Australian Government

Department of Health and Ageing

Australian Hospital Patient Costing Standards

Version 2.0 – 1 March 2011

ISBN: 978-1-74241-292-4

Online ISBN: 978-1-74241-293-1

Publication Number P3-6849

Paper-based publications

Internet sites

Disclaimer

These standards are presented by the Commonwealth Department of Health and Ageing for the purposes of disseminating health information free of charge for the benefit of the public. The Department cannot guarantee and assumes no legal responsibility for the accuracy, currency or completeness of the standards.

Contents

Foreward

The Australian Hospital Patient Costing Documentation consists of four modules, namely:

- Australian Hospital Patient Costing Standards
- Australian Hospital Patient Costing Quality Framework
- Australian Hospital Patient Costing Methodology
- Australian Hospital Patient Costing Technical Manual

While the modules can be accessed separately, users are advised to refer to all four modules to obtain a comprehensive understanding of contemporary patient costing activity in Australia.

About the Standards

Introduction

The National Hospital Cost Data Collection (NHCDC) has been producing national hospital costing results since 1995-96 as a voluntary collection. On 29 November 2008, the Council of Australian Governments (COAG) agreed to a National Partnership Agreement on Hospital and Health Workforce Reform[1] (the National Partnership) involving $1.383 billion in Commonwealth payments to states and territories to improve efficiency and capacity in public hospitals through four key reform components, one of which is the development of a nationally consistent approach to Activity Based Funding. The Activity Based Funding component of the National Partnership Agreement formalises the 26 March 2008 COAG commitment *"for jurisdictions, as appropriate, to move to a more nationally consistent approach to activity-based funding for services provided in public hospitals – but one which also reflects the Community Service Obligations required for the maintenance of small and regional hospital services"* and is the instrument by which the commitment will be put into effect.

Under the National Partnership Agreement, all jurisdictions are committed to:

- The development and implementation of patient classification and costing methodologies to enable activity based costing of public hospital services
- The development and implementation of funding strategies for training, research and development and other activities not directly related to the treatment of individual patients, and the establishment of a common public and private funding framework for teaching and research
- The development of an activity based funding methodology, including for setting price, incentives and transition arrangements, and to the implementation of these methodologies, should COAG agree to their implementation

All jurisdictions agreed to the costing model being built on the National Hospital Cost Data Collection.

For the private sector the NHCDC is the main vehicle by which relativities are developed to inform negotiations between private hospitals and health insurers. These standards will impact on the results of the NHCDC in the private sector, recognising that to date the majority of private hospitals are costed using nationally derived service weights.

The task of developing nationally consistent costing standards was delegated to the NHCDC Technical Working Group by the National Partnership Agreement Implementation Steering Committee and builds on the existing NHCDC standards. However, this task has a broader application than just the NHCDC and has therefore drawn on a wide range of sources for the methodological content rather than focussing on reporting requirements. Many of the standards relevant to patient costing systems did not previously exist within the NHCDC, and some of the existing NHCDC standards will need to be modified to align with these standards.

This document only considers the most technically correct standards and does not consider implementation issues. These will be specific to individual hospitals and jurisdictions and it is not expected that compliance with these standards will occur overnight, or at no cost. However, $133 million funding has been provided under the National Partnership Agreement to jurisdictions to enable changes to be made over an agreed period of time.

[1] National Partnership Agreement on Hospital and Health Workforce Reform, 2008

The National Health and Hospitals Network (NHHN) Agreement accelerated the timetable for the movement to activity based funding to July 2011 for state specific prices and July 2012 for the move to a national efficient price, set by a new independent body, the Independent Hospital Pricing Authority (IHPA).

Under the NHR, the Commonwealth moves away from becoming the majority funder of health services (except primary health) in Australia, and instead agrees to continue its committed base line funding for health as agreed under the Intergovernmental Agreement on Federal Financial Relations and the National Healthcare Agreement. In addition, the Commonwealth will increase its contribution to efficient growth funding to 50 per cent of additional health expenditure by 2017. The agreement also includes the establishment a national funding pool for the disbursement of health funding to Local Hospital Networks.

Comments on the standards are welcome. These can be provided through your current NHCDC jurisdictional Co-ordinator.

Hospital patient costing standards

In simple terms hospital patient costing is the process of identifying the inputs used in a hospital and applying the costs of those inputs to the delivery of patient care i.e. the outputs. In practice this is not a simple process and requires expertise in identifying inputs and outputs, guidance for allocating the costs, and considerable complex numerical processing.

This document aims to provide direction for hospital patient costing through the development and publication of standards for specific elements of the costing process and reporting requirements.

The Australian Hospital Patient Costing Standards are designed to underpin the consistent costing of Australian hospital activity.

Purpose and intended audience

These standards are for anyone conducting national costing activities. The standards are to provide the framework for regulators, funders, providers and researchers about the consistency of the cost data collection.

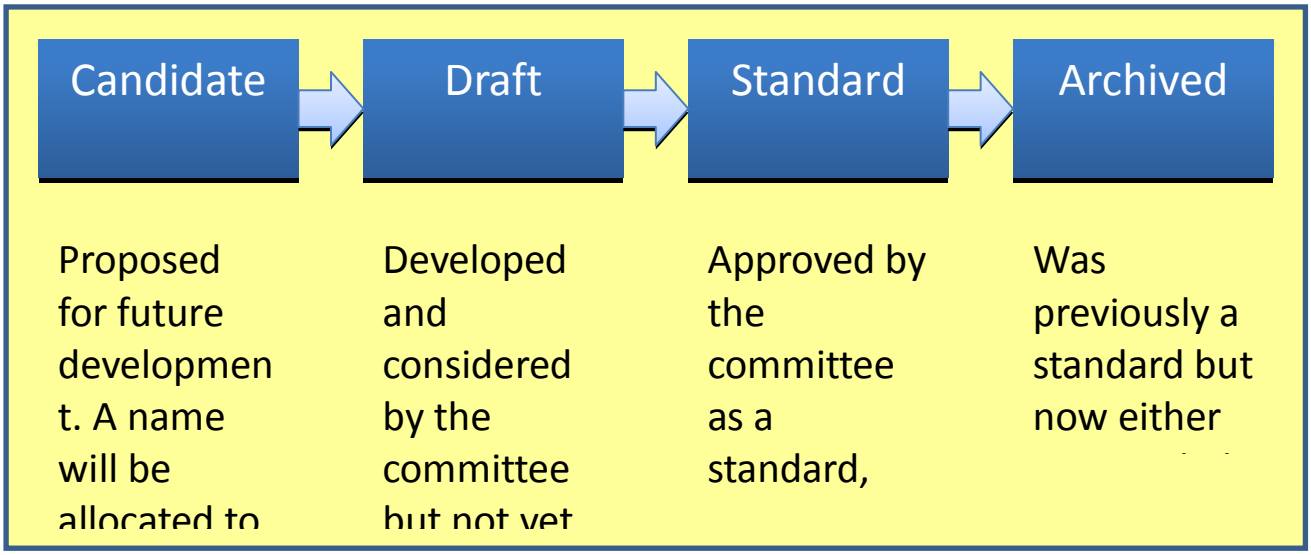
This standards document specifies standards for conducting patient costing activities in Australian hospitals which will ensure consistency with national costing activities, including (but not limited to):

- National Hospital Cost Data Collection (NHCDC) (including both the annual collection and service weight studies)
- Classification development work
- Other work that informs Activity Based Funding

It is important that costing data conforms to the costing standards outlined in this document to meet the COAG requirement for national consistency. This will also allow any relevant cost studies to consistently and reliably reflect the changes in hospital output prices and clinical practice in public and private sectors.

These standards are the intellectual property of the Commonwealth of Australia, however organisations and individuals are encouraged to adopt them in their own costing processes.

The diagram below provides the Australian Hospital Patient Costing Standards life cycle:



In the candidate phase a standard may have only minimal fields e.g. name and intended purpose / applicability. Candidate standards are designed to inform users that an area is under consideration and/or development towards the production of a standard. In order to become a draft standard all mandatory fields will need to be filled. A draft standard may be used for testing prior to being approved as a standard.

Standards governance committee structure and membership

The NHCDC Technical Working Group (TWG) will have the decision-making power to recommend new and revised standards to their higher-level committees.
Secretariat support for the committee will be provided by the Department of Health and Ageing. This support will include administrative arrangements including:

- formation of the committee, arrangements for meetings, agenda, minutes and related correspondence;
- coordination and circulation of papers for proposed new standards and proposed revisions;
- management of the standards and their versions, including publication and printing where required;
- prepare and distribute agendas and minutes of meetings.
- establishment and maintenance of a website for the standards, including on-line access to the standards and required education, training and support materials.

Secretariat support costs will be met by the Department of Health and Ageing. Members of the TWG will be responsible for their own travel and associated costs to attend committee meetings.

A minimum of three dedicated face-to-face meetings of the TWG are proposed in each financial year for standards development:

- First standards meeting – to set priorities for new standards and required revision for the next collection round (accept and consider submissions). This meeting should identify and initiate the work required for these standards, including the consultation and discussion required. After this meeting candidate standards may be published via the standards website.
- Second standards meeting – review of draft or proposed standards and changes to standards. This meeting will give participants advanced notice of the proposed revised content. After this meeting draft standards may be published via the standards website.

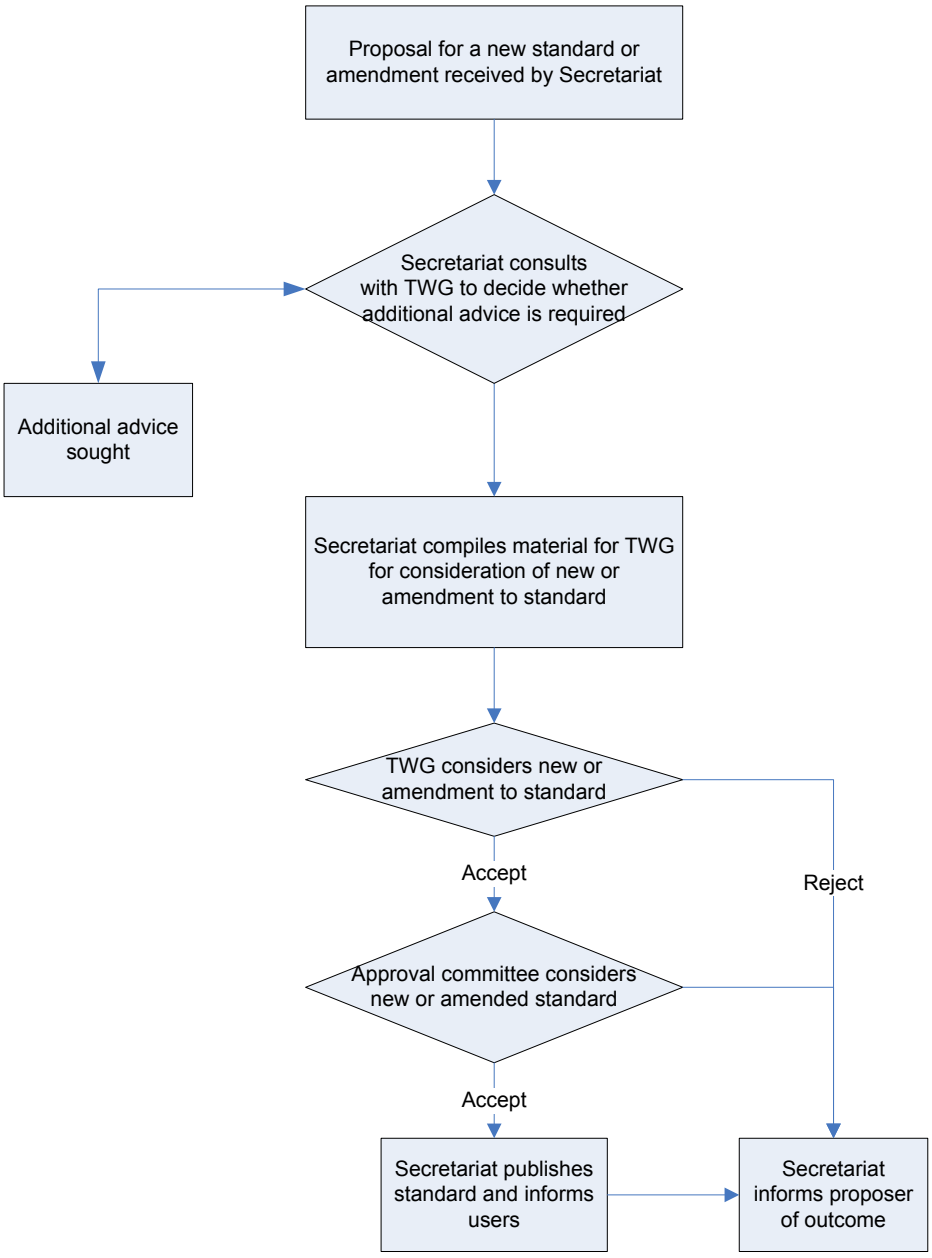
- Third standards meeting – to consider the final versions of proposed standards and changes to standards.

Standards may be considered at additional meetings throughout the year as appropriate.

Timing of implementation of changes to the standards will be determined by the TWG after consideration of the impact of the standard on hospital costing processes.

Standards development process

The diagram below shows the development process for a new standard or amendments to existing standards.



Australian Hospital Patient Costing Standards

Standards description

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

Number	See Below
Name	Title of Standard
Status	Candidate/ Draft / Approved / Archived
Effective Date	The date from which the standard must be applied (only approved standards)
Revised Date	Last date considered by Technical Working Group
Applicability	All hospitals/ public/ private/ acute/ specialist hospital
Principle	The fundamental issue which the standard is addressing
Standard	The standard which is to be met. A standard may incorporate one or more levels of the standard, with an explanation of the hierarchy of these levels e.g. Gold, Silver, Bronze where the aim is to work towards the Gold standard.
Definitions	An explanation of terms in the standard which need to be defined
Guidelines	Advice and assistance for implementation of the standard
Related Standards	Cross reference to other applicable standards
Reference Documents	Cross reference to modules within the Australian Hospital Patient Costing Documentation
Sources	Reference to the source of definitions, classification systems or other material used in the description of the standard

Standard Numbering

Standards will be numbered with an alpha prefix as set out below:
SCP – Scope
GL – General Ledger
FDR – Feeder system
COST – Costing process
DEP – Depreciation
REP – Reporting

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

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

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

Version Numbering

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

Master List

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

SCP 1.003 – Scope of Hospital Activity
SCP 2.002 – Expenditure in Scope
SCP 2A.002 – Teaching Costs
SCP 2B.001 – Research Costs
GL 1.002 – Accrual Accounting
GL 2.003 – Account Code Mapping to Line Items
GL 4.003 – Cost Centre Mapping
GL 4A.001 – Critical Care Definition
GL 4B.002 – Emergency Department Definition
GL 4C.001 – Operating Room Definition
GL 5.001 – Matching Activity and Cost
GL 5A.001 – Matching Activity and Cost – Overhead Cost Allocation
GL 5B.001 – Matching Activity and Cost – Non Patient Products
GL 5C.001 – Matching Activity and Cost – Commercial Business Entities
GL 5D.001 – Matching Activity and Cost – Negative Costs
GL 5E.001 – Matching Activity and Cost – Expenditure Offsets
COST 1.001 – Overhead Allocation Method
COST 1A.001 – Overhead Allocation – Hotel Services
COST 1B.001 – Overhead Allocation – Overhead Depreciation Costs
COST 2.003 – Overhead Allocation Statistics
COST 3.003 – Final Cost Allocation
COST 4.001 – Costing Frequency
COST 5.001 – Accumulating Patient Costs
COST 5A.001 – Order Request Point
COST 5B001 – Encounter Matching Method
DEP 1.001 – Capital Expenditure

DEP 1A.001 – Asset Recognition
DEP 1B.001 – Revaluation of Assets
DEP 1C.001 – Useful Life
DEP 1D.001 – Classes of Assets
DEP 1E.001 – Allocation of Depreciation and Amortisation
FDR 2.002 – Relative Value Units
REP 1.002 – Reporting of Patient Costs

Archive History of the Standards

The following tables provide an overview of changes to the standards between Versions 1 and 2.

