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THE UNIFORM CHART OF ACCOUNTS: A DESCRIPTION WITH
COMMENTS ON POTENTIAL USE WITH CASE MIX DATA(U) NAVAL
SCHOOL OF HEALTH SCIENCES BETHESDA MD R J HALL ET AL.
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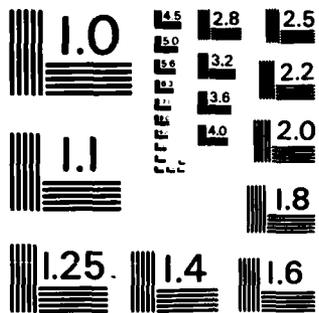
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THE UNIFORM CHART OF ACCOUNTS: A DESCRIPTION WITH COMMENTS ON POTENTIAL USE WITH CASE MIX DATA

AD-A148 518

Rosalie J. Hall
Terrence L. Kay

Research Paper 4-84
October 1984

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Bethesda, Maryland 20814-5033

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THE UNIFORM CHART OF ACCOUNTS:

A Description With Comments on Potential Use With Case Mix Data

Background and Perspective

The Research Department at the Naval School of Health Sciences, Bethesda, Maryland, has been conducting patient case mix related research for the past three years. During this time, the utility of Diagnosis Related Groups (DRGs) to monitor average length of patient stay and convalescent leave for active duty patients has been demonstrated (1,2,3,4). Current case-mix related efforts are being directed towards the development of hospital reimbursement methods that account for differences in the types of patients being treated. One option for military hospitals would be to adopt the DRG-based cost figures already in use by the Department of Health and Human Services for reimbursement of Medicare cases(5). An alternative solution would be to develop a set of military specific DRG cost figures that would take into account special characteristics of treatment in a military setting. This could be accomplished by interweaving the current cost accounting system used by the Navy Medical Command (the Uniform Chart of Accounts) with a resource allocation process based upon patient case mix to create a measure of average cost per patient within the DRG groupings.

To explore the possibilities of combining DRG information and UCA data to derive cost of treating patients in military hospitals, it is first necessary to have a general knowledge of UCA. An introduction to the key terms and concepts of the UCA is provided in this report. In addition, comments specific to issues involved in combining the UCA data with other sources of information about patients in military hospitals have been addressed.

Introduction to the UCA System

The Uniform Chart of Accounts (UCA) is a cost accounting system unique to military fixed medical treatment facilities. It had its inception when the Departments of Defense (DOD), Health, Education, and Welfare (DHEW), and Office of Management and Budget (OMB) conducted a joint study of the military health care system (1973-1975). The group's recommendations were published as a report in late 1975 (6). In response to some of the issues raised in the study, a decision was made by DOD to create an accounting system which would provide a common data base of military medical cost information. The result was the UCA, which was tested in 1978 and 1979, and implemented in the three services starting in FY 80.

According to the UCA manual published by DOD (7), the objectives of the system are to provide:

- 1) a single tri-service chart of accounts;
- 2) common definitions for workload, cost elements, and work centers;
- 3) a basis for management reports;
- 4) a means of measuring performance for:
 - (a) internal comparisons (within hospitals),
 - (b) inter-service comparisons,
 - (c) intra-service comparisons, and
 - (d) civilian sector comparisons;
- 5) a mechanism to measure efficiency and cost effectiveness; and
- 6) a common mechanism for the assignment of overhead and ancillary service expenses.

A particularly attractive feature of the UCA is that it has been designed to meet cost accounting needs for individual facilities while still providing expense and workload data that may be both compared and aggregated with information from other facilities. This is possible because of shared standardized procedures and definitions.

