Revising the Chart Of Accounts

BY SR. GERALDINE M. HOYLER, CSC

The chart of accounts is the basis of a healthcare provider's accounting and reporting system. The charts currently in use, most of which were modeled on an American Hospital Association chart of accounts, have evolved over the past 20 years without serious revision in the basic design. Now is an appropriate time for healthcare providers to consider revamping the chart of accounts.

As their corporate structures evolve and their scope of services increases, healthcare providers must change their chart of accounts. Otherwise, the information management makes available to board and management will not be as easy to access, display, and compare as it ought to be.

Planning and Design

Changing a chart of accounts requires about 18 months: 12 months to design the instrument and educate staff regarding its use, and 6 months to create a budget based on the new chart. Providers should begin using a new chart of accounts at the start of a fiscal year.

To create a chart that provides meaningful, usable information, persons throughout the organization must be involved. If only financial managers participate in the process, the resulting chart will not be a useful management tool.

A chart of accounts is divided into at least five basic sections: assets, liabilities, equity (fund balance), revenues, and expenses. Decisions about any one of these will affect available alternatives for others. For example, the definition of revenue centers will help determine how expense cost centers are defined. Once the revenue centers are defined, the numbering scheme for patient charges can be determined.

The numbering of items in a chart of accounts should be both logical and consistent. For example, the number for the revenue center of an off-site radiology laboratory might be 4400, while the matching expense cost center could be 7400. In this scheme, all revenue centers have the lead number 4 and all cost centers producing revenue have the lead number 7. The consistency would carry through to the asset accounts, where the capitalized radiology assets in that cost center would be recorded in account 1400 (i.e., with the lead number 1 for all assets).

Sr. Hoyler is regional coordinator, Mercy Housing, Inc., Denver.

In addition, many chargeable items are carried in inventory. The numbering scheme given to these chargeable items and the inventory number of that item should be related. A logical numerical relationship allows staff members to see more clearly the implications of not charging an item and thus creating both revenue and inventory problems. Such a system will also reduce recall errors. These basic numbering patterns allow a department manager to use the information contained in the chart of accounts with ease.

In designing the new chart, facilities should place special emphasis on:

- The definition of revenue-producing departments
- Placement of particular chargeable items in a revenue center
- Decisions regarding the handling of employee benefits, both those with an effect on payroll and those with only an accrual effect

The decisions arising from these considerations must be interactive, involving the respective managers, who will understand best what takes place in these areas, what should take place, and what historical circumstances may have created an ineffective treatment of these issues.

Establishing Appropriate Relationships

An inappropriate chart of accounts can be the source of disputes over responsibility for financial outcomes (both poor and good). With the old chart of accounts, a revenue department may include two kinds of services that managerially ought to be separated. For example, an off-site radiology center may be included as part of the hospital radiology department. With the creation of a new chart, it might be split into a new department. New revenue codes would be creat-

Continued on next page

Continued from page 15

ed so that revenue attributable to that off-site center would be appropriately reported.

Another example concerns the recording of employee benefit expenses. The institution must decide whether those expenses will be reported in a single cost center or in the department where individuals worked; however, the numbers for each expense would be the same regardless of the department in which the expense is reported. Such a decision should reflect the institution's human resource management philosophy, not the accounting preference, and thus the human resource department should help decide how to structure this portion of the chart of accounts. The decisions made should facilitate both the way departmental managers and human resource managers relate to individuals and how they are held accountable for expenditures.

Facilities should avoid designing charts of accounts to accommodate board preferences for reporting assets and equity. Different methods of reporting are more appropriate vehicles for meeting board needs. A financial reporting system based on a chart of accounts is a management tool. It should help those within the institution make good operating decisions based on easily understood information.

Board decisions, on the other hand, address policy and strategy issues. Thus board requests are more properly met with reporting outside that which results from the accounting records, and the chart should not be designed to meet these requests.

Time Well Spent

Providers may have neglected the design of the chart of accounts because other concerns have been more pressing. Taking the time to bring managers together to examine these questions may help all involved better understand the structures and relationships within the institution. Creating a chart of accounts that supports such relationships will be time well spent. □

Continued from page 14

Some market-oriented reforms allow consumers to choose the most efficient, cost-effective healthcare plans.

doubt that the way care is paid for influences the behavior of providers," they continued. Other concerns they cited include autonomy, patient advocacy, external regulations, paperwork, and professional development.

On the consumer side, choice is a key issue. Some market-oriented reforms allow consumers to choose the most efficient, cost-effective healthcare plans. Other plans take a more paternalistic view toward patients and limit choices. AARP's Rother said, "I'm tired of this either-or debate. Clearly there is going to be a regulated system, but we want to see some consumer choice" in it. In implementing healthcare reforms, we "need to look at *which* choices we make consumers responsible for," he continued.

Has the Time Arrived?

Although few policy analysts believe significant healthcare reform will be forged during this election year, many think it *will* happen eventually. Legislators are hearing calls for reform from their constituents at both the state and federal levels. Many states are actively pursuing and implementing reforms. Provider groups have stepped up their level of debate on reform. The Catholic Health Association (CHA), for example, plans to devote considerable energy this coming year to education forums on its new reform plan and is working on an implementation strategy. "We will have healthcare reform when middle-class Americans are so frustrated with the risk segmentation [of the current system] that they say to their member of Congress, 'Don't come home without a plan,'" said Bill Cox, CHA's vice president for government services.

"I surmise we have turned some sort of corner that will accelerate change," suggested Brown at the June meeting. The current debate between "comprehensive versus incremental change is a false dichotomy. We will proceed incrementally," he added. "If, however, the commitment to affordable universal coverage stays strong, one increment will lead to further ones, and it will be difficult to stop the action short of 'fundamental' change over a decade or two." □

NOTES

1. Lawrence D. Brown, "Getting There: The Political Context for Implementing Health Care Reform," paper presented at the Conference on the Implementation of National Health Care Reforms, Washington, DC, June 12, 1992.
2. James A. Morone, "Administrative Agencies and the Implementation of National Health Care Reform," paper presented at the Conference on the Implementation of National Health Care Reforms, Washington, DC, June 12, 1992.
3. Kenneth E. Thorpe, "Cost Containment and National Health Care Reform: Implementation Issues," paper presented at the Conference on the Implementation of National Health Care Reforms, Washington, DC, June 12, 1992.
4. Paul Ginsburg and Kenneth E. Thorpe, "Can All-Payer Rate Setting and the Competitive Strategy Coexist?" *Health Affairs*, Summer 1992, pp. 73-86.
5. Mitchell T. Rabkin and Eugene C. Wallace, "Provider Concerns and the Implementation of Health Care Reform," paper presented at the Conference on the Implementation of National Health Care Reforms, Washington, DC, June 12, 1992.