Table 1: Changes from Version 1

No	Previous Standard	Changes and Date	Comment
1	GL 3.001 and GL 3A.001	Merged into GL 5.001 (February 2011)	"Specific Adjustments" and "Specific Adjustments Matching Activity and Cost" combined into "Matching Activity and Cost"
2	GL 3B.001	Moved to GL 5C.001 (February 2011)	"Specific Adjustments – Commercial Business Entities" was replaced "Matching Activity and Cost – Commercial Business Entities"
3	GL 3C.001	Moved to GL 5D.001 (February 2011)	"Specific Adjustments – Negative Costs" was replaced "Matching Activity and Cost – Negative Costs"
4	GL 3D.001	Moved to GL 5E.001 (February 2011)	"Specific Adjustments – Expenditure Offsets" was replaced "Matching Activity and Cost – Expenditure Offsets"
5	FDR1.001 and QA 2.001	Merged into COST 5B.001 (February 2011)	"Encounter Matching Method" and "Encounter Matching Validation" combined into "Encounter Matching Method"
6	QA1.001	Deleted (February 2011)	Incorporated into Quality Framework Tool
7	SCP 1.003	Outpatient Tiers 1 and 2 updated (February 2011)	Outpatient lists updated to reflect more clinics
8	SCP 1A.003	Guideline moved into COST 5.001 and the remaining parts of the standard were deleted (February 2011)	Guidelines incorporated into "Accumulating Patient Costs"

Table 2: Addition to Version 2

No	New Standard	Title	Comment
1	GL 5A.001	"Matching Activity and Cost – Overhead Cost Allocation"	New standard around order of distribution of overheads.
2	GL 5B.001	"Matching Activity and Cost – Non Patient Products"	Addresses extent to which full costs are being recognised in costing results.
3	COST 1A.001	"Overhead Allocation – Hotel Services"	
4	COST 1B.001	"Overhead Allocation – Overhead Depreciation Costs"	
5	COST 4.001	"Costing Frequency"	
6	COST 5.001	"Accumulating Patient Cost"	
7	COST 5A.001	"Order Request Point"	
8	DEP 1.001	"Capital Expenditure"	Copied directly from KPMG consultancy
9	DEP 1A.001	"Asset Recognition"	Copied directly from KPMG consultancy
10	DEP 1B.001	"Revaluation of Assets"	Copied directly from KPMG consultancy
11	DEP 1C.001	"Useful Life"	Copied directly from KPMG consultancy
12	DEP 1D.001	"Classes of Assets"	Copied directly from KPMG consultancy
13	DEP 1E.001	"Allocation of Depreciation and Amortisation"	Copied directly from KPMG consultancy

SCP 1.003 – Scope of Hospital Activity

Number	SCP 1.003
Name	Scope of Hospital Activity
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	February 2011
Applicability	All Hospitals
Principle	All hospital auspiced services and all patient types are to be included in the costing process.
Standard	Hospitals will allocate costs to all hospital outputs as listed below: • Admitted patients by care type; • Emergency Department; • Non-admitted patients; • Hospital auspiced community health; and • Teaching and research. For the purpose of costing, all mental health activity within an acute campus (irrespective of the duration of care in a mental health unit), should be included in the relevant output regardless of whether this occurs in a designated mental health ward or unit.
Definitions	The overall nature of a clinical service provided to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or posthumous organ procurement (other care), as represented by a code. (METeOR website) Persons with mental illness may receive any one of the care types (except newborn and organ procurement). Classification depends on the principal clinical intent of the care received. Admitted care can be one of the following: CODE 1.0 Acute care (Admitted care) Acute care is care in which the clinical intent or treatment goal is to: • manage labour (obstetric); • cure illness or provide definitive treatment of injury; • perform surgery; • relieve symptoms of illness or injury (excluding palliative care); • reduce severity of an illness or injury; • protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function; or • perform diagnostic or therapeutic procedures. CODE 2.0 Rehabilitation care (Admitted care) Rehabilitation care is care in which the clinical intent or treatment goal is to improve the functional status of a patient with an impairment, disability or handicap. It is usually evidenced by a multi-disciplinary rehabilitation plan comprising negotiated goals and indicative time frames which are evaluated by a periodic assessment using a recognised functional assessment measure. It includes care provided: • in a designated rehabilitation unit (code 2.1), or

	• in a designated rehabilitation program, or in a psychiatric rehabilitation program as designated by the state health authority for public patients in a recognised hospital, for private patients in a public or private hospital as approved by a registered health benefits organisation (code 2.2), or • under the principal clinical management of a rehabilitation physician or, in the opinion of the treating doctor, when the principal clinical intent of care is rehabilitation (code 2.3). Optional: CODE 2.1 Rehabilitation care delivered in a designated unit (optional) A designated rehabilitation care unit is a dedicated ward or unit (and can be a stand-alone unit) that receives identified funding for rehabilitation care and/or primarily delivers rehabilitation care. CODE 2.2 Rehabilitation care according to a designated program (optional). In a designated rehabilitation care program, care is delivered by a specialised team of staff who provide rehabilitation care to patients in beds that may or may not be dedicated to rehabilitation care. The program may, or may not be funded through identified rehabilitation care funding. Code 2.1 should be used instead of code 2.2 if care is being delivered in a designated rehabilitation care program and a designated rehabilitation care unit. CODE 2.3 Rehabilitation care is the principal clinical intent (optional) Rehabilitation as principal clinical intent (code 2.3) occurs when the patient is primarily managed by a medical practitioner who is a specialist in rehabilitation care or when, in the opinion of rehabilitation care even if the doctor is not a rehabilitation care specialist. The exception to this is when the medical practitioner is providing care within a designated unit or a designated program, in which case code 2.1 or 2.2 should be used, respectively. CODE 3.0 Palliative care Palliative care is care in which the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive disease with little or no prospect of cure. It is usually evidenced by an interdisciplinary assessment and/or management of the physical, psychological, emotional and spiritual needs of the patient; and a grief and bereavement support service for the patient and their carers/family. It includes care provided: • in a palliative care unit (code 3.1); or • in a designated palliative care program (code 3.2); or • under the principal clinical management of a palliative care physician or, in the opinion of the treating doctor, when the principal clinical intent of care is palliation (code 3.3). Optional: CODE 3.1 Palliative care delivered in a designated unit (optional) A designated palliative care unit is a dedicated ward or unit (and can

	be a stand-alone unit) that receives identified funding for palliative care and/or primarily delivers palliative care. CODE 3.2 Palliative care according to a designated program (optional) In a designated palliative care program, care is delivered by a specialised team of staff who provide palliative care to patients in beds that may or may not be dedicated to palliative care. The program may, or may not be funded through identified palliative care funding. Code 3.1 should be used instead of code 3.2 if care is being delivered in a designated palliative care program and a designated palliative care unit. CODE 3.3 Palliative care is the principal clinical intent (optional) Palliative care as principal clinical intent occurs when the patient is primarily managed by a medical practitioner who is a specialist in palliative care or when, in the opinion of the treating medical practitioner, the care provided is palliative care even if the doctor is not a palliative care specialist. The exception to this is when the medical practitioner is providing care within a designated unit or a designated program, in which case code 3.1 or 3.2 should be used, respectively. For example, code 3.3 would apply to a patient dying of cancer who was being treated in a geriatric ward without specialist input by palliative care staff. CODE 4.0 Geriatric evaluation and management Geriatric evaluation and management is care in which the clinical intent or treatment goal is to maximise health status and/or optimise the living arrangements for a patient with multi-dimensional medical conditions associated with disabilities and psychosocial problems, who is usually (but not always) an older patient. This may also include younger adults with clinical conditions generally associated with old age. This care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative timeframes. Geriatric evaluation and management includes care provided: in a geriatric evaluation and management unit; or • in a designated geriatric evaluation and management program; or • under the principal clinical management of a geriatric evaluation and management physician or, • in the opinion of the treating doctor, when the principal clinical intent of care is geriatric evaluation and management. CODE 5.0 Psychogeriatric care Psychogeriatric care is care in which the clinical intent or treatment goal is improvement in health, modification of symptoms and enhancement in function, behaviour and/or quality of life for a patient with an age-related organic brain impairment with significant behavioural or late onset psychiatric disturbance or a physical condition accompanied by severe psychiatric or behavioural disturbance. The care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative timeframes. It includes care provided:

- in a psychogeriatic care unit;
- in a designated psychogeriatic care program; or
- under the principal clinical management of a psychogeriatic physician or,
- in the opinion of the treating doctor, when the principal clinical intent of care is psychogeriatic care.

CODE 6.0 Maintenance care
Maintenance care is care in which the clinical intent or treatment goal is prevention of deterioration in the functional and current health status of a patient with a disability or severe level of functional impairment. Following assessment or treatment the patient does not require further complex assessment or stabilisation, and requires care over an indefinite period. This care includes that provided to a patient who would normally receive care in another setting eg at home, or in a residential aged care service, by a relative or carer, that is unavailable in the short term.

CODE 7.0 Newborn care
Newborn care is initiated when the patient is born in hospital or is nine days old or less at the time of admission. Newborn care continues until the care type changes or the patient is separated:

- patients who turn 10 days of age and do not require clinical care are separated and, if they remain in the hospital, are designated as boarders;
- patients who turn 10 days of age and require clinical care continue in a newborn episode of care until separated;
- patients aged less than 10 days and not admitted at birth (eg transferred from another hospital) are admitted with

newborn care type;

- patients aged greater than 9 days not previously admitted (eg transferred from another hospital) are either boarders or admitted with an acute care type;
- within a newborn episode of care, until the baby turns 10 days of age, each day is either a qualified or unqualified day;
- a newborn is qualified when it meets at least one of the criteria detailed in Newborn qualification status.

Within a newborn episode of care, each day after the baby turns 10 days of age is counted as a qualified patient day. Newborn qualified days are equivalent to acute days and may be denoted as such.

CODE 8.0 Other admitted patient care
Other admitted patient care is care where the principal clinical intent does meet the criteria for any of the above. Other care can be one of the following:

CODE 9.0 Organ procurement - posthumous (Other care)
Organ procurement - posthumous is the procurement of human tissue for the purpose of transplantation from a donor who has been declared brain dead. Diagnoses and procedures undertaken during this activity, including mechanical ventilation and tissue procurement, should be recorded in accordance with the relevant ICD-10-AM Australian Coding Standards. These patients are not admitted to the hospital but are registered by the hospital.
CODE 10.0 Hospital boarder (Other care)

<table>
<tr><td></td><td>Hospital boarder is a person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care. Hospital boarders are not admitted to the hospital. However, a hospital may register a boarder. Babies in hospital at age 9 days of less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified.

Comments: Unqualified newborn days (and separations consisting entirely of unqualified newborn days are not to be counted under the Australian Health Care Agreements and they are ineligible for health insurance benefit purposes.</td></tr>
<tr><td>Guidelines</td><td>Admitted Care Types are described in the NMDS and are set out below:

1.0 Acute care (Admitted care)
2.0 Rehabilitation care (Admitted care)
2.1 Rehabilitation care delivered in a designated unit (optional)
2.2 Rehabilitation care according to a designated program (optional)
2.3 Rehabilitation care is the principal clinical intent (optional)
3.0 Palliative care
3.1 Palliative care delivered in a designated unit (optional)
3.2 Palliative care according to a designated program (optional)
3.3 Palliative care is the principal clinical intent (optional)
4.0 Geriatric evaluation and management
5.0 Psychogeriatric care
6.0 Maintenance care
7.0 Newborn care
8.0 Other admitted patient care
9.0 Organ procurement - posthumous (Other care)
10.0 Hospital boarder (Other care)

ED Triage Categories

ED Product type Admitted NonAdmitted
Triage Category 1 EDAdm1 EDDC1
Triage Category 2 EDAdm2 EDDC2
Triage Category 3 EDAdm3 EDDC3
Triage Category 4 EDAdm4 EDDC4
Triage Category 5 EDAdm5 EDDC5

ED Did Not Wait EDDNW

Outpatient Clinics
Outpatient clinics are defined according to the following list:

<table>
<tr><th colspan="2">Tier 1 Clinics</th></tr>
<tr><td>10.00 Allied Health &/or Clinical Nurse Specialist</td><td>60.00 Paediatrics</td></tr>
<tr><td>20.00 Dental</td><td>70.00 Pharmacy</td></tr>
<tr><td>30.00 Diagnostic</td><td>80.00 Procedural</td></tr>
<tr><td>40.00 Medical</td><td>90.00 Psychiatric</td></tr>
<tr><td>50.00 Obstetrics and Gynaecology</td><td>100.00 Surgical</td></tr>
<tr><td colspan="2"></td></tr>
</table>
</td></tr>
</table>

Tier 2 Clinics	
10.00. Allied Health and/or Clinical Nurse Specialist	
10.01. Audiology	10.10. Physiotherapy
10.02. Diabetes education	10.11. Podiatry
10.03. Midwifery	10.12. Prosthetics
10.04. Neuropsychology	10.13. Psychology
10.05. Nutrition / dietetics	10.14. Social work
10.06. Occupational therapy	10.15. Speech pathology
10.07. Optometry	10.16. Stomal therapy
10.08. Orthoptics	10.17. Wound management
10.09. Orthotics	
20.00. Dental	
20.01. Dental	
30.00. Diagnostic	
30.01. Clinical Measurement	30.04. Nuclear Medicine
30.02. General Imaging	30.05. Pathology (Micro, Haem, Biochem)
30.03. Medical Resonance Imaging (MRI) / Computerised Tomography (CT)	30.06. Positron Emission Tomography (PET)
40.00. Medical	
40.01. Aged Care	40.23. Immunology
40.02. Alcohol and other drug	40.24. Infectious diseases
40.03. Allergy	40.25. Medical oncology (Consultation)
40.04. Anti-coagulant	40.26. Metabolic bone
40.05. Asthma	40.27. Nephrology
40.06. Cardiology	40.28. Neurology
40.07. Cardiac Rehabilitation	40.29. Occupational medicine
40.08. Chronic Obstructive Pulmonary Disease	40.30. Pacemaker
40.09. Dementia	40.31. Pain management
40.10. Dermatology	40.32. Palliative care
40.11. Developmental disabilities	40.33. Pulmonary
40.12. Diabetes	40.34. Radiation oncology (Consultation)
40.13. Endocrine	40.35. Refugee Clinic
40.14. Epilepsy	40.36. Rehabilitation
40.15. Falls	40.37. Renal Medicine (pre and post transplant treatment, support and education)
40.16. Gastroenterology	40.38. Respiratory
40.17. General internal medicine	40.39. Respiratory – Cystic Fibrosis
40.18. General Practice/ Primary Care	40.40. Rheumatology
40.19. Genetic	40.41. Sex Health
40.20. Haematology	40.42. Spinal
40.21. Hepatobiliary	40.43. Stroke
40.22. Hypertension	

50.00. Obstetrics and Gynaecology	
50.01. Assisted Reproductive Technology	50.05. Gynaecology oncology
50.02. Childbirth Education	50.06. Obstetrics
50.03. Family planning	50.07. Urology-Gynaecology
50.04. Gynaecology	
60.00. Paediatrics	
60.01. Adolescent health	60.03. Paediatric medicine
60.02. Neonatal	60.04. Paediatric surgery
70.00. Pharmacy	
70.01. Pharmacy	
80.00. Procedural	
80.01. Colorectal	80.06. Haemodialysis
80.02. Endoscopy	80.07. Interventional Imaging
80.03. Epilepsy	80.08. Medical Oncology (Treatment)
80.04. Gastroscopy	80.09. Peritoneal Dialysis
80.05. Hyperbaric Medicine	80.10. Radiation Oncology (Treatment)
90.00. Psychiatry	
90.01. Psychiatry	
100.00. Surgical	
100.01. Breast	100.11. Neurosurgery
100.02. Burns	100.12. Ophthalmology
100.03. Cardiac surgery	100.13. Orthopaedics
100.04. Colorectal	100.14. Plastic surgery
100.05. Craniofacial	100.15. Pre-admission
100.06. Ear, nose and throat	100.16. Pre-anaesthesia
100.07. Foetal Surgery and investigations	100.17. Thoracic surgery
100.08. Fracture	100.18. Transplants
100.09. General surgery	100.19. Urology
100.10. Hepatobiliary	100.20. Vascular surgery

Related Standards	Nil
Reference Documents	
Sources	National Minimum Data Sets; NHCDC Hospital Reference Manual