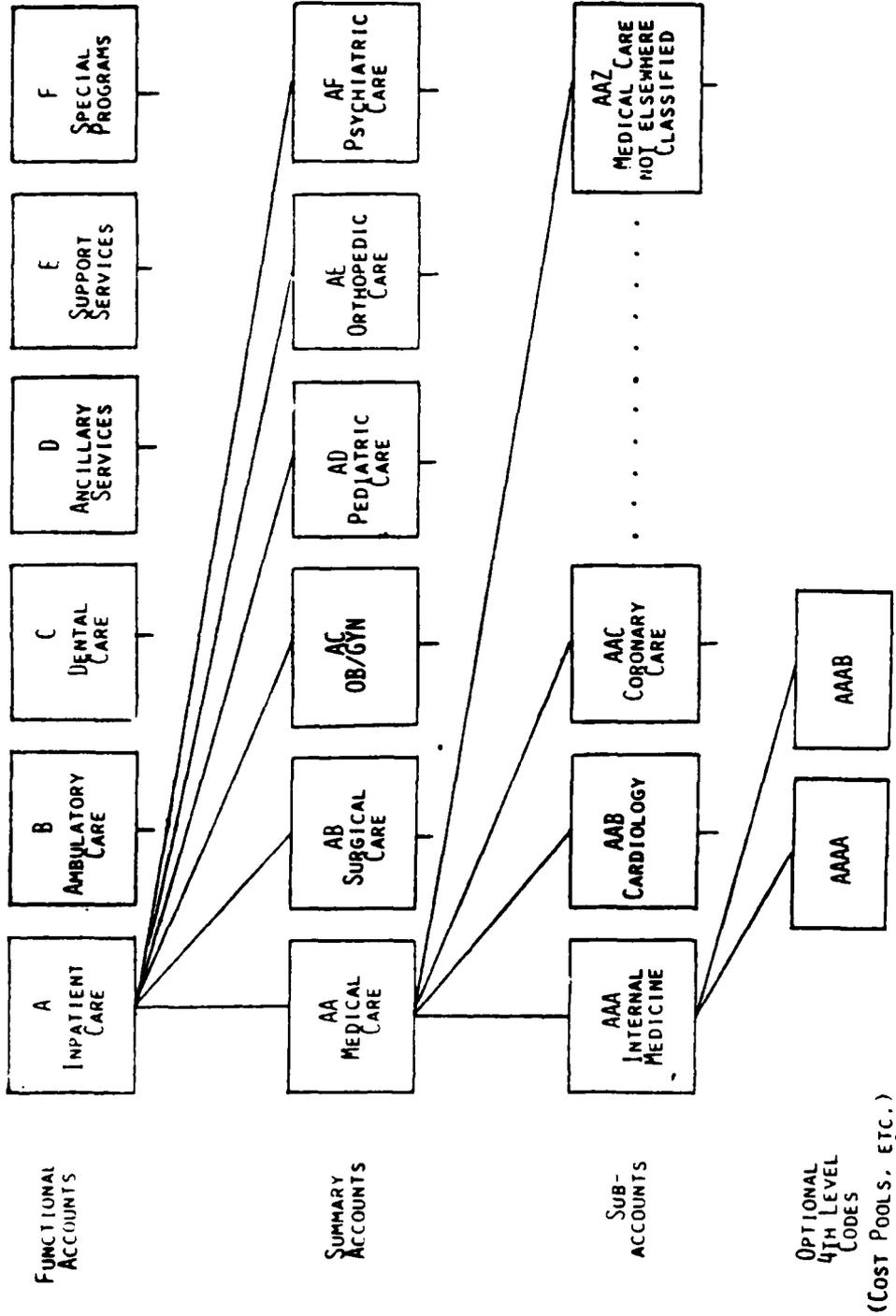
Structure of UCA Account Codes

The account codes to which expenses are allocated go to a depth of four levels, ranging from very general to very specific (See Figure 1). The highest level account is called a functional account. There are six major functional accounts: two accounts designated as intermediate functional accounts -- Ancillary Services and Direct Services, and four final functional accounts -- Inpatient Care, Ambulatory Care, Dental Care, and Special Programs. Expense and performance information is initially accumulated into all six functional accounts. However, costs accumulated initially into the two intermediate functional accounts represent indirect costs which must later be reallocated to the four final functional categories. Each of these functional accounts is coded with a single alphabetic character as follows: A - Inpatient Care, B - Ambulatory Care, C - Dental Care, D - Ancillary Services, E - Support Services, F - Special Programs. All of the costs of a medical treatment facility will fall into one of these categories. The categories are so broad, however, that it is helpful to break them down into more specific second, third, and even fourth level accounts.

Each of the six functional accounts listed above can be broken down into one or more summary accounts. For example, Inpatient Care (A)

Figure 1

FOUR LEVEL ACCOUNTING CODE STRUCTURE



contains six summary accounts, each with a unique second level account code: medical (AA), surgical (AB), OB/GYN (AC), pediatric (AD), orthopedic (AE), and psychiatric (AF) care. Some of these summary accounts are further subdivided into more detailed third level accounts.

The third level account, called a subaccount, reports cost information at the level of the work center. The work center is a functional or organizational subdivision of the medical facility that: accumulates identifiable, significant expenses; occupies physical space and has assigned manpower; produces a meaningful work output; and provides a unique service. In addition, its function is assigned or authorized by higher authority (7). (See Appendix A for a more detailed definition.) Specific examples of work centers include internal medicine, pathology, lab, and command administrative support services. To continue with the example begun above, under the summary account medical care (AA) fall the subaccounts of internal medicine (AAA), cardiology (AAB), coronary care (AAC), and so on through the final medical care subaccount: "medical care not elsewhere classified" (AAZ).

The fourth level account codes are primarily for internal use by the reporting facility. These optional codes are assigned meaning by the individual facility and may be used for purposes such as accounting for costs shared by specialty services on a single ward.

Overview of the UCA Process

The overall process of producing UCA data and summary reports consists of the following steps:

- 1) accumulation by work center of financial, personnel, patient, and facilities data from existing sources within each facility;
- 2) purification of the data collected in the previous step (involves reassigning expenses from one work center to one or more other expense accounts);
- 3) redistribution of intermediate expense account costs (support services and ancillary services) to final operating expense accounts (stepdown procedure); and
- 4) production of the major summary report (the Medical Expense and Performance Report, or MEPR).

Each of these steps is discussed in more detail in the following sections of this report.

