QUICK HITTING SURVEY:

Corporate Cost Allocation

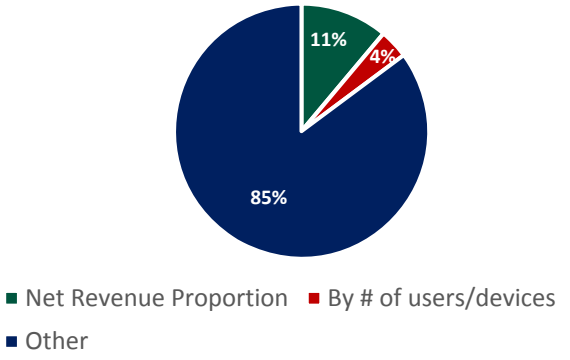
The Academy

Executive Summary

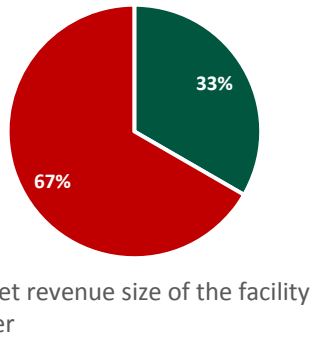
On behalf of a CFO member, The Health Management Academy surveyed CFO members on corporate cost allocation. We received responses from 27 health systems (response rate of 55%). Responding health systems represent 423 hospitals, 783,018 employees and average net patient revenue of $5.3 billion.

- ✓ There is considerable variation in the way health systems allocate their IT and fixed costs; however, nearly two-thirds (63%) say there is no difference in how they allocate costs to different facilities;
- ✓ One-third say they immediately implement their cost allocation methodology after an acquisition, 44% wait until the beginning of their next Fiscal Year;
- ✓ Responsibility for integration costs varies (integrated facility – 33%, health system – 19%, shared – 22%, other – 26%)

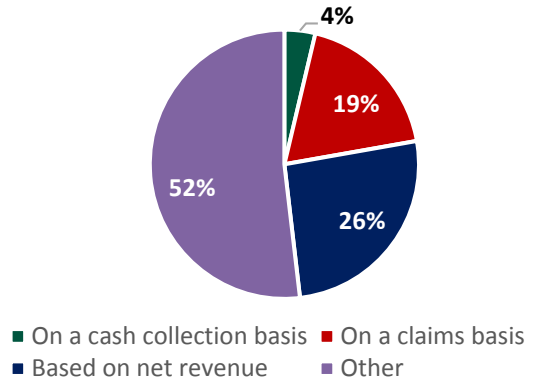
1. How do you allocate IT costs to your different regions/facilities?



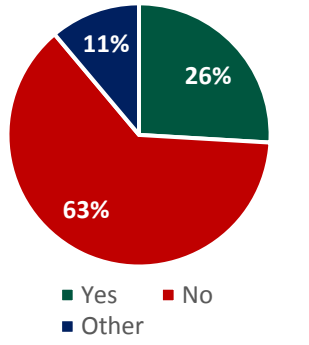
2. How do you allocate fixed costs to your different regions/facilities?



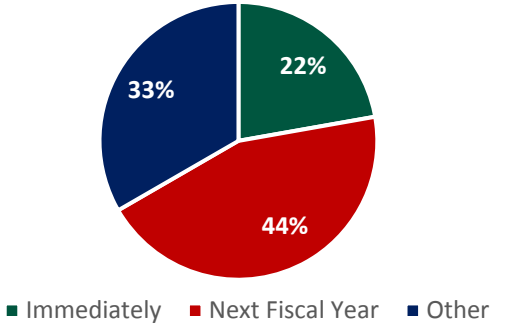
3. How do you allocate costs of centralized patient billing functions?



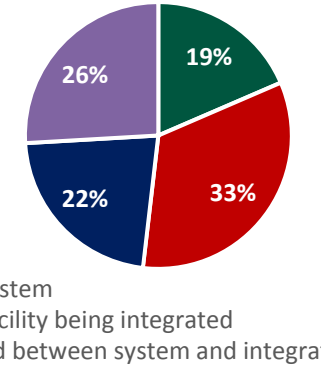
4. Is there a difference in how you allocate costs based on the type of facility?