SCP 2.002 – Expenditure in Scope

Number	SCP 2.002
Name	Expenditure in Scope
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	June 2010
Applicability	All hospitals
Principle	Ensure all expenditure related to hospital activity is included.
Standard	Include all expenditure incurred by or on behalf of the hospital related to day to day delivery of services.
Definitions	This includes all operating gross expenditure.
Guidelines	Those costs that are managed outside the hospital but are part of the day to day delivery of services should be included in the costing process. Those costs that are involved in long term or strategic development of hospital services should not be included in the costing process. Types of expenditure to be included (in addition to the standard line items): • Ambulance and patient transport (incurred by the hospital) • Area Health Services (as relevant) • Blood products • Centralised data reporting to hospitals • Hospital management • Insurance – building insurance • Insurance – equipment • Insurance – medical indemnity • Insurance – workcover • Organ and tissue donation for transplantation and retrieval • Shared services, human resources, payroll, finance, procurement unit, information and technology Note that some of these costs may appear under Corporate Office cost centres in the general ledger and will need to be allocated to the hospital level. The methodology by which this allocation is made needs to be justifiable and documented. Types of expenditure to be excluded (to the extent that they are not involved in day to day delivery of services) include: • Aerial retrieval and Royal Flying Doctors Services • Capital planning • Centralised data services (State and Territory health departments) • Chief medical officer (State and Territory Health Departments) • Clinical Governance – statewide • Clinical network management • Corporate management (ie large jurisdiction central offices) • Cross border payments • Health department executive • Health policy • Patient Assisted Travel Schemes • Patient safety centre • Public Relations – Media Centre

Related Standards	GL 2.003 – Account Code Mapping to Line Items
Reference Documents	
Sources	NHCDC Hospital Reference Manual

SCP 2A.002 – Teaching Costs

Number	SCP 2A.002
Name	Teaching Costs
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	February 2011
Applicability	All hospitals
Principle	Costs associated with non patient products need to be allocated using a robust and justifiable method which can be audited.
Standard	Teaching costs should be allocated to "teaching" where direct clinical teaching is clearly the purpose of the cost centre and within other cost centres where there is a robust and justifiable method of identification of actual teaching activity.
Definitions	*Teaching:* Teaching is any activity where the primary aim is to transfer clinical knowledge for ongoing professional development via a teacher or mentor to a student or candidate in a recognised program/course that will result in either: • Qualifications that may meet registration requirements; or • Other admission to a specified discipline where the right to practise in that discipline requires completion of the program or course. Teaching activities may include: • Automated/self directed learning where the teaching component is electronically provided. • Presentation and development of content. • Supervision/participation in curriculum based research. *Direct Teaching Costs:* Direct teaching is where the clinical student and the teacher have some contact. In this case the principal resource being consumed is staff time. (Example: Where the teaching takes place in a classroom). **Note:** Health Workforce Australia refer to teaching as clinical training.
Guidelines	Indirect or by-product teaching is considered as normal patient care and should not be allocated to the teaching product. Staff training, whether clinical or non-clinical, is considered normal cost of maintaining a safe workplace and appropriate patient care and should not be allocated to the teaching product. **Note:** This definition is interim pending the Activity Based Funding Workstream on Teaching, Training and Research
Related Standards	Nil
Reference Documents	
Sources	NHCDC Hospital Reference Manual

SCP 2B.001 – Research Costs

Number	SCP 2B.001
Name	Research Costs
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	March 2010
Applicability	All hospitals
Principle	Costs associated with non patient products need to be allocated using a robust and justifiable method which can be audited.
Standard	Research costs should be allocated to "research" where direct research is clearly the purpose of the cost centre and within other cost centres where there is a robust and justifiable method of identification of actual research activity.
Definitions	For the purposes of costing, research is an activity where the primary aim is the advancement of knowledge through: • Observation, data analysis and interpretation, or other means that are secondary to the primary purpose of providing patient care. • Activities associated with patient care where additional components or tasks exist (for example, the addition of control group in a cohort study). This excludes curriculum-based research projects. **Note:** This definition is interim pending the Activity Based Funding Workstream on Teaching, Training and Research
Guidelines	Indirect or by-product research is considered as normal patient care and should not be allocated to the research product.
Related Standards	Nil
Reference Documents	
Sources	NHCDC Hospital Reference Manual

GL1.002 – Accrual Accounting

Number	GL 1.002
Name	Accrual Accounting
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	February 2011
Applicability	All hospitals
Principle	Costs of resources will be matched to the period in which they are actually incurred.
Standard	Costing will be based on the accrual ledger used in the creation of audited financial statements (in accordance with Australian Accounting Standards).
Definitions	Accrual accounting records the costs of resources when they are actually consumed regardless of when they are paid for. In contrast, cash accounting attributes the costs of resources to the period in which they are actually paid for. If a hospital is wholly (or partly) using cash accounting, adjustments will have to be made to ensure that reported costs reflect accrual accounting methods.
Guidelines	Accrual accounting takes into account (for example) the following: • Creditors – where accounts are received near the end of the financial year but remain unpaid. • Prepaid Expenses – where expenses are paid near the end of one period, that relate wholly or in part to goods or services received in the next financial year (e.g. insurance payments can relate to two financial years). • Accrued Expenses – where expenses are recognised in the period in which the organisation is liable for them, even though the actual expense occurs in the next, or future, financial years. Accrued Long Service Leave and Superannuation that relate to that particular year, both fall into this category. Accrued expenses allow an organisation to "smooth out" major expenses over several, or many, years to lessen the impact of the expense when it actually occurs. • Non–Cash items – such as depreciation. Best practice is to make accrual adjustments on a monthly basis.
Related Standards	Nil
Reference Documents	
Sources	NHCDC Hospital Reference Manual Australian Accounting Standards Board Standard 101.

GL 2.003 – Account Code Mapping to Line Items

Number	GL 2.003
Name	Account Code Mapping to Line Items
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	February 2011
Applicability	All hospitals
Principle	All hospitals will utilise a standard set of line items in their costing process to ensure consistent treatment of costs.
Standard	All hospitals will map their GL account codes to the standard list of line items provided below.
Definitions	Line items are groups of GL expenditure account codes defined by input type (rather than type of function), and which define resources being used by a cost centre. **Note:** Agreed definitions of the line items are at Attachment A.
Guidelines	It is important that all relevant line items are used in order to allow reconciliation to the general ledger. However, not all line items will be used in the process of costing (in particular capital works and excluded costs will not be in scope of the costing process).
Related Standard	GL4.003 Cost Centre Mapping
Reference Documents	
Sources	NHCDC Hospital Reference Manual

Line Items

Code	Name
SWNurs	Nursing, Salaries and Wages
SWMed	Medical, Salaries and Wages (non VMO)
SWVMO	Medical, Salaries and Wages (VMO)
SWAH	Allied Health, Salaries and Wages
SWOther	Other staff types, Salaries and Wages
OnCosts	Labour (staff) oncosts, all staff types
Path	Pathology
Imag	Imaging
Pros	Prostheses (surgically implanted)
MS	All other medical and surgical supplies (excluding prostheses and drugs)
GS	All other Goods and Services
PharmPBS	Drugs PBS (eg high cost and S100)
PharmNPBS	Drugs Non PBS
Blood	Blood Products
DeprecB	Building Depreciation
DeprecE	Equipment Depreciation
Hotel	Hotel Goods and Services
Corp	Corporate costs (from outside the hospital GL and not otherwise specified)
Lease	Leasing costs
Cap	Capital works - not in scope
Exclude	Excluded costs – not in scope

GL 4.003 – Cost Centre Mapping

Number	GL 4.003
Name	Cost Centre Mapping
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	February 2011
Applicability	All hospitals
Principle	Hospitals will consistently map their own cost centres to a standardised set of codes, including a consistent definition of what constitutes final and overhead cost centres.
Standard	All hospitals will map their cost centres to the standard list provided below using the most specific description possible.
Definitions	A hospital cost centre is: "A production unit which creates a range of related products. Related products are those which involve use of similar mixes of staff and/or equipment, and technically similar production methods" (Hindle, 1994). Each cost centre represents an area of expense, and cost centre names and groupings will vary from hospital to hospital. There are ultimately two types of cost centre – final (or direct) and overhead (or indirect). *Final cost centres* A final cost centre is one that is directly involved in the delivery of patient care, and is usually directly attributable or specific to an episode. For this reason it is also known as a direct product cost centre or patient care cost centre. These three terms are interchangeable, but final cost centre is the preferred term and will be used for the sake of consistency throughout these standards. Final cost centres can either be directly related to treatment of patients (such as nursing care) or can be attributable to a patient episode as an input to the full treatment episode (such as pathology). Examples: Typical examples of cost centres that should be grouped as final are Renal Unit, Radiology and Anaesthesiology. They give their services to patients rather than to other cost centres. For this reason doctors and nurses salaries will usually be final costs. *Overhead cost centres* An overhead cost centre is a cost that has an incidental rather than a direct relationship to a specific episode of patient care. It will usually involve a service that is provided to parts of the hospital rather than to individual patients. One of the end aims of the costing process is to redistribute all overhead cost centre costs across the final cost centres so that statistics can be created for specific patient care costs. It is possible to use direct consumption data to allocate overhead costs (for example patient meals consumed). This does not imply that overhead cost centres can be allocated as direct costs. Examples: A typical example of a cost centre that should be grouped as overhead is the cleaning service. It does not care for patients, but provides services to other cost centres.

Guidelines	There may not be a direct one to one relationship to the cost centres listed below and those in each hospital. It may be necessary to move expenditure from one cost centre to another to ensure matching of activity to cost. It may be appropriate to seek clinical input where there is some uncertainty about the mapping requirements. Generic cost centres should only be used where it is not possible to allocate a more specific cost centre (eg Plain Radiology should be used in preference to General Imaging). **Note:** The group column is used in providing standardised reporting formats.
Related Standards	GL 2.003 Account Code Mapping to Line Items
Reference Documents	
Sources	NHCDC Hospital Reference Manual

List of Standard Cost Centres

Name	Code	Group	Final Overhead
Audiology	Audio	Allied	Final
Diabetes Educator	Diab	Allied	Final
General Allied Health	GenAllied	Allied	Final
Occupational Therapy	OccupatTher	Allied	Final
Nutrition / Dietetics	Dietetics	Allied	Final
Optometry	Optometry	Allied	Final
Other Allied Health (please specify)	OtherAllied	Allied	Final
Orthoptics	Orthoptics	Allied	Final
Orthotics	Orthotics	Allied	Final
Physiotherapy	Physiotherapy	Allied	Final
Podiatry	Podiatry	Allied	Final
Prosthetics	Prosthetics	Allied	Final
Psychology	Psychology	Allied	Final
Social work	SocialWork	Allied	Final
Speech Pathology	Speech	Allied	Final
Acupuncture	Acup	Clinical	Final
Adolescent Medicine	AdolMed	Clinical	Final
Aged Care	AgedCare	Clinical	Final
Allergy	Allergy	Clinical	Final
Anti – Coagulant Service	AntiCo	Clinical	Final
Assisted Reproduction Technology	AssTech	Clinical	Final
Asthma Service	Asthma	Clinical	Final
Birthing Centre	BirthCentre	Clinical	Final
Breast Services	Breast	Clinical	Final
Burns	Burns	Clinical	Final
Bone Marrow Transplant	BoneMar	Clinical	Final
Cardiology	Cardio	Clinical	Final
Cardiac Surgery	CardiacSurg	Clinical	Final
Cardio–thoracic Surgery	CardioThor	Clinical	Final
Clinical Decision Units	ClinDec	Clinical	Final

Name	Code	Group	Final Overhead
Clinical Haematology	ClinHaem	Clinical	Final
Clinical Immunology & Allergy	ClinImmun	Clinical	Final
Clinical Measurement	ClinMeas	Clinical	Final
Clinical Pharmacology	ClinPharm	Clinical	Final
Clinical Care Trials	ClinTrial	Clinical	Final
Colorectal	Colorectal	Clinical	Final
Community Medicine	CommMed	Clinical	Final
Continence	Cont	Clinical	Final
Craniofacial	Craniofacial	Clinical	Final
Day Surgery Ward	DaySurgWard	Clinical	Final
Delivery ward	DelivWard	Clinical	Final
Dementia	Dementia	Clinical	Final
Dental	Dental	Clinical	Final
Dermatology	Dermat	Clinical	Final
Dev Disabled Service	DevDisSer	Clinical	Final
Diabetes	Diabetes	Clinical	Final
Drug & Alcohol Service	DrugAlch	Clinical	Final
Dysplasia and colcoscopy	DysCol	Clinical	Final
Electrodiagnosis - neurology	ElecNeur	Clinical	Final
Emergency Management Units	EDmu	Clinical	Final
Endocrinology	Endocrin	Clinical	Final
ENT Services	ENT	Clinical	Final
Epilepsy	Epilepsy	Clinical	Final
Falls Clinic	Falls	Clinical	Final
Family Planning	FamPlan	Clinical	Final
Fracture Service	Fracture	Clinical	Final
Gait Laboratory - paediatric	GaitLab	Clinical	Final
Gastroenterology	Gastro	Clinical	Final
General Medicine	GenMed	Clinical	Final
General Surgery	GenSurg	Clinical	Final
General Ward	GenWard	Clinical	Final
Genetics	Genetics	Clinical	Final
Geriatrics	Geriatrics	Clinical	Final
Geriatric evaluation and maintenance (care type 4.0)	GEM	Clinical	Final
Gynaecology	Gynaecology	Clinical	Final
Head Injury	HeadInjury	Clinical	Final
Heart and Chest	HeaChest	Clinical	Final
Heart Transplant Services	HeartTrans	Clinical	Final
Hepatobiliary	Hepatobiliary	Clinical	Final
High Dependency Unit	HDU	Clinical	Final
Hospital in the Home	HITH	Clinical	Final
Hospital Boarder (care type 10.0)	Boarder	Clinical	Final
Hypertension	Hypertension	Clinical	Final
Infectious diseases	Infectious	Clinical	Final
Lithotripsy	Litho	Clinical	Final
Liver transplant	LiverTrans	Clinical	Final
Lung transplant	LungTrans	Clinical	Final
Maintenance care (care type 6.0)	Maintenance	Clinical	Final
Maternal foetal monitoring	MatMon	Clinical	Final
Medihotel	MedHot	Clinical	Final

Name	Code	Group	Final Overhead
Medical oncology	MedOncology	Clinical	Final
Metabolic bone	MetBone	Clinical	Final
Midwifery (including breast feeding support)	Midwif	Clinical	Final
Neonatology	Neonat	Clinical	Final
Nephrology	Nephrology	Clinical	Final
Neurology / Stroke	NeuroStroke	Clinical	Final
Neurosurgery	Neurosurg	Clinical	Final
Newborn care (care type 7.0)	Newborn	Clinical	Final
Non Acute Inpatients	NonAcute	Clinical	Final
Non-admitted patients (clinic)	Outpat	Clinical	Final
Non-admitted patients (other)	OutpatOther	Clinical	Final
Observations beds	ObsBed	Clinical	Final
Obstetrics, Gynaecology – General	ObsGynaeGen	Clinical	Final
Obstetrics	Obstet	Clinical	Final
Occupational Medicine	OccupatMed	Clinical	Final
Oncology	Oncology	Clinical	Final
Ophthalmology	Ophthalm	Clinical	Final
OralMaxillofacial surgery	OralMaxillofac	Clinical	Final
Organ Procurement (care type 9.0)	OrganProc	Clinical	Final
Orthopaedic appliances	OrthApp	Clinical	Final
Orthopaedics	Orthpaed	Clinical	Final
Other admitted patient care (care type 8.0)	Othadmpatcar	Clinical	Final
Other Clinical Service (please specify)	OtherClinServ	Clinical	Final
Outreach / Community	OutComm	Clinical	Final
Paediatric General	PaedGen	Clinical	Final
Paediatric General Medicine	PaedGenMed	Clinical	Final
Paediatric General Surgery	PaedGenSur	Clinical	Final
Pain Management	PainMgt	Clinical	Final
Palliative Care/Hospice	PalCare	Clinical	Final
Plastic surgery	PlasticSurg	Clinical	Final
Pre admission service	PreAdmit	Clinical	Final
Pre anaesthesia service	PreAnaes	Clinical	Final
Psychiatry	Psychiatry	Clinical	Final
Psychogeriatric care (care type 5.0)	Psychgeriatric	Clinical	Final
Public Health	PubHlth	Clinical	Final
Pulmonary Medicine	PulmMed	Clinical	Final
Radiation Medicine	RadMed	Clinical	Final
Radiation Oncology	RadOnc	Clinical	Final
Rehabilitation	Rehab	Clinical	Final
Renal Dialysis	Renal	Clinical	Final
Renal Medicine	RenalMed	Clinical	Final
Renal transplant	RenalTransp	Clinical	Final
Respiratory Medicine	Resp	Clinical	Final
Respite Services	ResSer	Clinical	Final
Rheumatology	Rheumat	Clinical	Final
Sexual Health	SexHealth	Clinical	Final
Short Stay Assessment	ESSU	Clinical	Final
Special Medical	SpecMed	Clinical	Final
Special Surgical	SpecSurg	Clinical	Final
Speciality Ward	Specialty	Clinical	Final

