8: Total Administration And Support Services

Total Administration and Support Services functional centres include:

- General Administration (71 1 10 **)
- Finance (71 1 15 **)
- Human Resources (71 1 20 **)
- Systems Support (71 1 25 **)
- Communications (71 1 30 **)
- Materiels Management (71 1 35 **)
- Volunteer Services (71 1 40)
- Housekeeping (71 1 45)
- Laundry and Linen (71 1 50 **)
- Plant Administration (71 1 53)
- Plant Operation (71 1 55 **)
- Plant Security (71 1 60 **)
- Plant Maintenance (71 1 65 **)
- Bio-Medical Engineering/Medical Physics (71 1 75 **)
- Registration (71 1 80 **)
- Patient Transport (71 1 85 **)
• Health Records (71 1 90 **)
• Administration & Support Services - Temporary Functional Centre (71 1 98)

The net expense for each functional centre is allocated to the patient activity based on the relative total direct (absorbing) cost by patient activity. Net expense is equal to total costs less all allowable recoveries (see Appendix 1). It is important to note that the net expense is limited to a minimum value of zero.

SECTION 9: Research

Net expenses of the Research (71 7 **) functional centre are allocated based on the ratio of total direct (absorbing) cost by patient activity. Net expense is equal to total costs less all allowable recoveries (see Appendix 1). It is important to note that the net expense is limited to a minimum value of zero.

SECTION 10: Undistributed Functional Centres

Non-Patient Food Services (71 9 10 *) are combined with Patient Food Services (71 1 95 **) and reduced by the recovery accounts (120**; 121**). The net expense is then prorated to the patient activity and included in the total direct costs (see Section 6).

With the exception of Non-Patient Food Services, the methodology considers the following Undistributed Functional Centres:

• Marketed Services (71 9 20 **)
• Emergency Physician Remuneration (71 9 30)
• Fund Raising (71 9 40)

Net expenses of Total Undistributed Functional Centres are allocated based on the ratio of total direct (absorbing) cost by patient activity. Net expense is equal to total costs less all allowable recoveries (see Appendix 1). It is important to note that the net expense is limited to a minimum value of zero.
**SECTION 11: Selected Expenses/Revenues Distributed To Functional Centre Types**

As of April 1, 1997 all hospitals are required to distribute depreciation/amortization expense, and as much of the expenses as possible to the functional centre incurring the costs. Due to hospitals reporting some operating expenses in an Undistributed Expense Accounting Centre, the following methodology was used to ensure that a consistent methodology is applied across all hospitals for these specific expense accounts.

### 11.1 Short Term Interest Charges

If a facility has distributed and reported Short Term Interest Charges (63030) expenses in functional centres (with the exception of the Research and Marketed Services functional centres), these costs will be collected and allocated based on the ratio of total direct (absorbing) cost by patient activity. The accounts will be collected from 711* + 712* + 713* + 714* + 716* + 718* + 71910* + 819* functional centres.

### 11.2 Depreciation/Amortization

Hospitals are encouraged to distribute major equipment depreciation/amortization to the functional centres incurring the costs using Amortization on Major Equipment - Distributed (75000). To enhance comparability of hospitals at the direct cost level, any undistributed equipment amortization expense (95080) in the 81 9 50 Accounting Centre is allocated to each direct functional centre in the ratio of total direct expenses (summarized in Column 2 of the spreadsheet). These expenses are then allocated to patient activities along with all other expenses at the direct functional centre level per their current allocation proxies.

### 11.3 Rental/Lease of Equipment and Amortization of Software License and Fees

Expenses for Rental/Lease of Equipment (76000) and Amortization-Software License and Fees (78000) in the 81 9 90 Accounting Centre are allocated based on the ratio of total direct (absorbing) cost by patient activity.
SECTION 12: Undistributed Accounting Centres

The following accounting centres are **not** included in the methodology:

- Operating Grants from Ministry (81 9 11)
- Inpatient Revenues (81 9 15 **)
- Outpatient Revenues (81 9 20 **)
- Ambulance Revenues (Receiving Hospital) (81 9 23)
- Provision for Doubtful IP Accounts (81 9 25 **)
- Provision for Doubtful OP Accounts (81 9 30)
- Provision for Doubtful Ambulance Accts. (81 9 35)
- Provision Other Doubtful Accounts (81 9 40)
- Other Undistributed Revenues - Operating (81 9 45)
- Amortization Undistributed Land Improvements (81 9 50 20)
- Amortization Undistributed Buildings (81 9 50 40)
- Amortization Undistributed Building Service Equipment (81 9 50 60)

The Provision for Doubtful IP Accounts accounting centres (81925 **, 81930, 81935, 81940) are not allocated as they are contra revenue. An offset revenue equal to the Provision for Doubtful Accounts is created to balance the distributed amount to zero.