5. When does your system implement your cost allocation methodology after you acquire a facility?

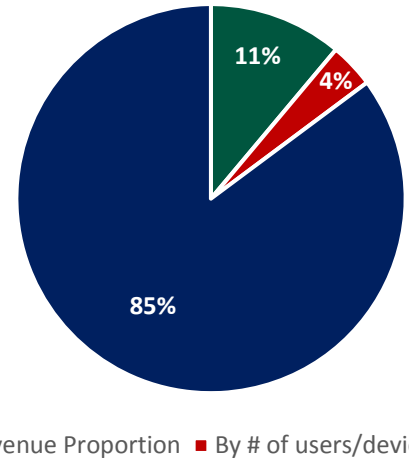


6. As you integrate a new facility into your system, who pays for the costs incurred as part of integration?



Full Analysis

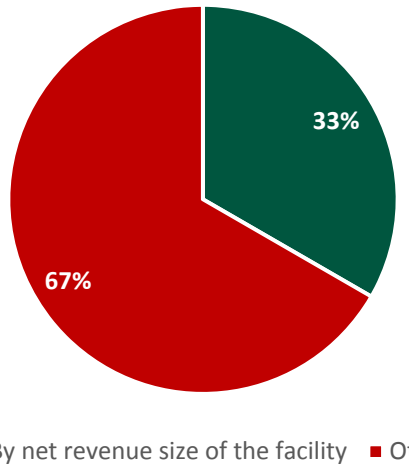
1. How do you allocate IT costs to your different regions/facilities?



Most health systems (85%) allocate their IT costs based upon their own unique combination of methods:

- *The largest component of our IT services are charged out in the following manner, broken into 3 main categories*
- *By audited expenses of the facility proportional to the audited expenses of the System*
- *IT allocation - hospitals are allocated IT costs on the basis of their adjusted admissions (CMI adjusted) to total adjusted admissions (CMI adjusted). IT costs for the medical groups are accounted for in separate DPT's and charged directly to them.*
- *Blend of actual costs attributable to local operations and overall allocations based on expense base*
- *Depending on the IT function it could be by net revenue or controllable costs*
- *Direct costs are absorbed by each department. Indirect costs are allocated based on an accumulated cost statistic consistent with CMS Cost Report Guidelines*
- *Percent of expenses-exclusive of depreciation and interest*
- *We allocate our revenue and clinical IT related systems such as billing and EMR based Net Revenue. Our IT Infrastructure systems such as storage, network, telecom, security, customer service is allocated based on FTE*
- *Total allocated application cost then by appropriate unit of service metric based on utilization by application area*
- *Based on $ of direct expenses of the operating units proportionate to direct costs of all the operating units.*
- *Using most recent audited total operating expense as a base for dividing budgeted IT operating expense.*
- *We break out IT costs into multiple lines, or services, each having its own allocation metric (FTEs, Revenue, # of devices, # of meals, # of telephones, etc.)*
- *X (# of users / devices is generally used for infrastructure costs. Applications are allocated using a variety of statistics including revenue, headcount and # of licenses)*
- *By operating expense of the facility proportional to operating expense of the system*
- *IT costs are budgeted and actual expenses are recorded in the main medical center legal entity. Some smaller subsidiaries are charged their actual costs, if applicable.*
- *Based on utilization for each system (i.e. bills dropped, tests performed)*
- *1 FTEs 2. Adjusted Patient Days 3. Total Expense 4. Physician revenue 5. Site-based operational costs allocated to each facility*
- *The various IT departments are allocated by a combination of methods. Some on devices, some on net revenue, some on combination of % time of effort, net revenue, devices and systems used etc.*
- *Direct assignment of on-site support, application specific for major elements, revenue for the rest*
- *Per APD*
- *Only exception is leased hardware (PCs, printers, etc.) are charged directly to the facility by actual device count.*

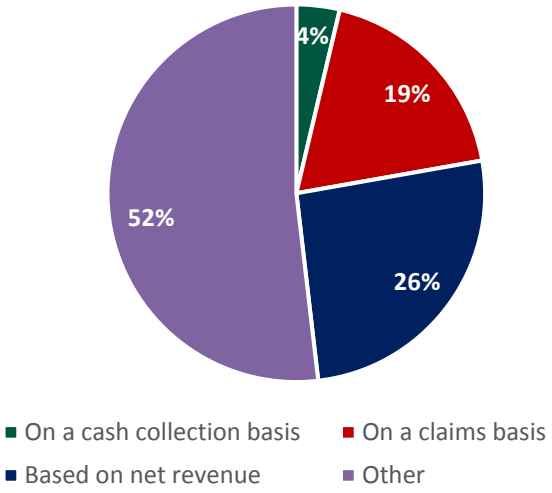
2. How do you allocate fixed costs to your different regions/facilities?