Name	Code	Group	Final Overhead
Special Care Nursery (not attached to Neonatal ICU)	SpecCN	Clinical	Final
Spinal Injury	Spinal	Clinical	Final
Stroke	Stroke	Clinical	Final
Stomal Therapy	StomTher	Clinical	Final
Surgical High Dependency Unit	SurgHDU	Clinical	Final
Thoracic medicine	ThoracicMed	Clinical	Final
Thoracic surgery	ThoracicSur	Clinical	Final
Transit Lounge	TranLoun	Clinical	Final
Transplants	Transplant	Clinical	Final
Trauma Centre	TraumCentre	Clinical	Final
Urology	Urology	Clinical	Final
Vascular Services	Vascular	Clinical	Final
Wound Management	Wound	Clinical	Final
Adult Intensive Care Unit	AICU	Critical	Final
Cardiothoracic Intensive Care	CTICU	Critical	Final
Coronary Care Units	CCU	Critical	Final
General Critical Care	GenCritCare	Critical	Final
High Dependency Unit (attached to ICU)	HDICU	Critical	Final
Neonatal Intensive Care Units	NICU	Critical	Final
Other Critical Care (please specify)	OtherCritCare	Critical	Final
Paediatric Intensive Care Units	PaedICU	Critical	Final
Psychiatric Intensive Care	PsychICU	Critical	Final
Special Care Nursery (attached to NICU)	SCNICU	Critical	Final
Emergency Department / Emergency Medicine	EmergMed	ED	Final
Other Emergency Departments (please specify)	OtherEMed	ED	Final
Trauma	EmergTrauma	ED	Final
Angiography	Angio	Imag	Final
Computed Tomography (CT)	CT	Imag	Final
Echo CardioGram	EchoCardio	Imag	Final
General Imaging	GenImag	Imag	Final
Mammography	Mammo	Imag	Final
Magnetic Resonance Imaging (MRI)	MRI	Imag	Final
Medical Illustration (including medical photography)	MedIll	Imag	Final
Nuclear Medicine	Nuclmed	Imag	Final
Positron Emission Tomography (PET)	PET	Imag	Final
Plain radiology	PlainRad	Imag	Final
Ultrasound	Ultrasound	Imag	Final
Other Imaging (please specify)	OtherImag	Imag	Final
Anaesthesia	Anaesth	OR	Final
General Day Surgery Suite	DaySurg	OR	Final
General Operating Rooms	GenOr	OR	Final
Operating Theatre Suite	OR	OR	Final
Other Operating Rooms (please specify)	OtherOR	OR	Final
Patient Induction / Anaesthesia area	AnaesthesiaArea	OR	Final
Recovery Rooms	RecoverRooms	OR	Final
Animal House	AnimHou	Path	Final
Autopsy	Autopsy	Path	Final
Blood Products	Blood	Path	Final
Clinical Biochemistry	ClinBio	Path	Final
Clinical Chemistry	ClinChem	Path	Final

Name	Code	Group	Final Overhead
Cytogenetics	Cytogen	Path	Final
Cytology	Cytology	Path	Final
Forensic	Forensic	Path	Final
General Pathology	GenPath	Path	Final
Genetics	Genet	Path	Final
Haematology (Laboratory)	Haemat	Path	Final
Histopathology	Histopath	Path	Final
Immunology (Laboratory)	Immunology	Path	Final
Microbiology	Microbio	Path	Final
Mortuary	Morgue	Path	Final
Pharmacology	Pharmac	Path	Final
Specimen collection services	Specimen	Path	Final
Toxicology	Toxic	Path	Final
Transfusion services (incl. blood bank / autologist services)	Transfusion	Path	Final
Other Pathology (please specify)	OtherPath	Path	Final
Cytotoxic drugs	Cytoxic	Pharm	Final
Dispensing costs of drugs	Dispense	Pharm	Final
General Pharmacy	GenPharm	Pharm	Final
High Cost drugs	HighDrugs	Pharm	Final
Imprest (Ward)	Imprest	Pharm	Final
Manufacturing	MfedDrugs	Pharm	Final
Other Pharmacy (please specify)	OtherPharm	Pharm	Final
Parenteral / Enteral Nutrition (goods & services only)	TPN	Pharm	Final
Other Services (e.g. business & commercial)	OtherServ	OtherServ	Final
Research	Research	OtherServ	Final
Teaching	Teaching	OtherServ	Final
Angiography	Angio	SPS	Final
Cardiac Catheter Suites	CardCath	SPS	Final
ECT Suites	ECT	SPS	Final
Endoscopic Suites	Endoscopic	SPS	Final
General Procedure Suites	GenProcSuites	SPS	Final
Hyperbaric Chamber	Hyperbaric	SPS	Final
Lithotripsy Suites	Lithotrip	SPS	Final
Lung function laboratories	LungFunc	SPS	Final
Non–invasive Cardiac Laboratories (e.g.Echo Labs)	NoninvasiveCar	SPS	Final
Other Procedure Suites (please specify)	OthProcSuite	SPS	Final
Physiology Laboratories	PhysioLabs	SPS	Final
Radiotherapy Suites	Radiotherapy	SPS	Final
Respiratory Laboratories	RespiratLabs	SPS	Final
Sleep Laboratories	SleepLabs	SPS	Final
Allied Health Administration	AHAdmin	Overhead	OtherOhds
Biomedical Engineering	BiomedEng	Overhead	OtherOhds
Central Sterilising and Supply Department	CSSD	Overhead	OtherOhds
Chaplaincy	Chap	Overhead	OtherOhds
Cleaning Services	Floorfrq	Overhead	OtherOhds
Clinical Information	ClinInfo	Overhead	OtherOhds
Computing	Comp	Overhead	OtherOhds
Corporate Management Fees	CorpMan	Overhead	OtherOhds
Document Transmission & Storage	DocXmit	Overhead	OtherOhds

Name	Code	Group	Final Overhead
Energy Supplies	EneSupp	Overhead	OtherOhds
Executive Services (Management)	ExecServ	Overhead	OtherOhds
Financial Administration	FinAdmin	Overhead	OtherOhds
Financing Costs (including interest)	FinCosts	Overhead	OtherOhds
Food Services (patients)	PatFood	Overhead	HotelOhds
Fringe Benefits Tax	FBT	Overhead	OtherOhds
Grounds and Gardens	Grounds	Overhead	OtherOhds
Health Information Management	HIM	Overhead	OtherOhds
Hospital Management and Administration	AdminCost	Overhead	OtherOhds
Hospital Staff Catering	StaffCat	Overhead	OtherOhds
Human Resource Management	HRM	Overhead	OtherOhds
Infection Control	InfectCtrl	Overhead	OtherOhds
Insurance	Insur	Overhead	OtherOhds
Interpreter Services	Interp	Overhead	OtherOhds
Legal Services	Legal	Overhead	OtherOhds
Library Services	Library	Overhead	OtherOhds
Linen & Laundry Services	Linen	Overhead	HotelOhds
Maintenance, Engineering & Repairs	MaintEngReprs	Overhead	OtherOhds
Medical Management & Admin	MedAdmin	Overhead	OtherOhds
Medical Records	MedRecord	Overhead	OtherOhds
Nursing Management & Admin	NurseAdmin	Overhead	OtherOhds
Occupational Health and Safety	OHS	Overhead	OtherOhds
Other Administrative Services	OtherAdmin	Overhead	OtherOhds
Other Hotel Services	OHSvrs	Overhead	OtherOhds
Other Overheads	OtherOhds	Overhead	OtherOhds
Patient Administration	PatAdmin	Overhead	OtherOhds
Patient Residential Accommodation	ResAcc	Overhead	OtherOhds
Patient Transport	PatTransport	Overhead	OtherOhds
Payroll	Payroll	Overhead	OtherOhds
Payroll Tax	PayrollTax	Overhead	OtherOhds
Porters & Orderlies	PortOrd	Overhead	HotelOhds
Printing, Postage and Stationery	PrintPost	Overhead	OtherOhds
Property Services	PropServ	Overhead	OtherOhds
Public Relations & Marketing	PubRel	Overhead	OtherOhds
Quality Assurance	QualAssur	Overhead	OtherOhds
Redundancy Payments	Reday	Overhead	OtherOhds
Sales Tax	SalesTax	Overhead	OtherOhds
Security	Security	Overhead	OtherOhds
Staff Accommodation	StaffAccom	Overhead	OtherOhds
Staff Development	StaffDev	Overhead	OtherOhds
Stores / Supplies & Transport costs	Stores	Overhead	OtherOhds
Telecommunications	Telecommun	Overhead	OtherOhds
Transport of Personnel	StaffTransport	Overhead	OtherOhds
Volunteer Services	Volt	Overhead	OtherOhds
Water	Water	Overhead	OtherOhds

GL 4A.001 – Critical Care Definition

Number	GL 4A.001
Name	Critical Care Definition
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	March 2010
Applicability	All hospitals
Purpose	To define the boundary between Critical care and General wards.
Standard	The following units will be costed as Critical Care: Intensive Care, Coronary Care, Cardiothoracic Intensive Care, Psychiatric Intensive Care, Paediatric Intensive and Neonatal Intensive Care. Units are required to have at least Level I Intensive Care (as per Australian and New Zealand College of Anaesthetists) to be considered. High dependency, special care nurseries and other close observation units either located within general wards or stand alone will be costed as general wards.
Definitions	A designated patient care area in a hospital which is staffed with experienced clinicians skilled in the care of high acuity patients requiring intensive treatment, invasive monitoring and/or life support. Includes: adult, paediatric and neonatal intensive care and coronary care.
Guidelines	This standard represents a pragmatic approach to ensuring that the critical care component represents true critical care and not ward based frequent observation care. Close observation units co-located with Critical Care units will be treated as critical care. This standard recognizes the difficulty in disaggregating Critical Care services from High Dependency services in combined Departments of Critical Care Medicine. Additionally these types of High Dependency units provide care for cases that were once the province of Intensive Care including invasive monitoring, complex medications and complex interventions for highly unstable patients. As they are co-located within a Critical Care Department, they also have continual medical care supervision available. Some Coronary Care units (CCU) are also ward based and care for monitored patients following coronary artery procedures. These will be considered as ward based units and excluded from Critical Care component. A number of close observation areas exist within general wards that may be called high dependency. In the private sector, units that are licensed as an Intensive Care Unit qualify under this definition.
Related Standards	Nil
Reference Documents	
Sources	Australian and New Zealand College of Anaesthetists http://www.anzca.edu.au/jficm/resources/minimum-standards-for-intensive-care-units.html

GL 4B.002 – Emergency Department Definition

Number	GL 4B.002

Name	Emergency Department definition
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	February 2011
Applicability	All hospitals
Purpose	To define the boundary between Emergency Department care and General wards.
Standard	Short Stay Admitted Units associated with or attached to an Emergency Department will be costed as general wards.
Definitions	An Emergency Department is defined as a department that provides initial treatment to patients with a broad spectrum of illnesses and injuries, some of which may be life threatening and require immediate attention.
Guidelines	Where patients who are admitted patients are managed in a discrete ward area, these areas will be considered to be general ward areas and reported outside the Emergency Department. Other titles with similar function include Clinical Decision Units, Short Stay Medical Assessment Units, and Emergency Management Units. The key defining attribute is admission to a bed (as opposed to a trolley or examination bay as these costs would be captured in the Emergency Department). For the purpose of costing, the ED service event is from presentation to departure from the ED and all ancillary services ordered for that patient during that period should be costed to that ED event.
Related Standards	Nil
Reference Documents	
Sources	NHCDC Hospital Reference Manual

GL 4C.001 – Operating Room Definition

Number	GL 4C.001
Name	Operating Room Definition
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	March 2010
Applicability	All hospitals
Purpose	To define the boundary between operating rooms and procedure suites.
Standard	Procedure suites will not be classified as operating rooms in the cost centre mapping.
Definitions	The operating room is that area of a hospital where significant surgical procedures are carried out under surgical conditions under the supervision of qualified medical practitioners. The operating room must be equipped to deliver general anaesthesia and conform to the College of Anaesthetists and the Faculty of Intensive Care standards
Guidelines	The following are examples of treatment areas which should be excluded from Operating Rooms and included as procedure suites: • Angiography; • Cardiac Catheter Suites; • ECT Suites; • Endoscopic Suites; • General Procedure Suites; • Hyperbaric Chamber; • Lithotripsy Suites; • Lung function laboratories; • Non–invasive Cardiac Laboratories (e.g. Echo Labs); • Physiology Laboratories; • Radiotherapy Suites; • Respiratory Laboratories; • Sleep Laboratories.
Related Standards	Nil
Reference Documents	
Sources	NHCDC Hospital Reference Manual

GL 5.001 – Matching Activity and Cost

Number	GL 5.001
Name	Matching Activity and Cost
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	February 2011
Applicability	All hospitals
Principle	Where hospital cost centre structures and expenditure do not align with their activity then hospitals will make adjustments outside the General Ledger.
Standard	All hospitals will adjust their General Ledger costs as required to align costs and activity where they have not been recorded appropriately for costing purposes, and the costs are material.
Definitions	Nil
Guidelines	Hospital outputs include admitted and non-admitted care. It may be appropriate to separate cost centres into inpatient and outpatient care. Alternatively the split may be better handled using patient consumption data or other appropriate statistic. It may be necessary to move expenditure from one cost centre to another to ensure matching of activity to cost. It may also be appropriate to seek clinical input where there is some uncertainty about the mapping requirements. A particular area where care needs to be taken is the allocation of medical costs. The costs of medical units are normally recorded within a single cost centre for each unit type (Medical, Surgery, O&G, Respiratory etc) with the granularity of the Unit type being a function of the hospital size and complexity. The issues with medical unit costs are: • Doctors by their very nature work right across every sector of the hospital, and each component of medical care may require a different feeder system to appropriately allocate the costs to the episode/occasions of service. • There are few (if any) all-encompassing feeder systems for the recording of medical activity. • The costs are normally grouped into unit cost centres that are required to be split across various patient products. • Doctors of various qualification levels will require a different consideration (Specialists, residents, registrars, interns, VMOs) • While there are small potential variations between public and private, in practice doctors will treat public and private patients with no discrimination of care. In addition, the junior doctors will work across public and private without any discrimination, smoothing the cost effect across public and private. It is important that medical staff costs are correctly allocated to areas such as ED, ICU and OR. If this is not done, then higher cost cases become under-costed and medical costs are inappropriately allocated. Costs of services provided to other hospitals or outside parties are to be excluded from the providing hospital and allocated to the recipient facility.
Related Standards	
Reference	

Documents	
Sources	NHCDC Hospital Reference Manual

GL 5A.001 – Matching Activity and Cost – Overhead Cost Allocation

Number	GL 5A.001
Name	Matching Activity and Costs – Overhead Cost Allocation
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	February 2011
Applicability	All hospitals
Principle	All hospitals will ensure appropriate allocation of Overhead Costs.
Standard	Overheads costs in the General Ledger should be allocated across patient and non patient categories prior to any final costs being allocated to products.
Definitions	Nil
Guidelines	Allocating overhead costs prior to distributing final costs is essential to ensure that all hospital products receive the appropriate share of their overhead allocation.
Related Standards	
Reference Documents	
Sources	NHCDC Hospital Reference Manual

GL 5B.001 – Matching Activity and Cost – Non Patient Products

Number	GL 5B.001
Name	Matching Activity and Costs – Non Patient Products
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	February 2011
Applicability	All hospitals
Principle	All costs need to be accounted for in the costing process.
Standard	All costs irrespective of whether they are related to patient or non patient products should be recorded in the costing process.
Definitions	Nil
Guidelines	Reporting of hospital costs needs to reflect both patient and non patient activities to allow full comparison between hospitals and reconciliation.
Related Standards	
Reference Documents	
Sources	NHCDC Hospital Reference Manual

