MVI Multi-View Incorporated

BENCHMARKING

The MVIB Benchmarking System Manual 15.0

Revolutionizing Benchmarking and the Way Hospices Manage!

Multi-View Incorporated Benchmarking
https://mvib.net 772-569-9811

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BENCHMARKING

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Overview

The Benchmarking System tracks over 900 operational elements of a hospice. With the press of a button or a simple cut and paste, a hospice can know the critical financial factors needed for managing, planning, and monitoring operations, as well as having the ability to compare performance with other hospices. The Hospice Benchmarking System is really 4 different applications.

The system is a set of very complex and integrated applications that have evolved since 1996, incorporating F9 (Dynamic Data Exchange), Visual Basic, and special coding in a user and analyst friendly Microsoft Excel environment. It is THE tool that MVI has used to help hundreds of hospices become more financially viable. The system has a proven track record of accuracy and reliability. Of course, like any system, the underlying data must be sound and accurate. However, even in the case of "dirty data", the system can quickly detect problem areas and even has provisions to deal with bad data so that decisions can still be made.

The Benchmarking System is made up of 4 different applications:

- The **Management Application (MA)** – This application is the heart of the system. It allows a hospice to easily bring together its statistical and financial data to provide meaningful management reports. This system will also allow you to produce a data Upload to submit via email for MVIB to review and load to the Master Data Set.
- The **Alerts Utility/Validator** – This application evaluates the Upload data that is submitted. It tests data for internal consistency and reasonableness. The data that is accepted is then included in the Master Data Set (MDS). Please allow two business days for our staff to process your data and load it to the MDS.
- The **Master Data Set** – This is the data repository. All of the data that is transmitted and passes evaluation by the Alerts Utility is included in the Master Data Set.
- The **Benchmarking Application (BA)** – This application is installed on a hospice's network to allow a hospice to compare its data to other hospices based on the criteria specified. When a user specifies criteria in the BA, the application accesses the Master Data Set via the internet. The results of the query are reported and saved. Each query is saved for additional analysis. In addition to benchmark reporting, the application offers summary reporting that allows a hospice to see its operations compared indirectly to other hospices in an attractive graphical representation.

Your information is held in strict confidence! We do not share it directly with any other organizations or individuals. It may only be shared indirectly through our benchmarking efforts that help to benefit all hospices we serve. No specific reference is ever directed towards any client unless the hospice has consented to such reference.

How to Make a Financial Success for Your Hospice?

As a leader in your organization, take it as a personal challenge to make this tool part of your management system. Let the Benchmarking System become your Business Model. This may mean charging a staff person to "own" the system or it may be something you want to master yourself. In smaller hospices, it is often the CEO that masters the system and there are many examples of leaders of small hospices that have made tremendous financial accomplishments using the system…many which had never in their history experienced positive Net Operating Incomes. There is a confidence that comes from "knowing your numbers" that leads to action. Becoming conscious of the quantified facts of your hospice will lead you to make more informed decisions based on precise information. It is only with this "consciousness" that a hospice can intelligently direct resources and energy.

MVIB has created the system and will train you to use it, but ultimately the benefits derived are determined by you. Within a few work hours you will have this system up and running. It is an example of spending a little time to get a big payoff. The time required to interpret the results takes more time. However, if you devote the necessary time to understand the system, it will provide long-term benefits that will save hundreds of hours of time and thousands of dollars…all for a few hours of effort.

Purpose of the System and a Word about Multiple Perspectives

The **primary purpose** of the Benchmarking System is to provide a hospice a set of meaningful management reports that can be used on a monthly basis to enable the intelligent direction of energy and resources based on precise information. This set of reports has proven to be very effective with hundreds of hospices of all sizes and compositions.