Two thirds also had their own method for allocating fixed costs to their respective system's different regions and facilities, while a third of the responding health systems allocate fixed costs strictly by the net revenue size of the facility. The other responses included:

- *The areas that are considered general overhead at the corporate level are charged to the regions/facilities through a general management fee. This general management fee is based on a standard percentage that is then applied against the entity's monthly Operating Expenses (Total GAAP Expenses less Rents, Depreciation and Interest).*
- *By audited expenses of the facility proportional to the audited expenses of the System*
- *Allocation of Fixed Costs – Non-I/T costs are categorized into four groups (i.e. Finance, HR, Plng/Mrktg/PR and Other).*
- *Depending on the function it could be by net revenue, controllable costs, or FTE*
- *Direct costs are absorbed by each department. Indirect costs are generally allocated according to CMS Cost Report Guidelines. HR costs are allocated based on full time equivalents.*
- *In general we allocate cost for these functions in the following way: Executive Administration = Total Expense, Legal = Total Expense, Accounting = Total expense, Payroll = FTE, AP = # of transactions processed, Financial Planning = Total Expense, Managed Care = Revenue, HR = FTE, Marketing based on direct use, Facilities = based on the shared service tenants and their allocations, Supply Chain = non-labor expense procured by them*
- *various unit of service metrics based on workload factor by service area*
- *Based on $ of direct expenses of the operating units proportionate to direct costs of all the operating units.*
- *Formula that allocates expenses based on 3 entity measures; EBIDA, Average Capital Spend and CMI adjusted FTE per AOB.*
- *Fixed costs are allocated differently depending on the department being allocated. Methodologies used include, but are not limited to, Subtotal Expense (Total Expense less depreciation), Total FTEs or Net Revenue.*
- *We allocate each function individually to align the allocations with the cost drivers. Allocation statistics include Revenue, headcount, or # of invoices processed, among others*
- *By operating expense of the facility proportional to operating expense of the system*
- *Presently we maintain a Corporate Division and all such costs are recorded in that Division. For certain programs that benefit from overhead charges, we develop an overhead percentage that is used.*
- *We use multiple measures depending on type of cost and appropriate driver*
- *FTE's for HR related costs, Total Expense for administration*
- *Some are allocated on budgeted expenses or budgeted revenue and others on # of FTEs. We always attempt to allocate based on the most rational metric.*
- *Per APD*
- *No allocation*

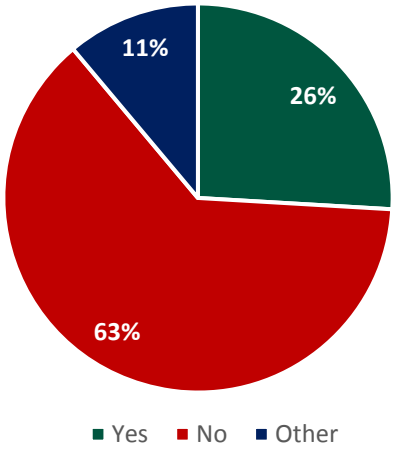
3. How do you allocate costs of centralized patient billing functions?