GL 5C.001 – Matching Activity and Cost – Commercial Business Entities

Number	GL 5C.001
Name	Matching Activity and Cost - Commercial Business Entities
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	February 2011
Applicability	Public Hospitals
Principle	All hospitals will adjust their General Ledger costs as required when they have not been recorded appropriately for costing purposes.
Standard	Hospitals will not report the cost or activity related to commercial business entities.
Definitions	Commercial business entities are services that reside on the hospital campus but are not operated by hospital funded staff and do not relate to products of the hospital.
Guidelines	Examples of commercial business entities might include the florist, commercial parking and child care centres. Entities such as staff cafeterias that are funded by the hospital and operated by hospital staff are within scope regardless of whether or not they generate revenue. Particular attention needs to be given to totally private medical clinics where the activity is not recorded against hospital activity. These need to be allocated to Other Services in the cost centre mapping.
Related Standards	
Reference Documents	
Sources	NHCDC Hospital Reference Manual

GL 5D.001 – Matching Activity and Cost – Negative costs

Number	GL 5D.001
Name	Matching Activity and Cost - Negative Costs
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	February 2011
Applicability	All hospitals
Principle	All hospitals will adjust their General Ledger costs as required where they have not been recorded appropriately for costing purposes.
Standard	Hospitals will ensure that outputs do not contain negative costs.
Definitions	Nil
Guidelines	Negative Dollars in the cost file: This may not be incorrect within the hospital costing process. The solution is to examine every negative cost value in the starting cost and check for errors and then post this cost against an appropriate positive value. However there may be abnormal accruals resulting in a negative expense. In this case the cause should be documented and amount offset against a positive value so that full reconciliation is possible.
Related Standards	
Reference Documents	
Sources	NHCDC Hospital Reference Manual

GL 5E.001 – Matching Activity and Cost – Expenditure Offsets

Number	GL5E.001
Name	Matching Activity and Cost - Expenditure Offsets.
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	February 2011
Applicability	All hospitals
Principle	All hospitals will adjust their General Ledger costs as required where they have not been recorded appropriately for costing purposes. The allocated cost will be based on gross expenditure.
Standard	Hospitals will not offset revenue against expenditure.
Definitions	Offsetting in this sense means the reduction in the cost of providing a service by revenue generated.
Guidelines	For costing purposes, hospital revenue should not be offset against expenditure Specific areas where revenue is not to be offset are: • Revenue received from private patient charging; • High cost S100, and PBS drugs and ; • Compensable and ineligible patient revenues Note: Staff may need to check the GL transactions in the Pharmacy cost centre to ensure that full drug costs have not been offset by recoveries (eg high cost drugs).
Related Standards	
Reference Documents	
Sources	NHCDC Hospital Reference Manual

COST 1.001 – Overhead Allocation Method

Number	COST 1.001
Name	Overhead Allocation Method
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	March 2010
Applicability	All hospitals
Principle	All hospital will allocate overheads using the most appropriate mathematical algorithm.
Standard	All hospital overheads will be allocated using a simultaneous equation matrix process.
Definitions	Nil
Guidelines	The key to understanding overhead allocation process is to consider that the allocation process mimics the flow of costs that would be captured if all services were billed internally. This means that overhead costs are also incurred by overhead cost centres including the centre to be allocated. This process recognises that overhead costs are distributed to all cost centres that interact with the overhead cost centre being allocated. The aim is to pass the costs of all overhead cost centres to the final cost centres. This occurs on multiple passes of the overhead allocation calculation.
Related Standards	Cost 2.003 – Overhead Allocation Statistics
Reference Documents	
Sources	NHCDC Hospital Reference Manual

COST 1A.001 – Overhead Allocation – Hotel Services

Number	COST 1A.001
Name	Overhead Allocation - Hotel Services
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	February 2011
Applicability	All hospitals
Principle	All hospitals will allocate hotel services to relevant target departments ensuring that irrespective of the staff award payment, staffing costs need to reflect the service area of employment.
Standard	All hotel service costs will be allocated to line item “Hotel” at the final cost level.
Definitions	Nil
Guidelines	The issue here is to ensure that costs of hotel services are not allocated as an overhead of other distinct salary classes during the overhead process. For example, a person paid under a nursing award working in a Catering operational area of the hospital. The overheard cost of this employee should not be linked against SW nursing but should instead be linked against Hotel services at the final cost centre level.
Related Standards	Cost 2.003 – Overhead Allocation Statistics
Reference Documents	
Sources	NHCDC Hospital Reference Manual

COST 1B.001 – Overhead Allocation – Overhead Depreciation Costs

Number	COST 1B.001
Name	Overhead Allocation - Overhead Depreciation Costs
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	February 2011
Applicability	All hospitals
Principle	Depreciation cost should not be merged with other line item costs throughout the costing process.
Standard	All depreciation overhead costs will be allocated to line items called Depreciation at the final cost centre level (DeprecE or DeprecB)
Definitions	Nil
Guidelines	This is to ensure that depreciation costs are not allocated to other line items.
Related Standards	COST 2.003 – Overhead Allocation Statistics DEP1.001 – Capital Expenditure DEP1E 001 – Allocation of Depreciation and Amortisation
Reference Documents	
Sources	NHCDC Hospital Reference Manual

COST 2.003 – Overhead Allocation Statistics

Number	COST 2.003
Name	Overhead Allocation Statistics
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	February 2011
Applicability	All hospitals
Principle	Hospitals will use the most appropriate statistic to allocate overhead costs.
Standard	All hospital overheads will be allocated using one of a hierarchy of preferred allocation statistics
Definitions	Allocation statistics are relativities used to distribute overhead costs to the appropriate cost centres. These relativities are the best available measure of the relative units of consumption. They are sometimes weighted – for example, service weights are a type of allocation statistic. There are two basic types of Overhead allocation statistics: • Financial allocation statistic: o Use of a statistic such as nurse salaries to allocate the cost of nursing management overhead costs to all relevant cost centres. • Non Financial allocation statistic: o Use of a statistic such as the number of meals, metres of floor space, or bed days to allocate an overhead cost to all relevant cost centres. The ideal allocation statistic is one that enables cost to be directly attributed to the patient (e.g. patient meals consumed). The table below provides hospitals with the preferred hierarchy of Allocation Statistics.
Guidelines	The allocation process is necessary as overhead costs generally comprise a significant proportion of a hospital's running costs and must be allocated correctly to best reflect actual expenditure. It is critical to ensure that overhead costs are allocated to the appropriate final cost centres as well as using the most appropriate allocation statistic. All overhead costs should be allocated prior to final allocation to products. Hospitals will need to document the allocation statistic used for each overhead cost centre.
Related Standards	COST 1.001 - Overhead Allocation Method GL 5B.001 -Matching Activity and Cost – Non Patient Products
Reference Documents	
Sources	NHCDC Hospital Reference Manual

List of Allocation Statistics

Code for Statistic	Description of statistic
ActualPatsCost	Actual cost of service directly allocated to a patient either externally or internally billed e.g. patient meals , transport cost
ActualCostCentreCost	Actual cost of service directly allocated to a cost centre either externally or internally billed e.g. biomedical service , payroll services, CSSD
ActualPatUnits	Actual units of service directly allocated to a patient either externally or internally billed e.g. patient meals, transport, interpreter services
ActualCostCentreUnits	Actual units of service directly allocated to a cost centre either externally or internally billed e.g. patient meals
Allpats	All episodes (admitted and weighted non-admitted)
ExpAll	General ledger total expenses for total hospital or specific service e.g. medical
ExpG&S	Goods and services expenses from general ledger for total hospital or specific service e.g. surgical
ExpSalwageAll	Salary and wages per cost area for all staff applied to the total hospital or a specific service.
ExpSalwageMed	Salary and wages per cost area for medical staff applied to the total hospital or a specific service
ExpSalwageNurs	Salary and wages per cost area for nursing staff applied to the total hospital or a specific service.
Floor	Floor space (sq metres)
Floorfrq	Floor space * frequency of cleaning
FteTotalALL	Full time equivalents for all staff applied across the total hospital or a specific service.
Ftemed	Total full time equivalent for medical staff applied across the total hospital or a specific service.
Ftenurs	Total full time equivalent for nursing staff applied across the total hospital or a specific service.
HeadCountAll	Total staff head count applied across the total hospital or a specific service.
HeadCountMed	Medical staff head count applied across the total hospital or a specific service.
HeadCountNurs	Nursing staff head count applied across the total hospital or a specific service.
InpatAll	Number of inpatient discharges or admissions.
InpatSS	Number of inpatient separations or admissions for a specific service e
MedAss	Medical equipment assets
Medrec	Time taken to code medical record (admitted and non-admitted)
Nopc	Number of computers
Obd	Occupied bed days (admitted)
ObdEquiv	Occupied bed day equivalents (admitted and non-admitted)
OutpatOcc	Outpatient occasion of service
Phones	Number of telephone lines connected
Stores	Stores issued
Totass	Total assets
TransGL	Total number of transactions by Cost Centre
WardAdm	Ward admissions to take account for ward transfers

Suggested Allocation Statistics and Code

Type of overhead cost centre	Order of Preference		
	1st	2nd	3rd
Allied Health Administration	ActualPatUnits (allied health time by patient)	Allpat	InpatAll
Biomedical Engineering	ActualCostCentreCost	MedAss	ObdEquiv
Central Sterilising and Supply Department	ActualCostCentreCost	InpatSS (surgical activity)	InpatAll
Chaplaincy	ObdEquiv	InpatAll	Allpats
Cleaning Services	Floorfrq	Floor	FteTotalAll
Clinical Information	Allpat	InpatAll	ExpG&S
Computing	Nopc	FteTotalAll	HeadCountAll
Corporate Management Fees	ExpAll	FteTotalAll	HeadCountAll
Document Transmission & Storage	ExpAll	ExpSalwageAll	FteTotalAll
Energy Supplies	Floor	ExpAll	ExpSalwageAll
Executive Services (Management)	ExpAll	FteTotalAll	HeadCountAll
Financial Administration	TransGL	ExpAll	FteTotalAll
Financing Costs (including interest)	ExpAll	Totass	ExpG&S
Food Services (patients)	ActualPatUnits	ActualCostCentreUnits	Obd
Fringe Benefits Tax	ExpSalwageAll	FteTotalAll	HeadCountAll
Grounds and Gardens	ExpSalwageAll	HeadCountAll	ExpAll
Health Information Management	Allpats	InpatAll	ExpG&S
Hospital Management & Administration	HeadCountAll	FteTotalAll	ExpAll
Hospital Specific Service Management & Administration	HeadCountAll	FteTotalAll	ExpAll
Hospital Staff Catering	HeadCountAll	FteTotalAll	ExpSalwageAll
Human Resource Management	HeadCountAll	FteTotalAll	ExpSalwageAll
Infection Control	Ftemed	Ftenurs	ObdEquiv
Insurance - Property	Totass	ExpG&S	ExpAll
Insurance – Professional Indemnity	FteMed	ExpSalwageMed	ExpAll
Interpreter Services	ActualPatUnits	ActualCostCentreUnits	ObdEquiv
Legal Services	InpatAll	HeadCountAll	FteTotalAll
Library Services	HeadCountAll	FteTotalAll	ExpSalwageAll
Linen & Laundry Services	ActualCostCentreCost	ActualCostCentreUnits	ObdEquiv
Maintenance, Engineering & Repairs	ActualCostCentreCost	Floor	Totass
Medical Management & Admin.	HeadCountMed	Ftemed	ExpSalwageMed
Medical Management & Admin Specific Service	HeadCountMed	Ftemed	ExpSalwageMed
Medical Records	Allpat	InpatAll	ObdEquiv
Nursing Management & Admin	HeadCountNurs	Ftenurs	ExpSalwageNurs
Nursing Management & Admin Specific Service	HeadCountNurs	Ftenurs	ExpSalwageNurs
Occupational Health and Safety	HeadCountAll	FteTotalAll	ExpSalwageAll
Other Administrative Services	HeadCountAll	FteTotalAll	ExpSalwageAll
Other Hotel Services	ObdEquiv	InpatAll	Floor

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

COST 3.003 – Final Cost Allocation

Number	Cost 3.003
Name	Final Cost Allocation
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	June 2010
Applicability	All hospitals
Principle	Hospitals will use the most appropriate method to allocate final costs.
Standard	All hospital final costs will be allocated using one of a hierarchy of preferred methods.
Definitions	Nil
Guidelines	The allocation of costs from Direct Cost Centres is often a pragmatic question based upon available feeder system data and the materiality of the costs determining the costing effort required. The table below provides hospitals with the hierarchy of methods to allocate final costs. The accurate allocation of costs to patients is best met through the use of relative value units for the human and material resources associated with the intermediate products actually consumed by the patient during the health care intervention. Human resources should be costed on a dollar value. Only where those values cannot be obtained due to limitations in electronically available information should a form of modelling be used. The standard allocation models highlighted below are not necessarily the absolute best allocation method in a perfect world. This standard requires the hospitals to apply a model which is considered to be reliable and will enable appropriate consistency across jurisdictions. There will be situations however where a hospital will have a more precise method of calculation, or a hybrid solution of one of the models described below. If this alternate method results in a more precise result that can be aggregated up to one of the preferred methods identified, then this is an acceptable approach. There will also be instances where hospitals make more granular allocation (allocation of nurse penalty rates to appropriate time of day etc). Where no other data is available, service weights can be used until more robust systems are available. It is important that a ward / bed transfer information is used to distinguish between costs that occur in different parts of the hospital.
Related Standards	Nil
Reference Documents	
Sources	Nil

List of Final Allocation Methods

Actual Cost	Use when the feeder system provides the purchase cost of the individual items consumed by the patient.
Actual With RVU	The feeder system may provide the number of units consumed, with a RVU applied to the feeder data to create a suitable cost allocation method.
AH Actual	Time from commencement to completion of the treatment. Time may be accumulated over several patient provider contacts.
Bands Costing	DVA theatre banding schedule published twice yearly following May and November amendment to CMBS (available in CMBS and ICD10AM).
Doctor Actual	Time from commencement to completion of the treatment. Time may be accumulated over several patient provider contacts.
ED Flag	Every ED occasion receives same proportion of cost.
Frac BD Gen	Fractional Bed Days - whole of hospital - This statistic is only likely to be used in very small hospitals. Bed day equivalents may be used for Non-admitted patients and other products.
Frac BD Spec	Fractional Bed Days - ward specific. Bed day equivalents may be used for Non-admitted patients and other products.
Nurse Actual	Time from commencement to completion of the treatment. Time may be accumulated over several patient provider contacts.
OBD Gen	Occupied Bed Days - whole of hospital - This statistic is only likely to be used in very small hospitals.
OBD Spec	Occupied Bed Days - ward specific. Bed day equivalents may be used for Non-admitted patients and other products.
OOS	Occasions of service - every occasion of service receives the same cost. May be hospital wide or, preferably specific to the clinic.
OOS AH Led	Occasions of service, Allied Health professional led - every occasion of service within an Allied health professional led clinic receives the same cost. May be hospital wide or, preferably specific to the clinic.
OOS Med Led	Occasions of service, Medical led - every occasion of service within a Medical led clinic receives the same cost. May be hospital wide or, preferably specific to the clinic.
OOS Nurse Led	Occasions of service, Nurse led - every occasion of service within a nurse led clinic receives the same cost. May be hospital wide or, preferably specific to the clinic.
Patient Time	Time duration the patient commenced the process to the time completed.
Pharm Actual	Cost of drugs, salaries and consumables consumed both during the hospital episode and post treatment (dispensed by the hospital).
Planned Nursing	The roster/ resource planning for nursing to determine the nursing to each encounter.
Planned Time	The resource planning for patient time to determine the nursing to each encounter.
Planned Medical	The roster/ resource planning for doctors to determine the nursing to each encounter.
Roster	The time that the practitioner (Medical, Nurse and Allied health) is rostered to provide care to a number of patients.
Standard Costs	Bottom up costing linked to procedures, diagnosis or service eg Triage categories.