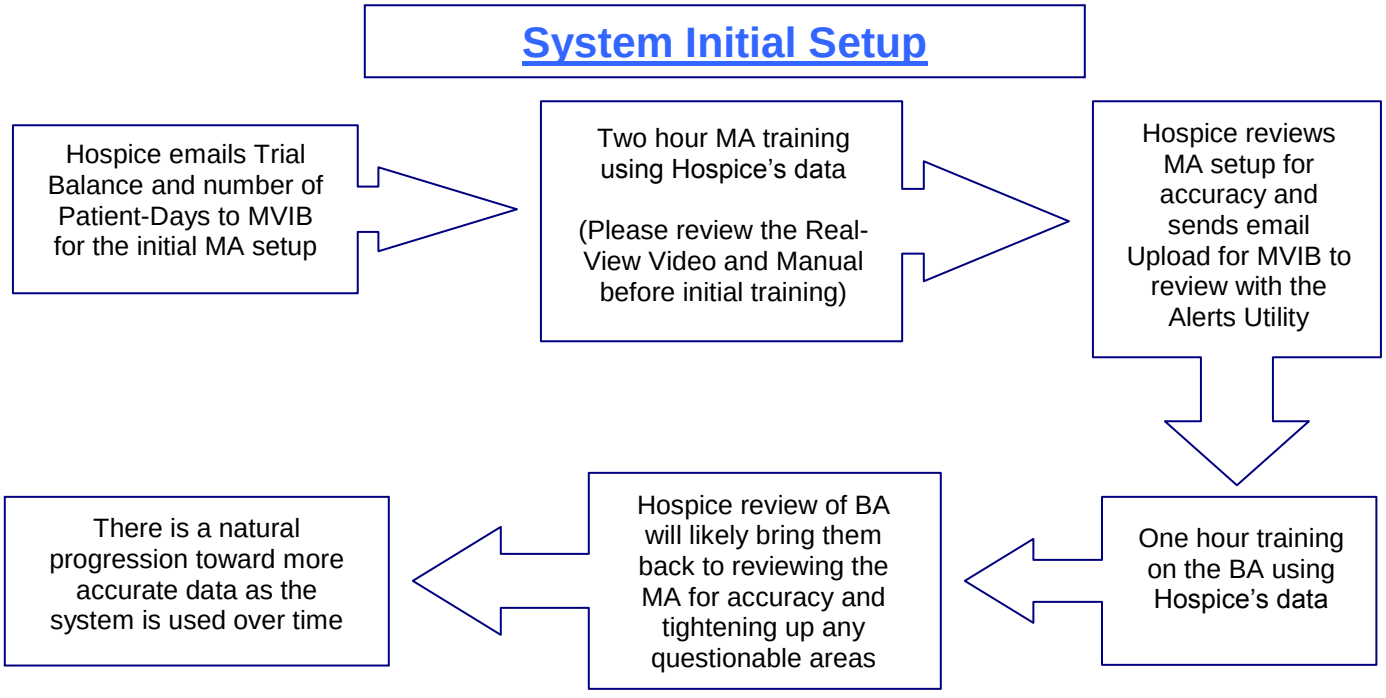
The **secondary purpose** of the system is to automate benchmarking whereby a hospice can compare its performance to other hospices with very little effort. For benchmarking, we suggest that each hospice email its data as often as desired, but at least quarterly. We will validate the data and, if it is acceptable, post it to the ***Master Data Set***. You can then access the data with the **Benchmarking Application** where your data is compared to other programs based on the criteria you define. Over 900 data points are benchmarked in the system.

The Benchmarking System provides a hospice with a multi-dimensional perspective of its operations. Multi-dimensional perspectives are needed for intelligent decision-making, as a single view may not show problem areas or give enough information to make sound judgments. For example, just because your patient-day costs are good does not in any way indicate that you are getting high productivity. Staff could be on the payroll and be sitting around the office. However, if you are looking simultaneously at visit-durations, visit costs, and visit-hour costs, you will get an idea of what is happening from a productivity perspective.

Access to the System

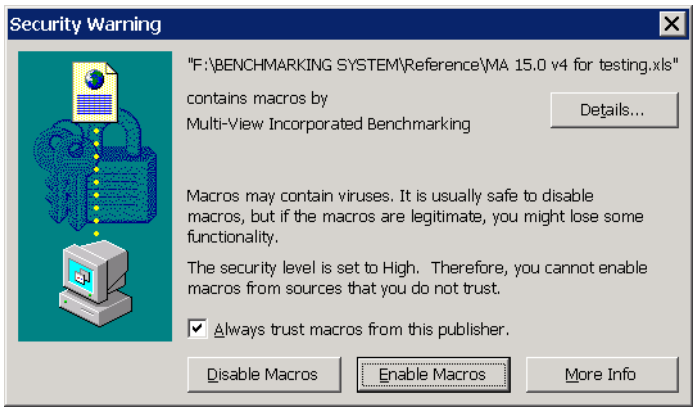
This system can be installed on **anyone's** computer with email capabilities, an internet connection, and Excel (preferably Excel 2007 or greater). What we mean by this is that it can be accessed by the CEO, CFO, COO, or anyone that you would like to view the information at no additional charge. In fact, all reports can be made accessible to anyone on the network. Since this is a pretty deep analysis, we suggest that the CEO, CFO, and director of clinical operations be given access to the system. This helps everyone be on the same page and have a common point of reference. It also encourages personal growth, as understanding and interpreting the results is required for the system to be useful.