The following accounting centres are included in the methodology:

- Amortization Undistributed Major Equipment (81 9 50 80) (distributed with other amortization in Section 11)
- Interest on Long Term Liabilities - Undistributed (81 9 55) (distributed with Short Term Interest Charges in Section 11)
- Municipal Taxes (81 9 60)
- Other Undistributed Expenses - Operating (81 9 90)
- Employee Benefits Debit Clearing Account (81 9 95)
- Employee Benefits Credit Clearing Account (81 9 96)

Net expenses are allocated based on the ratio of total direct (absorbing) cost by patient activity. Net expense is equal to total costs less all allowable recoveries (see Appendix 1).
SECTION 13:  Net Deficit On Capital Fund, Total Overhead Costs, And Total Cost

13.1 Net Deficit on Capital Fund

The allocation of the net deficit on the capital fund (the excess, if any, of Other Undistributed Expenses – Capital (85 9 90) over Other Undistributed Revenues-Capital (85 9 45)) is based on the ratio of total direct (absorbing) cost by patient activity. The net deficit is included in the formula in order to determine if a facility is funding capital projects with operating funds.

13.2 Total Overhead Costs

Expenses allocated based on the ratio of total direct (absorbing) cost by patient activity for Education (Section 7), Administration and Support Services (Section 8), Research (Section 9), Undistributed Functional Centres (Section 10), Selected Expense (Section 11), Undistributed Accounting Centres (Section 12), and Net Deficit on Capital Fund (Section 13) are totaled on the summary line ‘TOTAL OVERHEAD COSTS’.

13.3 Total Cost

TOTAL DIRECT COSTS (the sum of Sections 1 - 6) and Total Overhead Costs (the sum of Sections 7 to 13) are totaled on the line ‘TOTAL COSTS (DIRECT & OVERHEAD)’.

SECTION 14:  Adjustments, Net Total Costs, Net Direct Costs, Net Overhead Costs

14.1 Adjustments

Several financial adjustments are caps are applied “below the line” and allocated between direct and overhead costs prior to cost per weighted case calculations.
14.1.1 Net Deficits on Fund Types 2 and 3

The allocation of net deficits on fund type 2 (Other Votes) and fund type 3 (Other Sources of Funding) is based on the ratio of total cost by patient activity. The net deficit is the calculated excess, if any, of expenses (72 * **, 73 * **) over revenues (82 * **, 83 * **) within the respective fund types. The net deficit is included in the formula in order to determine if a facility is funding Clinical Education or Research with operating funds.

14.1.2 Restructuring Reconciliation and Restructuring Caps

Where restructuring expenses are reported in both YE Table 17 and functional centre 81 9 70, and these amounts do not reconcile, allowable restructuring expenses are limited to the total reported in YE Table 17. The difference, if any, is allocated based on the ratio of total cost by patient activity.

In 1996/97, allowable restructuring expenses were limited to 4% of total gross costs to ensure that consistent methodology was applied across all hospitals. For 1997/98 hospitals were asked to reconcile any variances between the amounts reported in YE Table 17 and functional centre 81 9 70 to reduce inconsistencies in reporting, and a cap was not applied.

14.1.3 Cash Discounts

Under the MIS Guidelines, Cash Discounts (12090; 12190) may be reported in Finance (71 1 15 **) or they may be distributed to any functional centre based on the use of the supplies related to the discount. If cash discounts are incurred at the time of purchase then a hospital’s inventory costs should be reduced.