Data Accumulation

Rather than require the facilities to duplicate existing management information systems, the UCA uses as its source of cost information data which have already been gathered by previously existing systems. In most cases, these data are adequate for direct use in the UCA or can be modified easily to fit the UCA requirements. The data are of two general types: expense information and performance measures.

Expense data includes any information, reported in dollar amounts, about the value of the transactions and events of each work center. Each work center has its own operating expense account (OEA) into which direct cost information is accumulated. First, all non-personnel expenses are assigned to both intermediate and final OEAs. These expenses include depreciation of any medical or dental equipment, purchased through a source other than Navy supplies, which has a value of over \$3,000. It is during this step that the full-time equivalent (FTE) man-months to be charged to each account are determined. Based upon the FTE's, salary expenses for civilian and military employees are charged to the appropriate work centers. At the end of this stage of the processing, all costs have been assigned to an operating expense account. In later steps some of these costs will be reassigned to reflect resource consumption of ancillary and support services by work centers providing direct patient care/services.

In addition to the expense information, each work center collects performance factors. These are measures of the work produced by a given function which, when divided into the total costs for that function, give a cost per workload ratio. The cost per workload ratio is a variation of the classic efficiency measure, a comparison of outputs to inputs. (See Table 1 for a listing of the individual UCA work centers and their associated performance factors). For example, consider the Internal Medicine work center whose functions are to: 1) provide inpatient care and consultative service to patients suffering from medically related disease and illness, 2) maintain communicable disease facilities, 3) maintain liaisons with government authorities, and 4) provide subspecialty assistance where needed (7). The

operating expense account for the Internal Medicine work center will contain all of the operating expenses incurred in providing and maintaining these functions. The performance measure, or performance factor, associated with the Internal Medicine work center is the occupied bed day (OBD). After the purified and

Table 1
Statistical Data for Each UCA Work Center

<u>Work Center(s)</u>	<u>Related Statistical Data</u>	<u>Work Center(s)</u>	<u>Related Statistical Data</u>
Inpatient Care Ambulatory Care Dental Care	Occupied Bed Day Visit Weighted Dental Procedure/Prosthodontic Work Unit	Public Works	Various
Ancillary Services Pharmacy Pathology	Weighted Procedure Weighted Procedure	Material Services Housekeeping and Janitorial Service Biomedical Equipment Repair Linen and Laundry Service	Dollars of Supply Hours of Service Hours of Service Pounds of Laundry
Radiology Special Procedures Services Central Sterile Supply/ Material Service Surgical Services Same Day Services	Weighted Procedure Procedure Hours of Service/ \$ of Supplies Hours of Service Hours of Service	Inpatient Food Service Inpatient Affairs Ambulatory Care Administration	Rations Served Occupied Bed Day Outpatient Visits
Rehabilitative Services Nuclear Medicine	Visit Weighted Procedure	Special Programs Specified Health Related Programs Public Health Services Health Care Services Support	Various Various Various
Support Services Depreciation Command and Administrative Support Services Personnel Support Services	OBDS/Visits FTE Man Months Square Footage	Military Unique Medical Activities Patient Movement and Military Patient Administration	Various

Source: LT Michael Jones, Head of Cost Accounting
Accounting Section, Naval Medical Command

processed expense data have been assigned to the Internal Medicine work center, a cost performance ratio (cost per occupied bed day) is calculated and reported. This ratio can be used to compare cost per occupied bed day for inpatient care work centers within a hospital or to compare costs for similar work centers in other facilities. The performance measures are also used later in the stepdown and purification process to assign costs accumulated in indirect operating expense accounts to the appropriate direct care work centers. For example, the performance factor of weighted procedures would be used to calculate the proportion of the total expense incurred by the Radiology work center which will be reassigned to the Internal Medicine work center during the purification process.

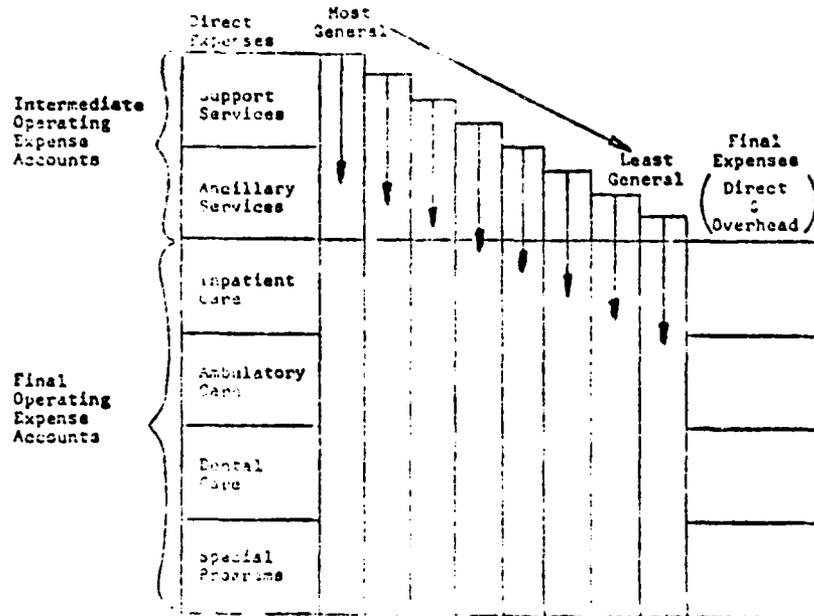
Data Purification and Stepdown Procedure