Suggested Allocation Method

Legend

OBD – Occupied bed days
OoS – Occasions of service
PNDS – Patient nurse dependency system
RVUs – Relative value units

Table shows: Line Item/Point of Delivery - Medical Salaries & Wages(Both VMO and salaried medical officers)

Preferences	Inpatients: Wards	Inpatients: Critical Care	Theatre & Procedure Suites	ED	Outpatients
Preference 1	Actual cost/patient time.	Actual cost/patient time.	Total cost/actual doctor time for all doctors present.	Actual cost/patient time.	Actual cost/patient time.
Preference 2	Fractional days/OBDs – unit specific with local RVUs.	Fractional days – unit specific with local RVUs.	Actual doctor/patient time for principal surgeon. ***OR*** Planned time/roster. ***OR*** Actual patient/procedure nursing time from PNDS/Theatre system.	Standard cost by patient group (other than Triage/UDG).	Planned time (total doctor time/number of OoS).
Preference 3	Fractional days/OBDs – general with local RVUs.	Planned time/Roster.	Fractional days/OBDs – unit/ward specific with local RVUs.	Planned time/roster - Triage/UDG category – local RVUs.	OoS – Doctor led with local RVUs.

Table shows: Line Item/Point of Delivery - Nurse Salaries & Wages

Preferences	Inpatients: Wards	Inpatients: Critical Care	Theatre & Procedure Suites	ED	Outpatients
Preference 1	Actual nursing cost/time from PNDS.	Actual nursing cost/time from PNDS.	Actual nursing cost/time (for all nurses present) from PNDS/theatre system.	Actual nursing cost/time.	Actual nursing cost/time.
Preference 2	Planned nursing time from PNDS.	Planned nursing time from PNDS.	Actual patient/procedure time from PNDS/theatre system. ***OR*** Fractional days – ward/unit specific with local RVUs (assumes ward/unit transfer to theatre).	Planned time/Standard cost/Roster.	Planned time/Standard cost/Roster.

Preferences	Inpatients: Wards	Inpatients: Critical Care	Theatre & Procedure Suites	ED	Outpatients
Preference 3	Fractional days – ward specific with local RVUs.	Fractional days – ward specific with local RVUs.	OBDs – unit specific with local RVUs. ***OR*** Planned time/Roster.	Triage/UDG category – local RVUs.	OoS – Nurse led with local RVUs.
Preference 4		OBDs – unit specific with local RVUs. ***OR*** Planned time/Roster.			

Table shows: Line Item/Point of Delivery - Allied Health Salaries & Wages

Preferences	Inpatients: Wards	Inpatients: Critical Care	Theatre & Procedure Suites	ED	Outpatients
Preference 1	Actual patient cost/time.	Actual patient cost/time.	Actual patient cost/time.	Actual patient cost/time.	Actual patient cost/time.
Preference 2	Planned time/Roster – ward specific/ Standard Cost. ***OR*** Inpatient Occasions of Service – Allied Health led with local RVUs.	Planned time/Roster – ward specific/ Standard Cost. ***OR*** Inpatient Occasions of Service – Allied Health led with local RVUs.	Planned time/Roster – ward specific/ Standard Cost. ***OR*** Inpatient Occasions of Service – Allied Health led with local RVUs.	Standard cost by patient group (other than triage).	Planned time/Roster/Standard cost.
Preference 3				Planned time/roster - Triage/UDG category with local RVUs.	OoS – Allied Health led with local RVUs..

Table shows: Line Item/Point of Delivery - Other Salaries & Wages

Preferences	Inpatients: Wards	Inpatients: Critical Care	Theatre & Procedure Suites	ED	Outpatients
Preference 1	Actual patient cost/time.	Actual patient cost/time.	Actual patient cost/time.	Actual patient cost/time.	Actual patient cost/time.
Preference 2	Fractional bed days – ward/unit specific with local RVUs.	Fractional bed days – ward/unit specific with local RVUs.	Fractional bed days – ward/unit specific with local RVUs.	Triage/UDG category with local RVUs.	Planned time/roster/standard cost.

Preferences	Inpatients: Wards	Inpatients: Critical Care	Theatre & Procedure Suites	ED	Outpatients
Preference 3	OBDs – ward/unit specific with local RVUs.	OBDs – ward/unit specific with local RVUs.	OBDs – ward/unit specific with local RVUs.		All OoS – local RVUs.
Preference 4	Fractional bed days – general with local RVUs.				

Table shows: Line Item/Point of Delivery - Prosthetics

Preferences	Inpatients: Wards	Inpatients: Critical Care	Theatre & Procedure Suites	ED	Outpatients
Preference 1	Actual cost.	Actual cost.	Actual cost.	Actual cost.	Actual cost.
Preference 2	Bands cost.	Bands cost.	Standard cost based on ICD10 procedure. *OR* Standard cost based on Health fund reimbursement.	Bands cost.	Bands cost.
Preference 3	Fractional days/OBDs – local RVUs.	Fractional days/OBDs – local RVUs.	Bands cost. OR Standard cost.	Triage/UDG category with local RVUs.	Clinic category with local RVUs.

Table shows: Line Item/Point of Delivery - Medical Supplies/ Consumables

Preferences	Inpatients: Wards	Inpatients: Critical Care	Theatre & Procedure Suites	ED	Outpatients
Preference 1	Actual/ standard cost.	Actual/ standard cost.	Actual/ standard cost.	Actual cost.	Actual cost.
Preference 2	Fractional days – ward/unit specific with local RVUs.	Fractional days – ward/unit specific with local RVUs.	Procedure time.	Bands cost.	Bands cost.
Preference 3	OBDs – ward/unit specific with local RVUs.	OBDs – ward/unit specific with local RVUs.	Fractional days – ward/unit specific with local RVUs.	Triage/UDG category with local RVUs.	Clinic type with local RVUs
Preference 4			OBDs – ward/unit specific with local RVUs.		

Table shows: Line Item/Point of Delivery - Pharmacy –PBS and Non-PBS (dispensed)

Preferences	Inpatients: Wards	Inpatients: Critical Care	Theatre & Procedure Suites	ED	Outpatients
Preference 1	Actual cost.	Actual cost.	Actual cost.	Actual cost.	Actual cost.
Preference 2	Standard cost.	Standard cost.	Standard cost.	Standard cost.	Standard cost.
Preference 3	Fractional days – ward/unit specific with local RVUs.	Fractional days – ward/unit specific with local RVUs.	Fractional days – ward/unit specific with local RVUs.	Bands cost.	Bands cost.
Preference 4	OBDs – ward/unit specific with local RVUs.	OBDs – ward/unit specific with local RVUs.	OBDs – ward/unit specific with local RVUs.	Triage/UDG category with local RVUs.	Clinic type with local RVUs.

Table shows: Line Item/Point of Delivery - Pharmacy (imprest) Non-PBS only

Preferences	Inpatients: Wards	Inpatients: Critical Care	Theatre & Procedure Suites	ED	Outpatients
Preference 1	Actual cost.	Actual cost.	Actual cost.	Actual cost.	Actual cost.
Preference 2	Standard cost.	Standard cost.	Standard cost.	Standard/Bands cost.	Standard/Bands cost.
Preference 3	Fractional days – ward/unit specific with local RVUs.	Fractional days – ward/unit specific with local RVUs.	Fractional days – ward/unit specific with local RVUs.	Triage/UDG category with local RVUs.	Clinic type with local RVUs.
Preference 4	OBDs – ward/unit specific with local RVUs.	OBDs – ward/unit specific with local RVUs.	OBDs – ward/unit specific with local RVUs.		

Table shows: Line Item/Point of Delivery - Pathology

Preferences	Inpatients: Wards	Inpatients: Critical Care	Theatre & Procedure Suites	ED	Outpatients
Preference 1	Actual cost.	Actual cost.	Actual cost.	Actual cost.	Actual cost.
Preference 2	Actual cost with RVU. ***OR*** Standard cost.	Actual cost with RVU. ***OR*** Standard cost.	Actual cost with RVU. ***OR*** Standard cost.	Actual cost with RVU.	Actual cost with RVU.

Preferences	Inpatients: Wards	Inpatients: Critical Care	Theatre & Procedure Suites	ED	Outpatients
Preference 3	Fractional days – ward/unit specific with local RVUs.	Fractional days – ward/unit specific with local RVUs.	Fractional days – ward/unit specific with local RVUs.	Bands cost.	Bands cost.
Preference 4	OBDs – ward/unit specific with local RVUs.	OBDs – ward/unit specific with local RVUs.	OBDs – ward/unit specific with local RVUs.	Triage/UDG category with local RVUs.	Clinic type with local RVUs.

Table shows: Line Item/Point of Delivery - Imaging

Preferences	Inpatients: Wards	Inpatients: Critical Care	Theatre & Procedure Suites	ED	Outpatients
Preference 1	Actual cost.	Actual cost.	Actual cost.	Actual cost.	Actual cost.
Preference 2	Actual cost with RVU. ***OR*** Standard cost.	Actual cost with RVU. ***OR*** Standard cost.	Actual cost with RVU. ***OR*** Standard cost.	Actual cost with RVU. ***OR*** Standard cost.	Actual cost with RVU. ***OR*** Standard cost.
Preference 3	Fractional days – ward/unit specific with local RVUs.	Fractional days – ward/unit specific with local RVUs.	Fractional days – ward/unit specific with local RVUs.	Bands cost.	Bands cost.
Preference 4	OBDs – ward/unit specific with local RVUs.	OBDs – ward/unit specific with local RVUs.	OBDs – ward/unit specific with local RVUs.	Triage/UDG category with local RVUs.	Clinic type with local RVUs.

Table shows: Line Item/Point of Delivery - On-costs

Inpatients: Wards	Inpatients: Critical Care	Theatre & Procedure Suites	ED	Outpatients
As per relevant Salaries & Wages line item.	As per relevant Salaries & Wages line item.	As per relevant Salaries & Wages line item.	As per relevant Salaries & Wages line item.	As per relevant Salaries & Wages W line item.

Table shows: Line Item/Point of Delivery - Hotel Services

Preferences	Inpatients: Wards	Inpatients: Critical Care	Theatre & Procedure Suites	ED	Outpatients
Preference 1	Actual cost.	Actual cost.	Actual cost.	Actual cost.	Actual cost.

Preferences	Inpatients: Wards	Inpatients: Critical Care	Theatre & Procedure Suites	ED	Outpatients
Preference 2	Standard cost.	Standard cost.	Standard cost.	Standard cost.	Standard cost.
Preference 3	Fractional days – ward/unit specific with local RVUs.	Fractional days – ward/unit specific with local RVUs.	Fractional days – ward/unit specific with local RVUs.	Triage/UDG category with local RVUs.	Clinic type with local RVUs.
Preference 4	OBDs – ward/unit specific with local RVUs.	OBDs – ward/unit specific with local RVUs.	OBDs – ward/unit specific with local RVUs.		

Table shows: Line Item/Point of Delivery - Depreciation

Preferences	Inpatients: Wards	Inpatients: Critical Care	Theatre & Procedure Suites	ED	Outpatients
Preference 1	Actual cost.	Actual cost.	Actual cost.	Actual cost.	Actual cost.
Preference 2	Standard cost.	Standard cost.	Standard cost.	Standard cost.	Standard cost.
Preference 3	Fractional days – ward/unit specific with local RVUs	Fractional days – ward/unit specific with local RVUs.	Fractional days – ward/unit specific with local RVUs.	Triage/UDG category with local RVUs.	Clinic type with local RVUs.
Preference 4	OBDs – ward/unit specific with local RVUs.	OBDs – ward/unit specific with local RVUs.	OBDs – ward/unit specific with local RVUs.		

Terminology:

- Actual cost – the feeder system provides the purchase cost of the individual items consumed by the patient.
- Actual with RVU – the feeder system provides the number of units by service consumed, and an RVU applied to the feeder system data creates a suitable cost allocation method.
- Doctor/Nurse/Allied Health actual time – total time from the commencement to completion of treatment for all staff within each category. Time may be accumulated over several patient/provider contacts.
- Actual and planned nursing time per patient is only available from patient/nurse dependency systems (PNDS) such as Trendcare.
- Planned time (other than nursing) are the costs of the rostered staff divided by the number of patients seen (ie an equal share is allocated to each patient).
- Fractional days discriminate between sameday and overnight inpatients, OBDs do not. Calculated by (date/time discharge – date/time of admission) in hours / 24. For all categories other than Ward Medical S&W, fractional bed days are considered superior to OBDs (they are deemed equal for Ward Medical S&W).
- Specific Fractional days/OBDs are specific to a ward or clinical unit, General Fractional Days/OBDs are not. General days should only be used in small hospitals

without a ward/unit structure, or where there is a gross mismatch between the ward/unit and cost centre structure.

- Bands Costing (theatre) – DVA theatre banding schedule amendment to CMBS/ICD10AM)
- Prosthetic Band costs are standard high/medium/low costs that are broadly sensitive to the procedure undertaken.
- Standard costs – bottom up costing linked to procedures, diagnosis or service (eg triage/UDG categories).

The allocation methods in each cell of the table are not exhaustive and are ranked in order of preference. Some methods (Actual cost for Medical or Other S&W) may never be used in practice and others are considered equivalent. Each site needs to use their own judgement as to which methodology and classification best fits their local approach.

COST 4.001 – Costing Frequency

Number	COST 4.001
Name	Costing Frequency
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	
Applicability	All hospitals
Principle	Regular costing of hospital activity improves the usefulness of information to health services
Standard	Hospitals should undertake regular costing of products (monthly or quarterly) and review the results for reasonableness. Quarterly data should be finalised within three months of the end of the reference period. Final costing for a financial year should be completed by the end of the calendar year.
Definitions	The reference period is the period being costed. The interim costing of the first quarter of the financial year should occur by the end of the second quarter.
Guidelines	Costing during the financial year (and within three months of the end of the financial year) are considered interim. Final costing is typically done after the end of the financial year when all source data is final and any adjustments indicated by the quarterly costing results have been made.
Related Standards	Nil
Reference Documents	
Sources	Nil

COST 5.001 – Accumulating Patient Costs

Number	COST 5.001
Name	Accumulating Patient Costs
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	February 2011
Applicability	All hospitals
Principle	The cost of all service events or intermediate products prescribed or ordered during an inpatient episode, ED presentation or outpatient visit should be captured and attributed to the correct episode, presentation or visit. When there are multiple possibilities for cost attribution, the point of referral or an explicit hierarchical encounter matching method must be used.
Standard	Intermediate products will be costed with the patient service event where the service is referred or prescribed.
Definitions	Patient service event refers to an admitted episode (from admission to discharge), and an outpatient or Emergency Department visit.
Guidelines	Best practice is to cost all associated services using a direct link between the patient episode data and the consumption data - preferably with associated cost data. Under this scenario, episode matching is not separately required as the process is explicit in determining that the two are part of the same service event. Best practice is to accumulate consumption data and costs for the full length of the patient episode (irrespective of whether the episode has ended or spanned different financial years) In cases where the direct link is not possible, there is a requirement to refer to the order request point and encounter matching method standards to ensure that appropriate costing to the Patient Service Event / Episode is occurring. In the case of a care type change, each episode is considered to be distinct with a clear boundary at the point of discharge from one episode and the commencement of the second episode. In the case of long stay episodes not discharged during the cost study period an interim cost calculation based on the summation of costs to the end of the fiscal period included in the cost study will ensure an accurate reflection of costs. There are two important components to this process: • All episodes need to receive appropriate cost allocations. In the case of long stay patients (who are not discharged in a cost study period) hospitals who cannot cost work in progress may need to undertake a “dummy” discharge to ensure that the appropriate costs for these patients have been allocated depending on the patient costing system used. • These patients will need to be recorded in the reconciliation of patient days and costs or full reconciliation will not be possible. Note: Where long stay episodes span multiple costing periods and

	the patient days and costs have been allocated in the previous period, it is important to ensure that the costing process does not account multiple times for the same episode.
Related Standards	
Reference Documents	
Sources	

COST 5A.001 – Order Request Point

Number	COST 5A.001
Name	Order Request Point
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	February 2011
Applicability	All hospitals
Principle	In order to associate the cost of intermediate products, the order request point needs to be clearly identified.
Standard	All hospitals will ensure that intermediate products ordered for patients of the hospital as part of a service event must be allocated to one of the following: • Inpatient Care • Non-Admitted Care • Emergency Department Care • Hospital Auspiced Community Health
Definitions	The services where it is particularly important to ensure correct allocation include: • Pathology • Imaging • Pharmacy • Allied Health For the purpose of matching order request point includes that part of the hospital where an intermediate product is ordered or prescribed.
Guidelines	It is important to capture the services that are provided to patients within each hospital output group. For a patient under the care of the Emergency Department who has an imaging test, the cost of that test must be reported against the ED episode even if the patient is subsequently admitted to a ward. Care type changes are regarded as distinct episodes.
Related Standards	REP 1.002 – Reporting of Patient Costs
Reference Documents	
Sources	NHCDC Hospital Reference Manual

COST 5B.001 – Encounter Matching Method

Number	COST 5B.001
Name	Encounter Matching Method
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	February 2011
Applicability	All hospitals
Principle	Encounter matching needs to be undertaken to ensure that all intermediate products are matched to the correct patient encounters.
Standard	Intermediate products will be matched to the appropriate patient encounter using appropriate business rules.
Definitions	Nil
Guidelines	The successful matching of feeder system to patient encounters is integral to the reliability of the costing process. The ideal is that each and every intermediate product is matched to the encounter where the service has been ordered (that is where a diagnostic test is ordered or drug prescribed). However the date/encounter matching of the feeder systems can sometimes result in discrepancies where the matching rules need to be relaxed to allow the matching of encounter with patient episode/occasion of service. The risk is that inappropriate matches can occur. These are often referred to as "false positive" matches. The purpose of this standard is to minimize the unmatched encounters while simultaneously minimising the false positive encounter matches. In some instances there will be a proportion of encounters which are not able to be matched without a high risk of false positives. Where there is a good date/time capture and patient identifier, the risk of false positives is low. Even in this circumstances there are explained failed encounter matches as the service is delivered outside the patient's episode/occasion of service period. There are several issues with the encounter matching that need to be managed under this standard: • Linked to the correct patient type (e.g. prostheses from the operating room feeder system should only go to Admitted Patients etc). • Where there are multiple possibilities, make a consistent decision (correct date, but no time stamp). For example, radiology for a patient presenting at ED and then subsequently admitted could always be matched to the Emergency attendance rather than the resultant inpatient admission episode. • Where the attendance is out of date scope, some flexibility may be required for the matching of the encounter before and/or after the episodic event. • If multiple matches are possible for the same intermediate product the default hierarchy is Inpatient, Emergency Department, Non-Admitted and Non-Hospital (in that order). Several issues need to be considered when applying the rules: • It is possible that valid encounters can occur outside these parameters. However if rules are applied to capture these unusual encounters, care must be taken not to create

undesired false positive encounter matches.