Given the small dollar value of cash discounts and to simplify reconciliation of expenses, cash discounts (not given at the time of purchase) will be collected and prorated based on TOTAL DIRECT COSTS by patient activity. Cash discounts reported in Marketed Services (71 9 20 **) and Research (717 **) are left in the respective functional centres and are not collected.

14.1.4 Net Gain or Loss on Disposal

For MIS Milestone 1, Net Gain or Loss on Disposal was to be reported in an undistributed Accounting Centre (81951) using the secondary account 95100. However, if a hospital has distributed these costs to the affected functional centres (with the exception of Research [717*] and Marketed Service [71920*]) using the secondary financial account 75100, these costs are collected and prorated by patient activity based on the TOTAL DIRECT COSTS. That is, the gain or loss
on disposal expenses are collected from the following Functional and Accounting Centres: 711* + 712* + 713* + 714* + 716* + 718* + 71910* + 819*. This will ensure that a consistent methodology is applied across all hospitals.

14.1.5 Palliative Care

Weighted cases for palliative care are reported along with acute patient activity to CIHI. To ensure appropriate matching of expenses and activity, any expenses allocated to the palliative care patient activity are adjusted 100% back to the acute patient activity.

14.1.6 Rehabilitation and Chronic Direct Per Diem Caps

Direct per diem caps, calculated at the 90th percentile for all hospitals with rehabilitation and chronic inpatient activity, are applied to Rehabilitation ($340.31) and Chronic Care ($276.45) to limit the shifting of acute costs to these patient activities. Any excess over the caps, along with a proportionate allocation for overhead, is adjusted back to the acute patient activity.

14.2 Ice Storm Funding

An adjustment was applied to hospitals that received a grant from the ministry for extraordinary expenses incurred due to the 1998 ice storm. The amount of the grant was netted from total expenses, allocated based on the ratio of total cost by patient activity.

14.3 Net Total Costs

The net of Total Costs calculated in section 13 and adjustments in section 14 is totaled on summary line ‘NET TOTAL COSTS’.
14.4 Net Direct Costs

The net of TOTAL DIRECT COSTS calculated in section 6 and a proportionate share of adjustments in section 14 (based on TOTAL DIRECT COSTS as a percentage of Total Costs) are totaled on summary line ‘NET DIRECT COSTS’.

14.5 Net Overhead Costs

The net of Total Overhead Costs calculated in section 13 and a proportionate share of adjustments in section 14 (based on Total Overhead Costs as a percentage of Total Costs) are totaled on summary line ‘NET OVERHEAD COSTS’.
SECTION 15: Methodology To Calculate Actual Acute Inpatient, Newborn & Qualifying Same Day Surgery Cost Per Weighted Case

(This section is not included in the spreadsheet itself, but the corresponding information is presented in Appendices A, B, C, and D of the spreadsheet).

A hospital’s actual (inpatient & same day surgery) cost per weighted case is calculated using the following formula:

Total Acute Inpatient, Newborn & Qualifying Same Day Surgery Expense

\[
= \text{Inpatient Wtd. Cases} + \text{Day Surgery Wtd. Cases} + \text{Multi Yr. Adjustment} + \text{Census Adjustment}^* + \text{DS Incentive}
\]

* NOTE: The census adjustment was removed from the formula for 1996/97 and 1997/98. See section 15.4.

15.1 Total Acute Inpatient, Newborn & Same Day Surgery Expense

Total Acute, Newborn and Same Day Surgery Expense is equal to the net expense of acute inpatient, newborn and qualifying same day surgery patients, from Section 14.

15.2 Number of Weighted Cases (Inpatient and Same Day Surgery)

Appendix A & B of the spreadsheet provide a breakdown of the number of weighted cases calculated. The total Inpatient and Same Day Surgery Weighted cases is determined by taking the number of cases by CMG™ multiplied by the Ontario Case Weight (OCW). The OCW for each CMG can be calculated using the following formula:

\[
\text{OCW} = \text{TYP} + ((\text{LOS-TRIM})*\text{PD}) + ((\text{TRIM-ALOS})*\text{PD}*0.2)
\]

Where: TYP = weight of Typical case in same CMG
       LOS = actual length of stay of case
       TRIM = CMG-specific LOS trim point
       ALOS = average length of stay of Typical cases in same CMG
       PD = ‘CMG specific’ per diem rate for long stay cases.