Purification of the expense account information involves reassigning costs from one work center to one or more other expense accounts. For example, surgery patients who fall under more than one account code may be cared for on the same ward. Expense information for all of those patients is initially accumulated in one expense account representing the costs for the entire ward. Therefore, the costs for different types of patients have been "pooled" together. Before reporting the final expense figures, the cost pools must be broken down and reallocated to conform to the standardized expense account definitions. This purification process may be done either before (pre-purification) or after (post-purification) the stepdown procedure described below. (Pre-purification does not reassign overhead costs.)

In the stepdown procedure, expense data is reallocated from the intermediate operating expense accounts in which it was initially accumulated to other intermediate operating expense accounts using their services, and lastly, to final operating expense accounts. Each intermediate expense account is stepped down (beginning with the most general of the intermediate accounts) then it is closed. Ultimately, all expense information is assigned to one of the four final operating expense accounts (see Figure 2). The rationale for this procedure is that work centers falling under the intermediate operating expense accounts provide services which constitute overhead for the work centers in the final operating expense accounts.

Figure 2

Stepdown Procedure for Assignment of Overhead Expenses



The intermediate OEA expenses are stepped down proportionally by workload data into the final OEAs. For example, Linen and Laundry Services accumulates \$150,000 in expenses in the first quarter. Inpatient Care makes use of the laundry services, using 3 of the total 4 tons that the laundry service provided during the first quarter. So, in the final OEA, three fourths of the \$150,000 spent by Linen and Laundry Services is reallocated to Inpatient Care as an expense. This procedure is repeated until all the expenses originally allocated to Linen and Laundry Services have been reassigned to final OEAs. This proportional reallocation of expenses occurs for all of the ancillary and support expenses, based upon the performance factors listed earlier in Table 1. The reallocation of funds is done by the computerized Expense Assignment System (EAS).

After the completion of the cost purification and stepdown procedures, management reports such as those discussed in the next section are produced.

Data Reporting

After UCA data have been processed through the Expense Assignment System, reports that summarize costs by work center within individual facilities are produced. These reports are created quarterly and include quarterly and up-to-date cost figures. Appendices B and C contain examples of such reports.

The Medical Expense/Performance Report (MEPR) (see Appendix B) is the standardized output envisioned by the creators of the UCA. It reports cost information by subaccounts (third level of account codes). Contingent upon the validity and reliability of the data reported by the individual facilities, the

expense figures, performance factors, and efficiency ratios generated are comparable across facilities.

Several of the additional data displays produced in the process of generating the MEPR are of potential interest to decision making or management oriented research. One of these is the Fourth Level Detail Unit Cost Report (see Appendix C), which lists expenses, performance factors, and selected cost/performance ratios (e.g., cost per occupied bed day) for each account code down to fourth level specificity for an individual facility. In the process of preparing the report, the cost data are edited for obvious errors, and the corrected data resubmitted until the report is consistent with other records the facility maintains. The Fourth Level Report is produced mainly for the facility's internal use. However, because of the detailed breakdown of cost and performance information, it might be useful for tracing costs down as far as the level of an individual ward or functional activity (e.g., cardiology, dermatology) for research purposes. Since fourth level codes are optional, there will be variability in the detail of the reports received from different facilities. A useful supplement to this report is the Computation Summary which lists separately the direct, stepped down, reallocated, and purified expenses for each account code, down to fourth level.

In addition to the MEPR, the Cost Accounting Section of the Naval Medical Command compiles individual level reports into a set of JCA program reports (UCAP). These reports display comparable expense figures in tabular form for all hospitals. For ease of comparison, many of the UCAP reports group each Naval Medical Command into one of seven activity groups, each of which is similar in size, expense, and to a certain extent, mission (all group A hospitals, for

example, are large, teaching hospitals). These reports contain very aggregated cost figures, presented in a format designed to facilitate inter-facility comparisons. (See the list of activity groups below in Table 2.) Inter-facility comparisons for the second quarter of 1983 are summarized under the following headings: 1) analysis of functional categories; 2) analysis of inpatient care; 3) analysis of ambulatory care; 4) analysis of ancillary services; 5) dental expenses and workload; and 6) average cost per occupied bed day and outpatient visit.