- Some of the encounter rules will rely on the episode type boundary specification for the study. If a planned ED attendance is considered an outpatient then the ED cost type rules will need to be invoked.
- The hierarchy of selection if multiple possibilities will not take precedence over the days of flexibility. For example if a Radiology test occurs within 4 days of an IP episode and within 2 days of an Non-Admitted episode the Non-Admitted Episode will be considered the best match.
- In the event that the date is ambiguous (e.g. the pharmacy system only records the date of script), then extend the match to incorporate the ambiguity, taking care to minimise false positive encounter matches.
- The date time for nursing acuity systems where used will have a patient admitted after midnight may have a record with the prior day due to these systems being based on start of shift.
- If no matching patient episode can be found, a dummy episode should be created.

For each of the feeder systems used in the hospital's costing process the following provide a measure of the reliability of the matching process:

- Type of feeder system
- Type of unit of allocation
- Total transaction count
- Total cost allocated by Feeder
- Percentage of transactions to admitted products
- Percentage of transactions to non-admitted products
- Percentage of transactions to Emergency dept products
- Percentage of transactions to non hospital products
- Percentage of unlinked activity

Indicative Matching Proportions:

Based on a sample of major metropolitan and regional hospitals, the following percentage ranges for matching ancillary services would be considered normal for similar hospitals:

	Pathology	**Imaging**	**Pharmacy**
Admitted Inpatients	50-70	30-50	55-80
Emergency Departments	5-20	15-40	1-10
Outpatients	10-30	15-40	10-40
Unlinked	1-10	1-10	1-10

Hospitals may have quite different profiles for a variety of perfectly valid reasons (eg small rural hospitals may have the only imaging services in the area and will therefore have a much higher proportion of services which cannot be linked to a hospital episode). Variation is quite acceptable provided the site can explain the reasons for the variation.

Note:
The type of feeder would typically be one of: Nurse Dependency,

	Radiology, Pharmacy, Allied Health, Procedure room, Laboratories etc. There will also likely to be more than one for some systems. For example Radiology may have a feeder for X-ray, MRI, Ultrasound etc. The type of unit of allocation will typically be one of: • Time • Actual Cost • RVU, or • Standard cost The total transactions count would be the number of the encounters as captured by the feeder system. The total cost allocation, represents the total cost allocated by the feeder and provides a weighting to assist in the measurement of hospital cost reliability. Percentage of activity linked to product types. The issues identified by these statistics are designed to ensure that expected flows of costs will be passing to non admitted products. A secondary issue will be the unlinked (failure in process) transactions.
Related Standards	
Reference Documents	
Sources	Nil

DEP 1.001 – Capital Expenditure

Number	DEP 1.001
Name	Capital Expenditure
Status	Approved – public sector
Effective Date	1 July 2012 (Round 16)
Revised Date	February 2011
Applicability	All hospitals
Principle	All assets used in the provision of patient services in hospitals must be reflected accurately in the Fixed Asset Register and included in a cost allocation exercise.
Standard	Hospital patient costing must include expenditure in relation to: • All purchased assets used in the provision of patient care including improvements to those assets; and • Donated assets (regardless of whether the assets are purchased with donated funds, donated physical assets or funds granted by the Commonwealth). Hospital patient costing must exclude expenditure in relation to: • Buildings surplus to requirements for operating a hospital; • Buildings exclusively used in the provision of teaching, research and training; and • Intangible assets with infinite useful lives. Hospital patient costing must: • Include depreciation and amortisation; • Include any loss or profit on the sale of assets; • Include any revaluation increments or decrements that are recognised in the profit and loss; and • Exclude any actual interest expense associated with financing asset purchases .
Definitions	*Improvements:* Improvements extend the useful life of an asset, increase its service capacity, increase income-earning capacity or reduces operating costs. These costs are capitalised and so will be included in the depreciated value of an asset. *Fair value:* The amount for which an asset could be exchanged between knowledgeable, willing parties in an arm's length transaction.
Guidelines	*Donated assets* Assets donated to a hospital (where the physical asset has been donated) must be recorded in the balance sheet and Fixed Asset Register at fair value in accordance with accounting standards. Hospitals cannot apply this standard retrospectively without affecting audited financial statements. Discussions with auditors must be held before any decision is made to recognise a donated asset on the balance sheet and asset register if the asset was obtained in a prior year.
Related Standards	
Reference Documents	
Sources	AASB 116 Property, Plant and Equipment AASB 1004 Contributions

DEP 1A.001 – Asset Recognition

Number	DEP 1A.001
Name	DEP 1A.001 Asset Recognition
Status	Approved – public sector
Effective Date	1 July 2012 (Round 16)
Revised Date	February 2011
Applicability	All hospitals
Principle	Consistency of asset recognition policies across all States and Territories
Standard	Asset recognition policies should be consistent across State/Territories to ensure comparability in cost data collection. The asset acquisition or improvement recognition threshold for all hospital property, plant and equipment should be no greater than $10,000.
Definitions	*Asset recognition threshold* The amount selected as appropriate for recognising assets, taking into consideration materiality and practicalities of maintaining the asset on an asset register. Amounts below this threshold are expensed at the time of purchase.
Guidelines	*Improvements vs Maintenance* Generally, the decision whether to capitalise subsequent expenditure on an asset or to expense it, is based on whether the expenditure maintains the asset's original service potential or whether it improves it. The accounting standards provide guidance only and the decision as to whether expenditure improves the asset is subjective. As such, each amount over the threshold will need to be considered on a case-by –case basis.
Related Standards	
Reference Documents	
Sources	AASB 116 Property, Plant and Equipment AASB 138 Intangible Assets

DEP 1B.001 – Revaluation of Assets

Number	DEP 1B.001
Name	Revaluations of Assets
Status	Approved – public sector
Effective Date	1 July 2012 (Round 16)
Revised Date	February 2011
Applicability	All hospitals
Principle	All assets requiring revaluation should be on the same valuation cycle to ensure comparability amongst States/Territories.
Standard	All assets subject to the revaluation method of accounting for Property, Plant & Equipment should be subject to an independent valuation at 30 June 2012 and then at least every 3 years following this date. Revaluation increments and decrements that are recognised in the profit and loss should be allocated to patients using the same allocation methods as for depreciation and amortisation.
Definitions	*Revaluation method:* After recognition as an asset, an item of property, plant and equipment whose fair value can be measured reliably shall be carried at a revalued amount, being its fair value at the date of the revaluation less any subsequent accumulated depreciation and subsequent accumulated impairment losses. *Independent Valuation* A valuation undertaken by a professionally qualified expert, such as a qualified valuer or quantity surveyor, who is independent to the Department of Health in the relevant State/Territory. The Valuer General in the relevant State/Territory is considered to be an independent party.
Guidelines	*Revaluations of fully written down assets* In line with AASB 116, if a fully written down asset is revalued, then all property, plant and equipment in the same class must be revalued at the same time. Given the large number of assets in each class, this is likely to be impractical. Instead adjustments to the useful life on individual assets should be made prior to an asset being fully depreciated. Refer to Cost Standard DEP 1C.001 - Useful Life for guidance on determining the useful life of assets. *Revaluation methodology* This standard prescribes the timing rather than the methods for revaluations. Revaluation methodology must still be in line with guidance from the relevant State/Territory. *Revaluation increments/decrements* Revaluation decrements recorded in the profit and loss of a hospital in accordance with accounting standards, should be costed using the same methodology as the depreciation for the asset to which the decrement relates. Revaluation increments recorded in the profit and loss of a hospital in accordance with accounting standards, should be offset against the depreciation for the asset to which the increment relates, prior to depreciation being costed in respect of that asset.
Related Standards	

Number	DEP 1B.001
Related Documents	
Sources	AASB 116 Property, Plant and Equipment

DEP 1C.001 – Useful Life

Number	DEP 1C.001
Name	Useful Life
Status	Approved – public sector
Effective Date	1 July 2012 (Round 16)
Revised Date	February 2011
Applicability	All hospitals
Principle	All assets currently used in the provision of patient services in hospitals must be consistently reflected in the Fixed Asset Register
Standard	All hospitals will assign useful lives to assets based on the minimum useful lives provided in this standard.
Definitions	*Useful life:* The period over which an asset is expected to be available for use by an entity.
Guidelines	The list of useful lives provided are the minimum useful lives to be assigned to classes of asset. Hospitals may select a longer useful life if this better reflects the service capacity of the asset. These minimum useful lives apply to asset purchases from 1 July 2011 onwards. *Reassessment of useful life* Reassessment of useful life is permitted where an asset has serviceability longer than its remaining useful life. A hospital can choose to depreciate an asset's written down value over the adjusted remaining years of serviceability. The reassessment must be performed in accordance with accounting standards. The reassessment of useful life cannot be performed on assets that are fully written down without revaluing all assets in that class.
Related Standards	
Reference Documents	
Sources	AASB 116 *Property, Plant and Equipment* *Taxation Ruling TR 2010/2 - Income tax: effective life of depreciating assets (applicable from 1 July 2010).* – To be updated annually

Full ATO list of useful lives as at 1 July 2010

ASSET	LIFE (YEARS)
Anaesthesia machines	10
Angiography assets:	
Image acquisition system (incorporating computer with digital subtraction capability, digital camera, monitor and integrated software)	4
Image intensifier	7
Patient gantry or table, patient monitoring assets, positioning assets, and pressure injectors	10
Cell savers and cell separators	7
Colposcopes	10
Defibrillators	10
Diathermy and cautery machines/electrosurgical generators	10
Endoscopic surgery assets (excluding disposable accessories):	
Arthroscopic fluid management systems	7
Endoscopes (flexible and rigid) and endoscopic surgical instruments	4
Endoscopic camera systems:	
Beam splitters and light sources	10
Printers, video cameras, video camera adaptors, couplers and heads, video image capture systems and video processors	5
Still cameras	7
Video monitors and video recorders	7
Endoscopic electrosurgical generators	10
Endoscopic lasers	10
Endoscopic ultrasound systems (incorporating scanner, transducers/probes, integrated computer and integrated software)	5
Haemodialysis machines	7
Head lights	7
Hospital furniture:	
Beds:	
Electronic	7
Mechanical	10
Bedside cabinets/lockers, carts and poles, blanket warming cabinets, blood warming cabinets, medical refrigerators, and overbed tables	10
Infusion pumps:	
General, pain management and rapid	8
Syringe driven	6
Insufflators	10
Lithotriptors used for extra-corporeal shock wave lithotripsy	7
Mechanical assist assets:	
Calf and cuff compression devices	8
Cardiac bypass and heart lung machines	8
Intra-aortic balloon pumps	8
Ventricular assist heart pumps	8
Natal care assets (including incubators, infant warmers and mobile infant warmers)	7

Operating tables and attachments:	
Electronic	10
Mechanical	13
Operating theatre lights	8
Pan flushers	10
Patient hoists and lifters	10
Patient monitoring assets:	
Bedside monitoring systems	7
Cardiac monitors	7
ECG (electrocardiographs)	7
Foetal monitors	7
Pulse oximeters	7
Vital signs monitors	7
Patient warming assets (excluding disposable accessories):	
Fluid warmers	10
Forced air patient warmers	10
Smoke evacuators	8
Sterilisation and autoclave processing assets:	
Drying cabinets	10
Endoscope sterilisers and disinfectors	5
Flash sterilisers	10
Instrument washers	10
Pre-vacuum sterilisers	10
Ultrasonic cleaners and baths	7
Surgical instruments:	
Hand held manually operated instruments	8
Powered instruments (including drills, saws, shavers, non-disposable instrument accessories and power sources)	7
Ultrasonic aspirators	10
Ultrasonic scalpels	10
Surgical lasers (excluding ophthalmic surgical lasers)	10
Surgical microscopes	10
Ultrasonic bladder scanners	10
Ultrasonic needle guides	10
Ultrasound systems (incorporating scanner, transducers, integrated computer and integrated software) used by cardiologists, obstetricians and vascular surgeons	5
Ventilators:	
Fixed	7
Portable	5
Wheelchairs	10

DEP 1D.001 – Classes of Assets

Number	DEP 1D.001
Name	Classes of Assets
Status	Approved – public sector
Effective Date	1 July 2012 (Round 16)
Revised Date	February 2011
Applicability	All hospitals
Principle	Assets should be grouped into classes that will assist with the allocation of capital expenditure-related costs to final cost centres.
Standard	For the purposes of cost attribution, depreciable assets will be categorised into the following classes: • Buildings and improvements • Plant and equipment • Intangibles
Definitions	*Intangible Asset* An intangible asset is an identifiable non-monetary asset without physical substance.
Guidelines	Nil
Related Standards	
Reference Documents	
Sources	Nil

DEP 1E.001 – Allocation of Depreciation and Amortisation

Number	DEP 1E.001
Name	Allocation of depreciation and amortisation
Status	Approved – public sector
Effective Date	1 July 2012 (Round 16)
Revised Date	February 2011
Applicability	All hospitals
Principle	The allocation methods for capital costs will apply the same allocation principles established by the other costing standards for the allocation of direct and overhead costs. In that context, the allocation of capital costs to patients should occur in three-stages: 1 Allocation of capital costs held in central cost centres to final or overhead cost centres (based on an appropriate allocation statistic) 2 Allocation of capital costs in overhead cost centres to final cost centres (using the same allocation statistic for capital costs as for other costs in the overhead cost centre). 3 Allocation of capital costs in final cost centre costs to patients (using an appropriate allocation statistic for direct capital costs and for overhead capital costs, the same allocation statistic as for other overhead costs in that cost centre)
Standard	**Stage 1 - Allocation of capital costs held in central cost centres to final or overhead cost centres** Capital costs, in central cost centres or held at an organisation-level, should be allocated to final and overhead cost centres based on an appropriate allocation statistic (which includes allocations to a specific cost centre where an asset is used by a single cost centre only). Where capital costs are already journalled directly to a cost centre and this attribution accurately reflects use of the asset, there is no need to identify and apply alternative allocation methods. **Stage 2 – Allocation of capital costs in overhead cost centres to final cost centres** The capital costs attributed to overhead cost centres should be allocated to final cost centres in the same way as all other costs in that overhead cost centre. **Stage 3 – Final cost allocation** Capital costs should be allocated to patients from final cost centres using one of the allocation methods set out in the hierarchy below.
Definitions	*Capital costs:* Capital costs are the expenses incurred in acquiring, producing or enhancing non-current (or fixed) assets. The associated expenses (that is, impacts on the profit and loss account) that are covered by this standard are: • Depreciation and amortisation – the annual charge that spreads the cost of an asset over its useful life (subject to variations for residual value and revaluations); • Any loss (or profit) on the sale of assets; and • Revaluation decrements and increments – revaluations only affect the profit and loss in very specific circumstances and so