When asked about allocating the costs of centralized patient billing functions, only one system reported that they allocate costs on a cash collection basis. 19% (5 health systems) of respondents allocate costs on a claims basis, while slightly over a quarter of respondents (7 health systems) allocate based on net revenue. Slightly over half of the respondents have their own method for allocating the costs of their centralized patient billing functions:

- *For the most part, the allocation is based upon billed claims, but there are indirect expenses (retirement, health, etc.) that are allocated on a per FTE basis. In addition to these charges, there are some expenses that are paid directly by a hospital's business office cost center vs. the CBO.*
- *Allocation of Centralized Billing Functions – This activity is currently transitioning from a decentralized hospital based function to a centralized function. At this time we are using the relationship of a hospital's historical billing expenses as a percent of total historical billing expenses to allocate these costs. Note – this function is not included in Corporate.*
- *Centralized Patient Billing costs are allocated to departments based on Gross Patient Charges.*
- *Based on $ of direct expenses of the operating units proportionate to direct costs of all the operating units.*
- *We do not have a system CBO function*
- *Billing we allocate on Admits, collection we allocate on cash collected.*
- *Various statistics are used to allocate including payer volumes and inpatient or outpatient registration. In some cases, we are able to directly allocate time based on what facilities the staff are supporting*
- *We maintain separate hospital and physician billing departments. The costs are all borne by these departments and not allocated out to hospital operations. The physician practices incur a standard billing fee meant to cover the costs of the physician billing department.*
- *Adjusted patient days for hospital billing - physician revenue for physician billing*
- *Patient billing cost centers are allocated using a combination of # of claims, FTE per entity, % of calls per entity, % of registration errors*
- *In transition from historic decentralized cost plus inflation, to a combined approach like IT*
- *Per APD*

4. Is there a difference in how you allocate costs based on the type of facility?



The majority of respondents (19 health systems) indicate that there is no difference in how costs are allocated based upon the types of facilities in their system. The other 30% of respondents (7 health systems) treat their various types of facilities differently when it comes to allocating costs.

Yes

- *Allocation of Costs for non-acute Facilities - With the exception of HR, non-acute facilities, including medical groups, are directly charged their site specific costs by function. In the case of HR, the methodology described above is utilized for all facilities that have a headcount greater than 50. No HR costs are allocated to the facilities that have a headcount less than 50.*
- *We have a 2 corporate functions our main corporate office and a secondary ambulatory corporate function. For the main corporate function it is allocated to all facilities, the ambulatory allocations are in addition to our main corporate allocation and only affect the ambulatory facilities.*
- *Acutes are the same. Flat percent for ambulatory. different methodology*
- *We use actual direct costs for fees to non-hospital affiliates*
- *We allocate to our Home Care entity slightly different than we do the hospitals. The others are all treated the same.*
- *Larger entities take a larger allocation*
- *Shared billing services are allocated on the basis of adjusted patient days. The driver is adjusted to reduce allocations to sites with Long-term Care units.*
- *Only difference is our hospital EMR is not allocated to clinics nor homecare*

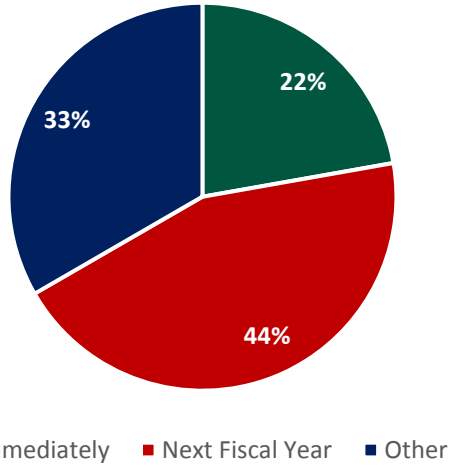
No

- *All entities are allocated consistently based on % of Total Revenue with one major exception - we are a non-profit organization. The only major exception to our allocation methodology is with our for-profit joint ventures. For those entities we calculate, by service provided, the budgeted cost of the services and allocate that cost accordingly. The allocation could be based on FTEs, number of invoices processed (Accounts Payable), number of timecards processed (Payroll) or other factors depending on the type of service.*
- *Not currently, but thinking about separating. Hospitals get proportionately more support.*
- *All costs are allocated the same way by facility; however, our allocation in done in aggregate at the entity level, this includes the outpatient and inpatient units of that entity*

Other

- *Only difference is our hospital EMR is not allocated to clinics nor homecare*
- *No, unless we have JV partners*
- *All generally based on net revenue*
- *We allocate to our Home Care entity slightly different than we do the hospitals. The others are all treated the same.*