Table 2

Naval Hospital Activity Groups, FY 82

<u>GROUP A</u>	<u>GROUP E</u>
Bethesda	Adak
Portsmouth, VA	Guantanamo Bay
San Diego	Roosevelt Roads
Oakland	Subic Bay
	Naples
	Rota
<u>GROUP B</u>	Guam
Pensacola	Yokosuka
Charleston	Okinawa
Jacksonville	
Long Beach	<u>GROUP F</u>
Great Lakes	Portsmouth, NH
Camp Lejeune	Annapolis
Camp Pendleton	Quantico
	Key West
<u>GROUP C</u>	Seattle
Memphis	Port Hueneme
Beaufort	New Orleans
New London	Pearl Harbor
Orlando	
Newport	<u>GROUP G</u>
Bremerton	Yuma
Philadelphia	London
	Idaho Falls
<u>GROUP D</u>	Cleveland
Corpus Christi	Crane
Cherry Point	Louisville
Lemoore	
Whidbey Island	
Patuxent River	

Source: LT Michael Jones, Head of Cost Accounting
Accounting Section, Naval Medical Command

Issues in the Use of UCA Data

UCA data can be used by medical department managers to 1) compare performance at the level of the ward, hospital, or service, and 2) allocate resources to hospitals and clinics. Managers should be aware, however, of several issues related to the use of UCA data.

--The UCA data do not account for differences in the case mix complexity of patients treated within each work center, therefore making comparisons among hospitals liable to misinterpretation.

--The MEPR report provides costs per occupied bed day (OBD), a statistic that is easily distorted by increasing patient length of stay. Because most of the costs associated with treating a patient tend to occur within the first few days of hospitalization, a hospital could easily reduce its cost per OBD by extending each patient's length of stay. Therefore, it might be useful to supplement OBD ratios with a report of cost per disposition. This ratio can be determined by dividing the cost data reported on the MEPR by the number of dispositions reported for each respective work center.

--The potential time lag between accumulation of data into operating expense accounts, submission of the expense and workload data for processing in the EAS, and receipt of a corrected MEPR may limit the usefulness of the UCA data for timely decision-making.

--Some editing of the data is done after the EAS has allocated the costs to work centers. This editing involves simple checks such as comparing the number of occupied bed days to the number of dispositions to ensure that the first number is larger than the second (see Expense/Workload Relationships in Appendix D for examples of the types of edit comparisons). More subtle errors such as the assignment of expenses to an incorrect work center are likely

to go undetected unless the reporting facility identifies or corrects them. This may cause problems when cost comparisons are made among different facilities.

--The use of cost pools may actually distort cost figures for some work centers. When costs are reallocated based upon a workload factor such as occupied bed day, a smoothing out, or an averaging effect occurs. The apparent costs of a work center with more intense resource consumption are likely to be deflated while the costs of the work center with less intense consumption are inflated. This gravitation toward the mean may make it more difficult to identify the true source of costs (3).

--The actual authority structure in a hospital may not closely correspond with the structure of the UCA system. This means that responsibility for controlling direct costs of a single work center may fall on more than one department head.

--Because the cost figures reported on the MEPR have been stepped down to include reporting of indirect costs and overhead of all final accounts, some sources of cost may actually be under the control of departments far removed from the work center. For example, control of cleaning costs may not be possible at the point of a medical, surgical, or ambulatory care work center; yet these costs contribute to the total costs reported on the MEPR for these work centers. In some instances management decisions should be based upon the expenses of a work center before the stepdown procedure has been done (this direct expense information is available from the Computation Summary).

--The cost figures reported are a mix of variable and fixed costs. Typically, the greater the caseload, the lower the fixed cost per patient. Erroneous conclusions may be drawn if the non-independence of caseload and cost per OBU is ignored.

Conclusion

The staff of the Research Department at the Naval School of Health Sciences plan a study of alternative methods for distributing resources to individual hospitals on the basis of average costs across all hospitals. The incorporation of a case mix measure such as diagnosis related groups (DRGs) may supply essential data for explaining cost and performance variations among facilities. Such a linkage would permit managers to refine the allocation process by reflecting the cost of treating the unique mix of patients cared for by each hospital. The UCA data issues discussed in this report need to be carefully addressed before these two systems can be integrated into a viable management tool.

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APPENDIX A

Definition of Work Center

WORK CENTER. A discrete functional or organizational subdivision of a military medical facility for which provision is made to accumulate and measure its expense and determine its workload performance. The minimum workcenters for a military medical facility are established by the prescribed operating expense accounts. Additional subordinate workcenters may be established by the military medical treatment facility. Generally the following criteria should be considered for establishing a workcenter:

- have identifiable expenses,
- have significant expenses,
- have allocated physical space,
- have allocated/assigned manpower,
- have meaningful work output,
- have a meaningful workload measure,
- have a uniqueness of service provided or expenses incurred when compared to other established work centers,
- have compatibility with the medical treatment facility organizational structure, and
- facilitate management decision making process.

Specifically, the following criteria shall be satisfied to establish a work center:

- The performance of the function is one that is assigned or authorized by higher medical authority.
- Manpower (staffing) is assigned. Such staffing may or may not be authorized on the facility manning/staffing documents. In the areas of Inpatient Care, Ambulatory Care, and Dental Care, this is defined to mean that the medical or dental specialty or subspecialty is assigned.
- Physical space to accomplish the workload is allocated and utilized.
- Workload is generated.