NOTE: At anytime, the Upload data in the system can be emailed to MVIB. It is important that the results be e-mailed at least every quarter, preferably monthly. It takes 2 business days for our staff to review the results with the Alerts Utility/Validator and email comments back to your hospice. At that time you can communicate with your hospice team that the most recent data is ready to be looked at in the BA. We can then provide professional commentary and interpretation or other assistance as needed.



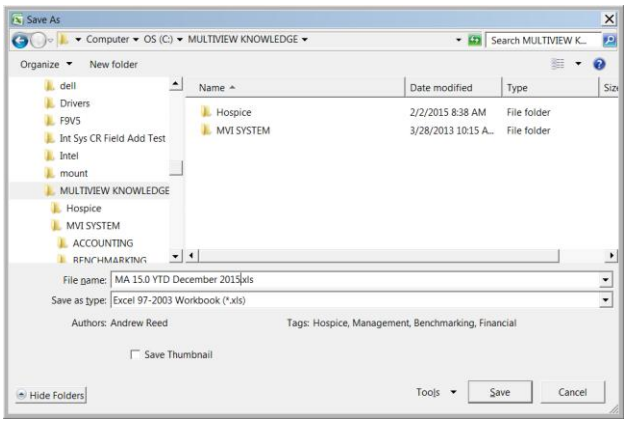
Excel Basics and F9

Most hospices are very familiar with Microsoft Excel so we use Excel as the front of both the MA and BA. ***Note on F9****: F9 is an add-in program for Excel that simplifies the use of this system and enables the creation of automated reports in a familiar Excel environment. F9 got its name from the Excel F9 button function that recalculates the workbook. Additionally, a statistical set of accounts (STATCO) can be created in your accounting system that would allow for elimination of manual entry of statistics. F9 works with CYMA, Dynamics, MAS90, Solomon, Platinum, BusinessWorks, and many other popular accounting systems. For more information on F9, contact MVI or see www.F9.com. MVI has been using F9 since its beginning and has developed hundreds of reports and tools for hospice. MVI is an authorized F9 Dealer.*



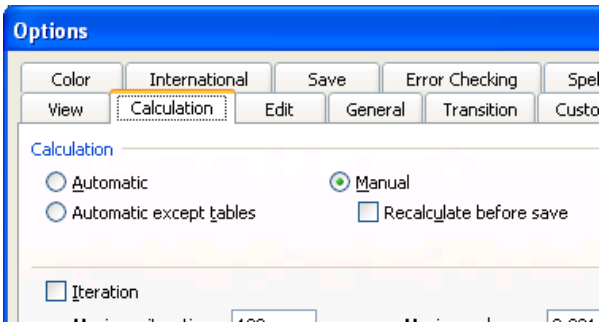
Macro Security

We use Visual Basic for quite a few features in the system. In order for you to have the option of allowing all of our features, Excel must have the Macro Security set to Medium or High by going to the Excel Options/Trust Center Settings/Macro Settings. Then close out of Excel to set the new security level and opening up the MA you can choose the "Always trust macros…" box. We digitally sign our Visual Basic code with VeriSign to prevent tampering with the code. Checking "Always trust..." will prevent this security warning in the future.