The overall effect of the OCW is that it discounts the inlier portion of the outlier case by 80%.
15.3 Multi-Year Adjustment

Appendix B of the spreadsheet provides detail on the hospital-specific Multi-Year Adjustment. The Multi-Year Adjustment is applied to each hospital’s total weighted cases to eliminate the effects of cases with length of stay (LOS) greater than 365 days. All cases with a LOS greater than 365 days are identified. The total number of days beyond this 365-day cap and the number of weighted cases associated with these days are determined. A Routine and Ancillary Weight per Day (specific to the CMG the case was classified in) is then multiplied to the respective weighted case and this is summed for all cases with a LOS greater than 365 days. This total is then subtracted from each hospital's total weighted cases.

15.4 Census Day Adjustment

A Data Review Sub-Group of the JPPC Hospital Funding Committee recommended the elimination of this adjustment for 1996/1997 cost per weighted case calculations due to inconsistencies in the reporting of Daily Census Days that resulted in wide variations in Census Day Adjustments. This adjustment was not applied to the 1997/98 cost per weighted case calculations. Ongoing analysis will be conducted to determine whether this adjustment is to be eliminated for subsequent years’ calculations. The methodology is described below to highlight the relationship between resource consumption and the number of weighted cases for a fiscal year.

The hospital-specific Census Day Adjustment would be made to the Canadian Institute for Health Information (CIHI) reported weighted cases to improve the strength of the relationship between acute, newborn and same day surgery cost and weighted cases. Hospital costs are based on a fiscal year while weighted cases are credited only upon discharge of the patients. Some of the resource consumption during the fiscal year was for patients that have not yet been discharged and are not credited in the weighted cases. Similarly, in the case of the multi-year patients, some of the weight associated with weighted cases is for previous fiscal year's expenses. The Census Day Adjustment adjusts the CIHI weighted cases to estimate the total weight relating to resource consumption during the fiscal year. The adjustment is applied as follows:

(Daily Census Days - CIHI Discharge Days) * (The Routine & Ancillary Weight/Day)
The Routine and Ancillary Weight/Day is estimated at 0.145. The Census Day Adjustment would be the number of equivalent cases to be added or subtracted from the total weighted cases in a fiscal year.

### 15.5 Day Surgery Incentive

Appendix B of the spreadsheet calculates the Day Surgery Incentive value specific to every hospital. A Day Surgery Incentive was implemented to remove the disincentives in the formula respecting ambulatory care and same day surgery and to encourage hospitals to allocate resources to use these delivery systems. The methodology is based on the percentage of cases by procedure that a hospital completes on an outpatient care basis relative to the provincial average. The model provides a financial incentive for hospitals to perform more procedures as day surgery where appropriate.

In order to determine which procedures the Incentive should be applied to, an exclusion list was created. The following exclusions were applied to the 1993/94 statistical outpatient database for Ontario hospitals:

1. Cases not assigned to patient sub-service 01 (i.e. non-qualifying same day surgery cases). Note: Cases that are re-assigned to sub-service 09 are excluded.

2. Cases where the principal procedure suffix was:
   - 0 - procedure performed out of hospital,
   - 8 - canceled surgery, or
   - 9 - previous surgery prior to admission.

3. Cases where the principal procedure code was blank or invalid.

4. Cases not assigned to a Day Procedure Group (DPG™).

5. Stillborns.

6. Cases assigned to patient service 51- obstetrics delivered and patient service 54 - newborn. Dilation and Curettage (D&Cs) following delivery or abortion (ICD-9 81.01) are not excluded.

7. Cases assigned to the following DPGs:
   - DPG 02 Spinal Procedures
   - DPG 03 Nerve Injections
• DPG 20 Angiography
• DPG 59 Skin Procedures (no complications/comorbid conditions)
• DPG 62 Haemodialysis
• DPG 63 Cardioversion
• DPG 65 Chemotherapy
• DPG 66 Myelogram
• DPG 99 Ungroupable.

8. Minor endoscopic procedures (ICD-9 codes):
• Rhinoscopy
• 01.23 Sigmoidoscopy
• 01.24 Proctosigmoidoscopy
• 01.25 Anoscopy
• 01.32 Otoscopy
• 82.81 Culdoscopy/Colposcopy.