APPENDIX A (cont'd)

If the aforementioned criteria are satisfied, then a work center will be established and expenses identified, collected, and reported as provided for in this Uniform Chart of Accounts. If physical space is allocated and utilized for the performance of a function, and the specialty/subspecialty (in the case of a ward or clinic) is provided on some periodic basis, through consultative service, contract offices, TAD or TDY expenses will be identified, collected, and reported only if they are considered to be significant by the medical treatment facility commander. Exceptions to the above criteria are:

- Reimbursement accounts,
- Summary accounts,
- Base operations accounts,
- Holding or variance accounts,
- Indirect cost pools.

From: Department of Defense Uniform
Chart of Accounts for Fixed Military
Medical and Dental Treatment Facilities,
Office of the Assistant Secretary of Defense
(Health Affairs) (DOD 6010.10-M: July, 1979)

APPENDIX B

PREPARED: 02 02 03 12:02 PMS MEDICAL EXPENSE/PERFORMANCE PCN
 FACILITY NAME: NMMC NEVEPSAIL
 FACILITY CODE: 049994 DOD REGION: 0
 QUARTER 1 : 01 OCT 81 - 31 DEC 81

PART I - DIRECT PATIENT CARE

SECTION 1 - INPATIENT SERVICES

ACCT DESCRIPTION	DISPOSITIONS	TOTAL EXPENSES	CLINICIAN SAL	OCCUPANCY BED DAYS
AA MEDICAL CARE	4950	1269013	0	22990
AB SURGICAL CARE	4331	2969510	0	25740
AD PEDIATRIC CARE	891	688092	0	3174
TOTAL	10172	4926623	0	51904

SECTION 2 - AMBULATORY SERVICES

ACCT DESCRIPTION	TOTAL EXPENSES	OUTPATIENT VISITS	INPAT VISITS
BA MEDICAL CARE	471468	20346	0
BB SURGICAL CARE	310127	8124	0
UD PEDIATRIC CARE	254142	12745	0
BH PRIMARY MEDICAL CARE	394313	12792	0
BT EMERGENCY MEDICAL CARE	595034	10000	0
TOTAL	2025884	64007	0

PART II - ANCILLARY SERVICES

ACCT DESCRIPTION	DIRECT AND SUPPORT EXPENSE	ANCILLARY COST	TOTAL EXPENSE ASSIGNED	ANCILLARY SERVICES	COST PER UNIT
DA PHARMACY	59430	0	59430	228020	2.4448
DB PATHOLOGY	588286	0	588286	623012	0.9442

APPENDIX B (continued)

PCN
 PREPARED: 82 02 03 17:02 HRS
 FACILITY NAME: NMHC NEVERSAIL
 FACILITY CODE: 099999 DDD REGION: 0
 QUARTER 1 : 01 OCT 81 - 31 DEC 81
 MEDICAL EXPENSE/PERFORMANCE

-----PART II - ANCILLARY SERVICES-----

ACCT DESCRIPTION	DIRECT AND SUPPORT EXPENSE	ANCILLARY COST	TOTAL EXPENSE ASSIGNED	ANCILLARY SERVICES	COST PER UNIT
DC RADIOLOGY	478977	0	478977	127659	3.7520
OTHER	888688	249697	1138385	0	0.0000
TOTAL	2515381	249697	2765078	0	0.0000

-----PART III - SUPPORT SERVICES-----

ACCT DESCRIPTION	TOTAL EXPENSES
E SUPPORT SERVICES	3055927
TOTAL	3055927

-----PART IV - SPECIAL PROGRAMS-----

ACCT DESCRIPTION	TOTAL EXPENSES
FA SPECIFIED HEALTH RELATED PROGR	188203
FD MILITARY UNIQUE MEDICAL ACTIVI	605074
FE PATIENT MOVEMENT AND MILITARY	22316
TOTAL	815593

APPENDIX B (continued)

FACILITY CODE: 099999 DUU REGION: 0
 QUARTER 1 : 01 OCT 81 - 31 DEC 81

-----PART I - DIRECT PATIENT CARE-----

SECTION 1 - INPATIENT SERVICES

ACCT DESCRIPTION	DISPOSITIONS	TOTAL EXPENSES	CLINICIAN SAL	OCCUPIED BED DAYS	COST PER 000
AAA INTERNAL MEDICINE	4950	1269013	0	22990	55.19
ABA GENERAL SURGERY	4215	2396853	0	24430	98.11
ABC INTENSIVE CARE UNIT (SURGICAL)	116	572665	0	1310	437.14
ADA PEDIATRICS	891	688092	0	3174	216.79
	10172	4926623	0	51904	94.91

SECTION 2 - AMBULATORY SERVICES

OUTPATIENT

5

ACCT DESCRIPTION	TOTAL EXPENSES	INPAT VISITS	INPAT COST PER VISIT
BAA INTERNAL MEDICINE CLINIC	471468	20346	23.17
BBA GENERAL SURGERY CLINIC	310127	8124	38.17
BDA PEDIATRIC CLINIC	254142	12745	19.94
BMA PRIMARY CARE CLINICS	394313	12792	30.82
B1 EMERGENCY MEDICAL CARE	595834	10000	59.58
TOTAL	2025884	64007	31.65