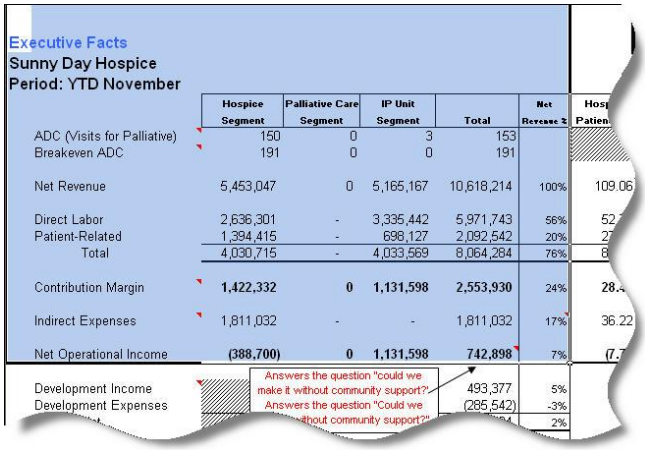
Saving Multiple Copies

Many hospices have found it best to save off a copy of the MA for each month for reference and backup purposes. We highly recommend **keeping the original name and version number** and simply add the time period. Creating an MVI Folder is an excellent idea for maintaining your work.



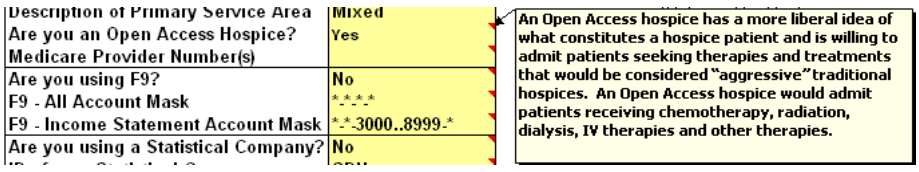
Manual Calculation

By default Excel is set to calculate automatically every time you select the ENTER key. The MA can take 5-10 seconds to calculate so it is highly recommended to set the calculation to Manual by going to Tools/Options/Calculation tab.



Modifications to Reports

While you are unable to structurally modify the original report, you are able to copy the report or a specific portion of the report to perform such operations as eliminating unnecessary columns, reformatting, creating additional calculations, adding to a PowerPoint presentation… Simply select the area you desire to bring over, open up a new workbook and Paste. You may also want to try experimenting with the Paste Special function. Charts may also be brought over by highlighting the area around the chart when doing the copy function.



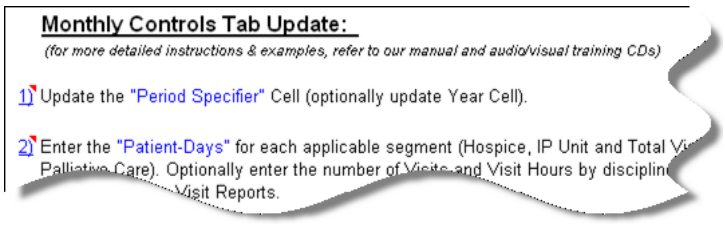
Yellow Cells and Comment Indicator

Any area that you can enter information into the MA will be formatted with a yellow cell background. Also, anywhere that you see the Comment Indicator (red corner bracket) you can mouse-over the field to display the associated comment.

Using the Management Application (MA)

The **Management Application** is designed to either automatically bring over your financial information using the F9 Application or by using an Import logic. If you are using F9 you will ignore the Import fields and vice versa. By the time we do the initial two hour training of the MA our staff will have lined up the system about 90% of the way or as much as possible depending on the clarity of your chart of accounts. So the focus of the hospice can be on reviewing the accuracy instead of setting up the system from scratch.

Instructions Tab


Monthly Controls Tab Update:

(for more detailed instructions & examples, refer to our manual and audio/visual training CDs)

1) Update the "Period Specifier" Cell (optionally update Year Cell).

2) Enter the "Patient-Days" for each applicable segment (Hospice, IP Unit and Total Vi
Palliative Care). Optionally enter the number of Visits and Visit Hours by disciplin
Visit Reports.

Instructions Tab

If it has been a few months since last using the MA please reference the Instructions Tab for a friendly reminder of the basic steps on using the MA.