9. Cardiac Catheterizations (i.e., ICD-9 codes: 49.95 right, 49.96 left, and 49.97 combined right and left catheterizations).

10. Outpatient surgery cases where the procedure was performed and the patient returned to the referring hospital on the same day.

Note: Day Surgery Definition: the timeframe for reporting same day surgery/procedures is the same calendar day or, if over midnight is less than 12 hours.

The expected inpatient provincial percentage of ICD-9 procedures was then determined for the inpatient and outpatient data sets. The following calculation was then made to determine the weighted case adjustment for every ICD-9 procedure:

\[
\text{Hospital Expected Inpatient Cases} = (\text{Hospital Inpt + Outpt Cases}) \times (\text{Ontario \% Inpt Cases})
\]

\[
\text{Wtd. Case Adjustment} = (\text{Hospital Actual Inpt Cases} - \text{Expected Inpt Cases}) \times (\text{Avg. Inpt RIW}^{TM} - \text{Avg. Outpt RIW}^{TM})
\]

The Weighted Case Adjustment is then summed for all ICD-9 procedures and the Day Surgery Incentive is then applied to the hospitals total weighted cases. Further detail on the Day Surgery Incentive Model is provided in the JPPC Reference Document #3-1: Day Surgery Incentive Model.
SECTION 16: Calculation of Cost per Weighted Case and Cost per Patient Day

16.1 Cost per Weighted Case

The total acute cost per weighted case (direct + overhead expenses) is calculated by:

Dividing the Net Total Costs for Acute, Newborn and Qualifying Same Day Surgery (identified in Section 14) by the number of acute weighted cases (from Appendix B).

16.2 Cost per Patient Day

The total cost per patient day (direct + overhead expenses) for each inpatient activity, Acute, Rehabilitation, Chronic and ELDCAP, is calculated by:

Dividing the Net Total Costs for each inpatient activity (identified in Section 14) by the corresponding number of patient days reported for the respective patient activity.
REFERENCES


GLOSSARY OF TERMS

Direct (Absorbing) Costs
Direct (Absorbing) Costs are those costs that are attributed to providing direct patient care. Direct costs include all the expenses for salaries, supplies, equipment amortization and other outlays seen in the budget of the functional centre (Nursing Inpatient Services, Ambulatory Care Service, Diagnostic and Therapeutic Services, Food Services).

Expenses
Expenses reflect the cash and non-cash cost of operations or the consumption of resources within the current reporting period. These include labour, supplies, services, use of equipment, use of capital assets. While amortization is part of these costs it is treated separately (refer back to section 11).

Joint Policy and Planning Committee (JPPC)

Management Information in Canadian Health Care Facilities (MIS Guidelines)
The MIS Guidelines provide a national standard for hospital data collection, processing and reporting. The MIS Guidelines are produced and maintained by the Canadian Institute for Health Information (CIHI).

Ministry of Health (MoH)

Ontario Cost Distribution Methodology (OCDM)

Ontario Hospital Association (OHA)

Ontario Hospital Reporting System User Guide, Version 3 (OHRS)
The Ontario Hospital Reporting System represents one component of the province-wide implementation of the MIS Guidelines - Departmental Dimension. The OHRS defines the level of reporting required by the MoH, provides a standardized chart of financial and statistical accounts, is based upon general accepted accounting practices and account definitions; provides a single stream of reporting, and supports comparisons across hospitals.
Patient Activity
Patient activity defines the type of care provided in the specific functional centre. Net expenses are allocated to the seven patient types based upon the methodology detailed in this user guide. The seven patient activities include:

- Acute Inpatient & Newborn and Qualifying Same Day Surgery
- Rehabilitation
- Palliative Care
- Chronic and Respite Care
- ELDCAP
- Hospital Outpatient
- Other Hospital or Community Outpatients.

Recoveries
Recoveries are received for the sale of non-patient services, materiel, staff perquisites and rentals. They may be from external sources, facilities within the legal entity or other hospital accounts. Recoveries occur when financial sources that were intended to fund patient activity are temporarily used for another purpose and then repaid.