Number	DEP 1E.001
	the impact of revaluations is most commonly recorded in a revaluation reserve (leaving the profit and loss account unaffected).
Guidelines	Nil
Related Standards	GL 5.001 – Matching Activity and Costs GL 4.003 – Cost Centre Mapping COST 1.001 – Overhead Allocation Method COST 3.002 – Final Cost Allocation
Reference Documents	
Sources	Nil

List of overhead allocation methods – Stage 1

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

Suggested allocation Statistics and Code – Stage 1

Type of capital cost	Statistic	Statistic
	1st preference	2nd preference
Medical equipment	Actual usage or relevant allocation statistic	OBD
P&E	Relevant allocation statistic	OBD
Buildings and improvements	Floor area	Floor area
Intangibles	Actual usage or relevant allocation statistic	OBD

List of final allocation methods – Stage 3

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

Suggested allocation method – Stage 3

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

FDR 2.002 – Relative Value Units

Number	FDR 2.002
Name	Relative Value Units
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	February 2011
Applicability	All hospitals
Principle	Where direct cost allocation is not possible, intermediate products costs should be allocated using validated Relative Value Units (RVUs).
Standard	All intermediate products must be assigned with appropriate RVUs that reflect the relative resource intensity of the products.
Definitions	*Intermediate products* are department specific and may represent either a product (e.g., catheter, medication) or a service (e.g., nursing care, x-ray) or a combination of products and services used in patient care. One example of an intermediate product that is a product includes the medications provided by the pharmacy or a hospital gown from central supplier. Intermediate products that are services include a cardiopulmonary resuscitation in the emergency department or nursing care in the intensive care unit. Examples of intermediate products that combine products and services include a coronary angioplasty in the cardiac catheterisation laboratory or a chest x-ray in the department of radiology. Relative Value Unit: The weighting of one product against another within a department to reflect the intensity of resource use.
Guidelines	In determining which RVUs to use, a series of factors should be considered, including whether it: • Has been through a validation process which should include expert review; • Is comprehensive and complete; • Is used for management purposes; and • Reflects current practice.. RVUs should be updated if there are changes in the purchase price; changes in clinical practice and technology and changes in the way the department is operated. Review of RVUs should be undertaken in conjunction with the staff involved in the service. Where labour costs are involved actual minutes should be used. The final verification of the product costs should occur in consultation with the relevant clinical staff. If RVUs external to the hospital are used, this must be documented.
Related Standards	GL 5.001 Matching Activity and Cost
Reference Documents	
Sources	Clinical Costing Standards Association of Australia Number 10

REP 1.002 – Reporting of Patient Costs

Number	REP 1.002
Name	Reporting of Patient Costs
Status	Approved – public sector
Effective Date	1 July 2011 (Round 15)
Revised Date	February 2011
Applicability	All hospitals
Principle	Hospitals will report costed episodes at a level of granularity that allows aggregation into different meaningful categories for benchmarking and informing price-setting.
Standard	Hospitals will report the full cost of episodes that are completed within the study period by line item, cost centre, date of service and order request point.
Definitions	Nil
Guidelines	Nil
Related Standards	GL 2.003 – Account Code Mapping to Line Items GL 4.003 - Cost Centre Mapping COST 5A.001 – Order Request Point
Reference Documents	
Sources	NHCDC Hospital Reference Manual

Glossary of Terms

Accrual accounting	An accounting approach which matches the costs of resources to the production period in which they were used (and hence to the products of that period). It is essential that costs are matched to the products in scope. In contrast, cash accounting involves attribution of the costs of resources to the period in which the expenditures were actually incurred. If accounts were handled in this way, you need to adjust them for the purposes of the complying with these standards.
Admitted patient	A patient who has been formally admitted to a hospital. Sub–categories of overnight stay and same–day are defined, as is the care type.
Allocation Statistics	Allocation statistics are relativities used to distribute overhead costs to the appropriate direct cost centres. These relativities are the best available measure of the relative units of consumption.
Amortisation	The systematic allocation of the depreciable amount of an asset over its useful life.
Average cost	In the costing context, the total cost of production divided by the number of products in a period. Also known as full average cost.
Capital costs	In general, costs relating to use of resources which can be applied to production over a prolonged period of time. They include costs associated with land, buildings, and equipment.
Casemix	The term Casemix refers to both the number and types of patients treated and the mix of bundles of treatments, procedures and so on, provided to patients. In general, Casemix is the use of resources in treating patients which is the key to understanding Casemix as a measure of hospital output and activities.
Cash accounting	*See* accrual accounting.
Commercial Business Entities	Commercial business entities are services that reside on the hospital campus but are not operated by hospital staff and do not relate to products of the hospital. .
Cost centre	An accounting entity where all costs associated with a particular type of activity can be recorded. Sometimes abbreviated to CC.
Cost group	Is a high level aggregation of the cost centres. Generally, Cost Groups relate to Allied Health, Operating Rooms, Radiology etc.
Cost weight	A measure of the average cost of an AR–DRG, compared with the average cost of a reference AR–DRG. Usually the average cost across all AR–DRGs is chosen as the reference value, and given a weight of 1.

Critical Care Unit	A designated patient care area in a hospital which is staffed with experienced clinicians skilled in the care of high acuity patients requiring intensive treatment, invasive monitoring and/or life support. Includes: adult, paediatric and neonatal intensive care and coronary
Depreciation	Depreciation is a non-cash expense which represents the decline in value of an asset over an estimate of how long the asset will effectively last.
Direct costs	Used in several ways to designate costs which are relatively easily related to products. In the standard product costing method, costs which are passed directly to cost centres from the general ledger (rather than allocated via overhead cost centres).
Direct product	In product costing, a product which emerges from the end of the production line. In the health setting this is the completed patient episode of care. It could be a acute admitted patient episode involving diagnostic imaging, pathology tests, drug therapies, surgical procedures, nursing care, physiotherapy, and so on. It could also be an outpatient clinic visit, or teaching.
Direct Product Cost Centre	*Direct cost centers* are patient care departments (e.g., radiology, operating room) that directly provide services to patients, In the product costing context, cost centres are generally classified as either overhead or final product. The latter type are also known as 'Final Cost Centres' and 'Patient Care Cost Centres'. Other final products include research and teaching
Direct Teaching	Direct teaching is where the student and the teacher have some contact. In this case the principal resource being consumed is staff time. (Example: Where the teaching takes place in a classroom or where a senior member of staff is supervising a junior member of staff.)
Episode of care	A phase of treatment from admission to separation. An admission may be 'statistical' in that the patient changed from one type of admitted patient category to another (between any two of acute, rehabilitation, palliation, or non–acute) without being separated from the hospital. It follows that there must be a 'statistical separation' before every statistical admission.
Feeder Systems	Information systems used throughout a given hospital to provide data on the services used by patients.
Final Cost Centre	A final cost centre is one that is directly involved in the creation of final products, and is usually directly attributable or specific to an episode of patient care. For this reason it is also known as a direct product cost centre or patient care cost centre
Full cost	The total cost of producing a service (product). It consists of the direct cost of producing a service, together with a share of the indirect costs.

General Ledger	A general ledger is a central repository of the accounting information of an organisation in which the services of all financial transactions during an accounting period are recorded
Indirect costs	Indirect cost centres are hospital overhead departments (e.g., administration, housekeeping), and the costs incurred by these departments are called *i*ndirect costs.
Inpatient	See admitted patient.
Intangible Asset	**An identifiable non-monetary asset without physical substance.**
Intensive Care Unit (ICU)	See Critical Care Unit.
Intermediate product	*Intermediate products* are department specific and may represent either a product (e.g., catheter, medication) or a service (e.g., nursing care, x-ray) or a combination of products and services used in patient care. One example of an intermediate product that is a product includes the medications provided by the pharmacy or a hospital gown from central supplier. Intermediate products that are services include a cardiopulmonary resuscitation in the emergency department or nursing care in the intensive care unit. Examples of intermediate products that combine products and services include a coronary angioplasty in the cardiac catheterization laboratory or a chest x-ray in the department of radiology.
Length of stay (LOS)	The number of days an inpatient spends in hospital. (ie the total number of days– usually measured in multiples of a 24-hr day that a patient occupies a hospital bed .) The most common methodology for deriving length of stay involves subtracting the admission date from the discharge date.
Line item	Line items are groups of GL expenditure account codes defined by input type (rather than type of function), and which define resources being used by a cost centre. For example, they might be drugs, prostheses, or nursing salaries.
Long Stay Patient	For the purpose of costing, the definition of long stay patients are those remaining in the hospital for more than 200 days but not discharged at the end of the financial year
LOS or ALOS	See length of stay. ALOS is the acronym for “average length of stay”.
Occupied bed day (OBD)	A term used in Australia to describe an admitted patient day of stay. Also termed bed–day. An overhead cost centre provides its services to other cost centres rather than directly to patients (as is the case for patient care cost centres). Examples are building costs and linen services.

Offsetting Costs	Offsetting means the reduction in the cost of providing a service by revenue or recoveries generated
Operating Room (OR)	A designated patient care area in a hospital which is staffed with experienced clinicians skilled in the care of patients requiring operations
Order Request Point (OPR)	Where an intermediate product is ordered or prescribed.
Overhead Cost Centre	An overhead cost centre is a cost that has an incidental rather than a direct relationship to a specific episode of patient care. It will usually involve a service that is provided to parts of the hospital rather than to individual patients.
Relative Value Units	The weighting of one product against another within a department to reflect the intensity of resource use
Research	For the purposes of costing, research is an activity where the primary aim is the advancement of knowledge through: observation, data analysis and interpretation, or other means that are secondary to the primary purpose of providing patient care and/or activities associated with patient care where additional components or tasks exist (for example, the addition of control group in a cohort study). This excludes curriculum-based research projects
Teaching	Teaching is any activity where the primary aim is to transfer clinical knowledge for ongoing professional development via a teacher or mentor to a student or candidate in a recognised program/course that will result in either qualifications that may meet registration requirements; or other admission to a specified discipline where the right to practise in that discipline requires completion of the program or course.

Related Links

- Department of Health and Ageing, National Hospital Cost Data Collection
- Australian Accounting Standards Board, Presentation of Financial Statements Report
- METeOR website

ATTACHMENT A: Line Items Definitions

Salary and Wages

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

a) to an individual;
b) as remuneration for services; and
c) provided under a contract of service (employment contract).

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

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

1. Nursing, Salaries and Wages

Nursing Salary and Wages includes the following categories of staff:

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

Refer to Schedule A for secondary details of these categories.

2. Medical, Salaries and Wages (non VMO)

Medical Salary and Wages includes the following categories of staff:

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

Refer to Schedule A for secondary details of this categories.

3. Medical, Salaries and Wages (VMO)

Visiting Medical Officers are defined as:

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

4. Allied Health, Salaries and Wages

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

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

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

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

Other staff types, Salaries and Wages

5.1 Other Personal Care staff

- Staff engaged primarily in the provision of personal care to patients or residents, who are not formally qualified or undergoing training in nursing or allied health professions and are not allocated as an overhead cost.

This category includes attendants, assistants or home assistants, home companions, family aides, ward helpers, ward assistants, assistants in nursing and Aboriginal Health Workers.

5.2 Other Administrative, Maintenance and Clerical Staff

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

5. Labour (staff) on costs, all staff types

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

6. Pathology

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

Animal Testing
Autopsy
Blood Products

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

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

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

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

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

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

1. The product must be included or being considered for inclusion on the Australian Register of Therapeutic Goods; and
2. The product must be provided to a person as part of an episode of hospital treatment or hospital-substitute treatment; and
3. A Medicare benefit must be payable in respect of the professional service associated with the provision of the product (or the provision of the product is associated with podiatric treatment by an accredited podiatrist); and
4. The product should:

(a) be surgically implanted in the patient and be purposely designed in order to:
(i) replace an anatomical body part; or
(ii) combat a pathological process; or
(iii) modulate a physiological process; or

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

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

5. The product has been compared to alternate products on the Prostheses List or alternate treatments and:
(a) assessed as being, at least, of similar clinical effectiveness; and
(b) the cost of the product is relative to its clinical effectiveness.

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

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

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

It also includes dressings, minor surgical instruments, medical gases, disposable medical supplies, medical and surgical appliances such as splints, crutches and wheelchairs.
In addition, includes items of medical equipment, surgical instruments and patient appliances which have a life of less than one year.

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

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

Services**:** labor performed by an individual or organisation on behalf of others. Provision of services for which they are paid by a client.

Goods and Services also include the following:
Repairs and Maintenance

The costs incurred to bring an asset back to an earlier condition or to keep the asset operating at its present condition**.**

Costs incurred on existing non-current assets that maintain the usefulness of an asset are repairs and maintenance expenses.

Costs incurred on repairs and maintenance of assets are to be expensed in the Operating Statement when incurred.

Pharmaceuticals
Pharmacy costs are goods and services used in the provision of a pharmaceutical service and consumables or the actual cost as billed by a provider. The costs are to split in PBS reimbursed pharmaceuticals and PBS non – reimbursed pharmaceuticals, as defined below.

PBS reimbursed pharmaceuticals
A "pharmaceutical benefit" within the meaning of the Act refers to:

(a) An item which is listed in the Schedule of Pharmaceutical Benefits; or
(b) An item, which is listed in the Schedule of Pharmaceutical Benefits and is supplied by an approved supplier under Part 7 of the NHA subject to subsidy. Includes Section 100/High Cost Pharmaceuticals

Section 100 /high cost drugs criteria for inclusion of drugs in the program can be summarised as follows:

(a) Ongoing specialist medical supervision required.
(b) Treatment of chronic medical conditions, not acute episodes of inpatient treatment (includes out patient, day patient and discharge medication).
(c) Drug highly specialised.
(d) Marketing approval in Australia for approved indications.
(e) High unit cost and identifiable patient target group.

PBS non- reimbursed pharmaceuticals
Non-PBS drugs are defined as: where a patient's clinical condition does not match the restriction on the Schedule of Pharmaceutical Benefits, and a non-PBS prescription is written using a PBS prescription form. However, it must be identified as "Non-PBS" on the prescription.

Drugs are defined as Non-PBS when prescribing of a medicine that is not listed on the Schedule of Pharmaceutical Benefits.

This includes the purchase, production, distribution, supply and storage of drug products and clinical pharmacy services of all drugs not covered in PBS.

Blood Products and Services
Defined as the following:

(a) products *(*blood products) that are used or intended for use for human therapeutic or diagnostic purposes and that:
    (i) consist of human blood or components of human blood; or
    (ii) are derived from human blood; or
(b) products (blood-related products) that are used or intended for use for human therapeutic or diagnostic purposes and that:
    (i) are alternative, analogued or complementary to the use of blood products; and
    (ii) are regarded as blood-related products for the National Blood Agreement; or
(c) services, equipment or procedures that are regarded as blood-related services for the National Blood Agreement and that:
    (i) are used in the collection, supply or use of blood products or blood-related products; or
    (ii) are alternatives to the use of blood products or blood-related products; or
    (iii) reduce the need for blood products or blood-related products; or

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

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

Building Depreciation
The systematic allocation of the depreciable amount of an asset over its useful life. Includes Fixed Fitout such as items fitted to the building e.g. lights, partitions etc.

Equipment Depreciation

The systematic allocation of the depreciable amount of an asset over its useful life.

Includes non fixed building fitout includes facility fitout items such as theatre tables, moveable furniture, and chemotherapy chairs etc.

Hotel Goods and Services (Source NHCDC: Hospital Reference Manual)

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

Corporate costs (from outside the hospital GL and not otherwise specified)
For the purposes of the NHCDC corporate overheads costs comprise expenditures related to the provision of health care services, but occurring outside the hospital cost centre structure. Examples of these costs include:

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

List of exclusions

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