-----PART II - ANCILLARY SERVICES-----

ACCT DESCRIPTION	DIRECT AND SUPPORT EXPENSES	ANCILLARY EXPENSE UNIT	TOTAL EXPENSE UNIT	ANCILLARY SERVICES	COST PER
DA PHARMACY	559430	0	559430	228820	2.4448

APPENDIX B (continued)

PREPARED: 82 02 03 17:02 HRS
 FACILITY NAME: NPMC NEVERSAIL
 FACILITY CODE: 099999 DUD REGION: 0
 QUARTER 1 : 01 OCT 81 - 31 DEC 81
 PCN

DETAIL UNIT COST REPORT

PART II - ANCILLARY SERVICES

ACCT DESCRIPTION	DIRECT AND SUPPORT EXPENSES	ANCILLARY SERVICES	TOTAL EXPENSE UNIT	ANCILLARY SERVICES	COST PER
DBA CLINICAL PATHOLOGY	58286	0	58286	623012	0.9442
DCA DIAGNOSTIC RADIOLOGY	478977	0	478977	127659	3.7520
DEA CENTRAL STERILE SUPPLY	173361	0	173361	6240	27.7822
DFB ANESTHESIOLOGY	108363	37413	145776	6240	23.3615
DFC SURGICAL SUITE	606964	212284	819248	22880	35.8062
TOTAL	2515381	249697	2765078	1014851	0.0000

APPENDIX C

ATMAYRA DETAIL UNIT - LOSL RECORD

PREPARED BY: (M/1/A)
 FACILITY NAME: ██████████
 FACILITY CODE: ██████████
 QUARTER 7 NET (Y 0)

PART I - DIRECT PATIENT CARE

SECTION I - IMPATIENT SERVICES

ACCT DESCRIPTION	TOTAL EXPENSE	CLINICIAN SALARY	OBQ	DISP	ALOS	COST/ OBQ	AMCCL COST/ OBQ	COST/ DISP	CLIN SAL/ DISP
AAA INTERNAL MEDICINE	267,169	57,943	2,500	502	6.2	106.07	56.75	666.60	166.16
AAV INTERNAL MEDICINE P	28,370	2,648	261	96	2.7	108.70	36.61	295.52	27.58
AAA CARDIOLOGY	1,348	2,648							
AAA ORTHOPEDY	16,093	16,633	67	3	15.6	342.60	3.77	5,364.33	3,556.33
AAA ICU IMPR	3,900		341			11.70			
AAA RADIOLOGY	7,001	2,668	148	29	5.1	67.50	27.08	261.61	91.31
AAA PA (OBIMD & DENTAL)	196,883								
AAA PA (CYN IMOLCT GEN SURG OTO O)	241,702								
AAA PA TECH RADOT	15,372								
AAA PA TECH RADOT	122,029								
AAA PA PSYCHIATRIC	198,138								
AAA PA (ICU)	379,697								
AAA PA (PEDIATRICS)	142,628								
AAA PA (GEN MED & GEN SURG)	221,966								
AAA PA (ICU WARD)	252,717								
AAA PA (INTERNAL MEDICINE)	320,116								
AAA GENERAL SURGERY (ICU IMPATIENT)									
AAA GENERAL SURGERY P	240,106	93,988	1,300	239	9.2	176.52	113.62	927.04	326.20
AAA ICT SURGERY									
AAA OPHTHALMOLOGY	28,737	20,731	105	10	3.5	273.00	222.48	978.37	691.03
AAA ORAL SURG	9,357		57	16	6.0	166.16	121.02	668.36	
AAA OTOLARYNGOLOGY	63,080	10,196	132	77	1.9	203.68	189.25	559.60	132.47
AAA RADIOLOGY	63,215	6,207	239	54	4.4	266.50	133.78	1,170.65	93.46
AAA GEN	143,230	76,381	539	156	3.6	256.23	168.91	930.86	666.29
AAA GEN P	11,132		66	19	6.6	262.66	67.11	1,115.33	
AAA OBSTETRICS	123,675	66,896	928	291	3.1	133.27	38.37	625.00	209.26
AAA OBSTETRICS P	30,173	28,798	228	73	3.1	132.36	31.76	612.33	206.70
AAA PEDIATRICS	21,094	11,719	666	136	3.6	65.27	17.68	151.42	67.66
AAA PEDIATRICS P	5,074	15,495	105	105	5.2	68.32	5.31	253.70	276.75
AAA RADIOLOGY	21,234		738	243	3.0	28.77	9.66	81.38	
AAA RADIOLOGY P	6,693		166	53	3.8	28.62	3.36	88.55	
AAA RADIOLOGICS	206,665		2,056	648	6.6	136.51	29.56	637.88	
AAA RADIOLOGICS P	213		2	1	2.0	136.50		273.00	
AAA RADIOLOGY	36,107	27,487	631	79	8.2	32.67	29.29	238.75	
AAA RADIOLOGY							6.82	921.08	357.95
AAA RADIOLOGY	3,655,392	412,910	11,160	2,666	6.5	327.56	72.59	1,982.31	167.66