Revenues
Revenues reflect the total income used to fund the operations of the facility. They include global funding, other votes and other sources, grants, and donations.
APPENDIX I: TREATMENT OF FINANCIAL SECONDARY ACCOUNTS

1.0 General Approach to All Functional Centre & Accounting Centre Expenses

The Ontario Cost Distribution Methodology incorporates the net expenses for each of the following secondary accounts:

- Compensation (310**, 350**, 390**)
- Supplies (4****)
- Patient Specific Supplies (55070; 560**, 565**, 566**)
- Sundry (6****, not including 69700 and 63030)
- Equipment Expense (710**, 720**, 765**)
- Referred Out Expense (8*)
- Buildings and Grounds Expense - Undistributed (910***; 94000; 97000).

* Note: Distribute expenses to the appropriate accounting centres.

Each of these expenses is to be charged to the functional centre where the costs are incurred.

Please refer to Section 11 for treatment of the following Selected Secondary Accounts:
- Short Term Interest Charges (63030)
- Amortization on Major Equipment - Distributed (75000)
- Amortization on Major Equipment - Undistributed (95080)
- Rental/Lease of Equipment (76000)
- Amortization - Software License and Fees (78000)

Please refer to Section 14 for treatment of the following Selected Secondary Account:
- Gain or Loss on Disposal (75100 or 95100)

The following expenses are not included in the formula:

- Interdepartmental Services (69700)
- Interest on Major Equipment Loans (75500)
- Amortization - Land Improvements (95020)
- Amortization - Buildings (95040)
- Amortization - Building Service Equipment (95060)
- Interest on Long Term Liabilities (95500).
2.0 **General Approach to All Functional Centre Revenues**

MoH Institution Branch funding for acute and same day surgery activities is based on comparative actual costs per weighted inpatient/same day surgery cases.

Revenues are financial sources that are intended to fund patient activity and therefore do not reduce costs.

This would include:
- Funding
- Donations
- Grants
- Other Revenue.

Recoveries occur when financial sources that were intended to fund patient activity are temporarily used for another purpose and then repaid. These recoveries offset patient activity expenses in order to accurately reflect the cost of providing the patient service.

All Recoveries - From External Sources (120**) and Recoveries Within Legal Entity (121**) (with the exception of Cash Discounts - 12090; 12190) are allowed in Nursing Inpatient Services, Ambulatory Care Services, Operating Rooms, Nursing Administration, Patient Food Services, Non-Patient Food Services, Administration and Support (71 1 **) and Education (71 8 **). These recoveries offset the total expenses reported in the 71 2 **, 71 3 **, 71 1 95 **, 71 9 10 **, 71 1 **, and 71 8 ** functional centres. In addition, OHIP Revenue (11015) is allowed in the Nursing Inpatient Services (71 2 **) to account for those hospitals that pay out a flat fee to physicians.

Materiel recoveries (12024; 12124) and recoveries identified in YE Table 15 (Table 2 in the Lotus spreadsheet) are allowed for Diagnostic and Therapeutic Services. These recoveries offset the total expenses reported in the 71 4 ** functional centres.

All Recoveries - From External Sources (120**) and Recoveries Within Legal Entity (121**) (with the exception of Cash Discounts - 12090; 12190) and revenues (14***, 15***, 16***, 17***, 19***) are allowed in Research (71 7 **), Marketed Services (71 9 20), Emergency Physician Remuneration (71 9 30) and Capital Funds (85 9 45). It is important to note that the net expense is limited to a
minimum value of zero prior to the net expense being allocated to the patient activity.

Note: Interdepartmental Recoveries (122**) are not included in the methodology (see point 3.0 below).

Note: OHIP recoveries should be treated as a recovery for absorbing functional centres.

3.0 Treatment of Interdepartmental Expenses & Recoveries

Interdepartmental Expenses (69700) and Recoveries (122**) are excluded because they would overstate the actual expenses incurred by the facility. It is assumed that Interdepartmental Expenses equal Interdepartmental Recoveries therefore the net effect is zero.

Omitting Interdepartmental Expenses and Recoveries results in a more consistent distribution of overhead expenses. If the expenses and recoveries were left in the formula then a hospital could theoretically reduce their acute, inpatient and same day surgery costs by charging a significant proportion of their overhead costs to the ambulatory care functional centres.