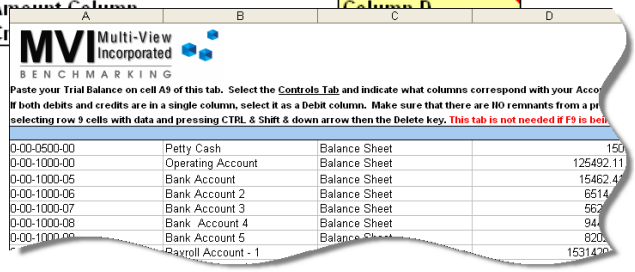
Controls Tab

General Information	
Company	Sunny Day Hospice
Multi-View Client ID Number	1234
NHPCO Member Number	
Your State	FL
Service Area Population	100,000
Fiscal Year End	December
Do you have an Inpatient Unit?	No
Have a Palliative Care program?	No
Profit Status	Not for Profit
Agency Type	Free Standing
Description of Primary Service Area	Mixed
Are you an Open Access Hospice?	Yes
Medicare Provider Number(s)	
Are you using F9?	No
F9 - All Account Mask	*-*-*-*
F9 - Income Statement Account Mask	*-*-3000..8999-*
Are you using a Statistical Company?	No
ID of your Statistical Company	SDH
Type - Budget or Transactions?	Transactions
Year	2006
Period Specifier	YTD November

General Information

This area is mostly one time setup information and we set this up quickly during the training. The Year and Period cells will be modified on a monthly basis as they update your report headers.

Import Tab Lineup	
Account Number Column	Column.A
Description Column	Column.B
Amount Column	Column.D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Paste your Trial Balance on cell A9 of this tab. Select the Controls Tab and indicate what columns correspond with your Acco
If both debits and credits are in a single column, select it as a Debit column. Make sure that there are NO remnants from a pr
selecting row 9 cells with data and pressing CTRL & Shift & down arrow then the Delete key. This tab is not needed if F9 is bei

0-00-0500-00	Petty Cash	Balance Sheet	150
0-00-1000-00	Operating Account	Balance Sheet	125492.11
0-00-1000-05	Bank Account	Balance Sheet	15462.4
0-00-1000-06	Bank Account 2	Balance Sheet	6514
0-00-1000-07	Bank Account 3	Balance Sheet	562
0-00-1000-08	Bank Account 4	Balance Sheet	94
0-00-1000-09	Bank Account 5	Balance Sheet	820
	Payroll Account - 1		1531420

Import Tab Lineup

For Import users this area tells the MA what column each item is in on the Import Tab. If you have a Trial Balance with a single column amount (not debit and credit) you will set the Credit Amount Column to an unused column. Updating the Import tab is done by simply clearing out the old data and pasting the new Trial Balance.

Hospice Statistical Elements	Manual	Manual	These columns will only be used with F9 and a Statistical Company: Total With Statco	Total With Statco	Stat Account	Stat Account
Patient-Days	50,000		50,000		1..9-60-9010-*	
Patients Served	-		-		4..6-60-9090-*	
Direct Service Labor	**Visits**	**Visit-Hours**	**Visits**	**Visit-Hours**	**Visits**	**Visit-Hours**
RN	15,000	15,000	15,000	15,000	1-61-9100-*	1-61-9110-*
LPN	-	-	-	-	1-62-9100-*	1-62-9110-*
CNA	20,000	20,000	20,000	20,000	1-65-9100-*	1-65-9110-*
SW	5,000	5,000	5,000	5,000	1-66-9100-*	1-66-9110-*
PC	2,000	2,000	2,000	2,000	1-67-9100-*	1-67-9110-*
Physician	-	-	-	-	0-00-0000-*	0-00-0000-*
On-Call	-	-	-	-	1-63..64-9100-*	1-63..64-9110-*
Allocated Direct Services	**Visits**	**Visit-Hours**	**Visits**	**Visit-Hours**	**Visits**	**Visit-Hours**
Admissions	1,000	1,000	1,000	1,000	1-I0-9100-*	1-I0-9110-*
Volunteer	-	-	-	-	1-V0-9100-*	1-V0-9110-*
Bereavement Staff	-	-	-	-	1-B0-9100-*	1-B0-9110-*
Totals	43,000	43,000	43,000	43,000		

Statistical Elements

The system tracks 3 segments… Hospice, Palliative Care and IP Unit(s). There is an area for each segment to enter statistics. The **Patient-Days is a mandatory statistic** as many calculations are done against this. The Visit statistics are optional and it is often best to focus on the primary report areas first and then dig into the Visit Reports after you have had a month or two to get familiar with the system. If you maintain a STATCO (you would know if you do) to track Statistics then the Stat Account ranges may be setup on the yellow cells on the far right. The grey cells will always combine the Stat Account results (if used) and the Manual stats.