APPENDIX F

UNIFORM CHART OF ACCOUNTS
ANALYSIS OF INPATIENT CARE
2011-M02 AS OF 07/08/83

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REPORT PERIOD: 2ND QUARTER 1983 YEAR-TO-DATE

ACTIVITY GROUP A

ACTIVITY NAME	TOTAL EXPENSE	CLINICAL SALARY	% MED SUR	CLINICIAN SALARY TO TOTAL EXPENSE	TOTAL OBO	MED SURG	COST PER OBO	UMTH	NP				
		OBO	OBO	PER OAT PER	OBO		UU PER						
MRMC BEVERLY	23,575,765	2,800,883	5.50	5.51	87	92	76,307	321	373	306	355	300	150
MRMC PORTSMOUTH	22,993,307	1,717,110	1.81	2.23	85	86	79,939	361	366	341	205	215	152
MRMC SAN DIEGO	25,224,802	3,025,203	5.33	4.30	63	63	80,777	357	393	208	195	272	224
MRMC OAKLAND	12,680,174	640,867	1.93	1.42	58	64	38,356	361	365	502	263	232	234
GROUP TOTAL/AVERAGE	84,676,048	8,244,063	3.30	3.33	96	70	275,379	347	376	306	239	248	171
GROUP LMS	12,680,174	640,867	1.81	1.42	58	64	38,356	361	365	208	195	215	152
GROUP MEANS	21,169,012	2,061,015	3.30	3.33	96	70	68,844	347	376	306	239	248	171
GROUP HIGHS	25,224,802	3,025,203	5.60	4.61	88	67	80,777	361	393	502	355	300	234

NOTE: These facilities are grouped into categories composed of hospitals which are similar in size, expense, and admissions. This group (Activity Group A) is also similar in mission-teaching.

APPENDIX D (continued)

UNIFORM CHART OF ACCOUNTS
ANALYSIS OF FUNCTIONAL CATEGORIES
20381-M06 AS OF 03/09/83

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REPORT PERIOD: 2ND QUARTER 1983 YEAR TO DATE

DOLLARS IN THOUSANDS

ACTIVITY GROUP A	TOTAL MEPR	101 IMPAT. EXPENSE - E -	TOT AMOVL EXPENSE - E -	TOTAL D C EXPENSE - E -	SPEC. PROG. EXPENSE	AMILLARY EXPENSE	-SUP SERV- EXPENSE		
NAME BETHESDA	53,774.9	23,375.8	63.84 10,051.4	18.49	519.6	.96 19,628.1	36.50 13,513.0	25.12 14,577.3	27.10
NAME PONTIAC/WIN	54,228.2	22,993.3	62.40 18,056.4	33.29	688.3	1.26 12,490.2	23.03 15,804.1	29.14 14,440.4	26.62
NAME SAN DIEGO	54,083.0	25,226.8	42.69 20,741.7	35.17	326.5	.55 12,744.0	21.57 15,546.0	26.31 13,388.0	22.65
NAME OAKLAND	37,916.7	12,880.2	33.96 13,634.0	35.95	511.9	1.35 10,890.7	28.72 9,373.5	24.72 12,251.0	32.31
GROUP TOTAL	205,002.8	84,674.1	41.30 62,523.5	30.49	2,046.2	.99 55,757.0	27.19 54,236.6	26.45 54,657.5	26.66
GROUP LOWS	37,916.7	12,880.2	10,051.4	326.5	10,890.7	9,373.5	12,251.0		
GROUP MEANS	54,250.7	21,169.0	15,630.9	511.6	13,939.3	13,559.1	13,664.4		
GROUP HIGHS	59,085.0	25,226.8	20,781.7	688.3	19,628.1	15,804.1	14,577.3		

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REPORT DOCUMENTATION PAGE		READ INSTRUCTIONS BEFORE COMPLETING FORM
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4. TITLE (and Subtitle) The Uniform Chart of Accounts: A Description With Comments on Potential Use With Case Mix Data		5. TYPE OF REPORT & PERIOD COVERED
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7. AUTHOR(s) Rosalie J. Hall Terrence L. Kay		8. CONTRACT OR GRANT NUMBER(s)
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19. KEY WORDS (Continue on reverse side if necessary and identify by block number) Uniform Chart of Accounts Diagnosis Related Groups Case Mix		
20. ABSTRACT (Continue on reverse side if necessary and identify by block number) The Uniform Chart of Accounts (UCA) is a standardized cost accounting system developed specifically for use in military fixed medical treatment facilities. By providing a single tri-service chart of accounts with common definitions for all elements, the UCA generates a unique source of standardized data for making cost and workload comparisons among military hospitals and clinics.		

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To interpret the UCA data, it is essential to be familiar with the basic procedure for generating the cost figures on the UCA final reports, including accumulation and purification of cost and workload data from the reporting work centers; for the redistribution of costs among work centers to reflect shared resources and indirect expenses; and for production of the summary reports. This report provides a short description of these procedures, plus comments and discussion concerning the use of other medical data such as Diagnosis Related Groups (DRGs) to supplement the UCA inpatient cost data.

Original copy of this report: Case mix

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