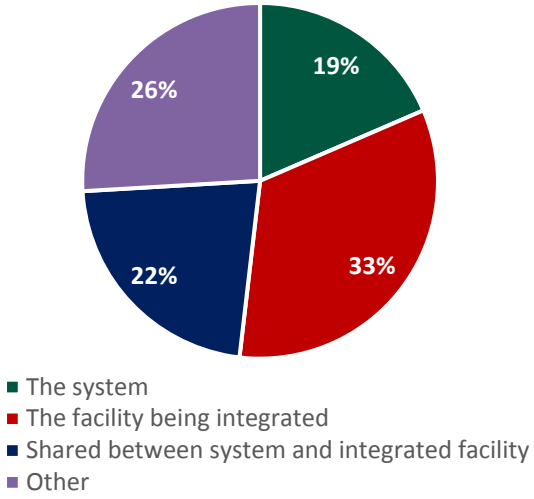
5. When does your system implement your cost allocation methodology after you acquire a facility?



22% of respondents (6 health systems) immediately implement their cost allocation methodology after acquiring a new facility, while 44% (12 health systems) wait until the following fiscal year to implement it. The other third either hadn't acquired a facility recently enough to say, or typically handled it on a site to site basis.

- *Implementation of Cost Allocation Methodology - This is handled on a site by site basis. Allocations are transitioned based on functions being phased out at the site and included in corporate costs.*
- *Depends on the timing of the purchase, generally once we have established the budget we don't go back to modify the allocations.*
- *First budget year following acquisition*
- *We haven't acquired a facility in the recent past but when we build a new facility we start allocating immediately.*
- *We are currently assessing this approach due to an acquisition in November 2013*
- *6 month anniversary of acquisition*

6. As you integrate a new facility into your system, who pays for the costs incurred as part of integration?



When it comes to allocating integration costs for new facilities. 19% of respondents (5 health systems) said the health system pays for the integration costs. A third of respondents (9 health systems) said the acquired facility usually accepts the costs, while 22% (6 health systems) said costs are normally shared between the system and the integrated facility. About a quarter of respondents (7 health systems) had their own methodologies for allocating the costs, most of which depended upon the negotiated terms of the merger or acquisition.

Facility

- *The payment of integration costs are paid for by the integrated facility (as it relates to expenses incurred after the merger).*
- *To the extent there are specific one-time costs that are material and can be identified. Otherwise, no change to allocation methodology above.*
- *Costs incurred prior to the closing of the acquisition were borne by the Acquiring entity. However, once the acquisition was consummated, the new operating entities are being charged for their actual IT costs.*

Shared

- *Each situation is evaluated individually. Capital and training costs are usually borne by the new facility. We do not allocate costs of existing staff for the integration process*
- *If the cost is specific to the facility it is allocated to the facility, however if it is a corporate function it is captured and allocated based upon the allocation methodology.*
- *IT capital costs are funded by the system. Training costs are borne by the integrated facility.*
- *Corporate pays for trainer costs and facility pays for the trainee costs*
- *No consistent method – we establish guidelines for each deal*
- *The facility bears all training costs and cash funds the capital costs. Any ongoing incremental costs (depreciation on capital, additional licensing costs, etc.) are allocated based on net revenue to all system members*

Other

- *Integration Costs Responsibility – determination of party responsible for funding these costs is negotiated as part of the merger or acquisition.*
- *Generally, the corporate office would hold those costs but it is dependent on the transaction and how it was built into the budget. It could be shared with the new entity.*
- *Direct costs are absorbed by each integrated facility.*
- *The main campus facility incurs most of this cost during the first year*
- *The business unit integrating the facility pays for integration.*
- *Each addition has varied*

Appendix A. - List of Participating Health Systems

Adventist Health
Adventist Health System
Advocate Health Care
Ascension Health
Aurora Health Care
Banner Health
Christiana Care Health System
CHRISTUS Health
Cleveland Clinic
Fairview Health Services
Hawaii Pacific Health
Hospital Sisters Health System
Intermountain Healthcare
MedStar Health
MemorialCare Health System
Montefiore Medical Center
New York Presbyterian
North Shore-Long Island Jewish Health System
Novant Health
SCL Health System
Sharp HealthCare
SSM Health Care
Tenet Healthcare Corporation
Texas Health Resources
UnityPoint Health
University of Michigan Health System
Virtua