Other Programs:

Name of Program
Community Bereavement
Home Health
Peds
Program 4
Program 5
Program 6

Other Programs

This is an important area as the goal is to not mix extracurricular programs in with the actual hospice amounts. Entering your Name of Program and recalculating the MA will allow you to select your program on the Account Lineup tab.

Controls

(Problem areas appear in RED)

Net Income Control	
Calculated from this System	1,037,977.02
BE and CM Report Total	1,037,977.02
Trial Balance Net Income	1,037,977.02
Difference in System and Trial Balance	0.00
F9 Calculation	0.00
Trial Balance Control	
Does the System Trial Balance Net to Zero?	0.00
Does your F9 Trial Balance Net to Zero?	0.00
Salary and Benefit Control	
Salaries Per Trial Balance	5,559,630.02
Salaries Per System	5,559,630.02
Benefits Per Trial Balance	1,077,548.07
Benefits Per System	1,077,548.07
Benefits %	19.38%

Date Last Processed: 10/01/2015

Controls

Your typical monthly process will be to update the Period, Year and few statistic fields; copy the import and recalculate. If the Controls are in balance and your reports appear accurate then submit your Upload email. Within two business days we will email the Alerts results back to you so you can run the BA reports.

E-mail Upload to National Financial Data Set

Automatic Upload will save the current workbook; create the Upload.csv; create an e-mail to MVIB with the Upload as an attachment and finally, reopen the MA. You will need to say "Yes" to the windows security options to perform this process.

Manual Upload will create a new workbook on your taskbar (book1,2...). You will then need to save and e-mail the file to benchmark@mvib.net. You may also directly copy the Upload Tab that is located at the end of the MA tab list.

E-mail the Upload

The Automatic button will attempt to email the Upload without you needing to do anything but select "yes" to a couple of windows. This will not function if your firewall prevents it or if you did not allow macros to run when opening the MA. Manual will create the Upload file for you to email as an attachment to us. In a rare case the firewall may prevent the Manual button from working, in which case just email us the entire MA.

Import Tie-Out

This tab is used to compare all accounts on your Import Tab with the Trial Balance Tab.
If FALSE displays in the Evaluation column for any row, make sure that account is included in the Account Lineup Tab.
If you are using F9, ignore this tab. Perform an F9 Analyze function on the Trial Balance Tab.

Controls: (0.00) 133,983.58

Account	Description	From Trial Balan	From Import	Evaluation
0-00-0500-00	Petty Cash	150.00	150.00	TRUE
0-00-1000-00	Operating Account	125,492.11	125,492.11	TRUE
0-00-1000-05	Bank Account	15,462.41	15,462.41	TRUE
0-00-1000-06	Bank Account 2	6,514.83	6,514.83	TRUE
0-00-1000-07	Bank Account 3	5,620.78	5,620.78	TRUE
0-00-1000-08	Bank Account 4	9,444.57	9,444.57	TRUE
0-00-1000-09	Bank Account 5	8,202.82	8,202.82	TRUE

Import User Balance Issues

For Import users the Import Tie-Out tab can quickly alert you to the balance issue. You can filter the Evaluation column for "False" and all accounts that do not match balances between the Account Import and the Trial Balance will display. **The most common balance issue is from adding a new account on your Trial Balance but not including it on the Account Lineup tab.**

Trial Balance Report
Sunny Day Hospice
Period: YTD November

E-Mail Trial Balance to MVI

F9 Balance F9 Not Used

This balance should equal zero since it should match the Trial Balance. When performing the F9 Analyze function all accounts should be counted twice if included on this tab. Ignore if not using F9.

Note: If using Excel 2003, filter this tab t...

Trial Balance Amount	Account	Description	Org	Category	
150.00	0-00-0500-00	Petty Cash	BS	Balance Sheet	Assets
125,492.11	0-00-1000-00	Operating Account	BS	Balance Sheet	Assets
15,462.41	0-00-1000-05	Bank Account	BS	Balance Sheet	Assets
6,514.83	0-00-1000-06	Bank Account 2	BS	Balance Sheet	Assets
5,620.78	0-00-1000-07	Bank Account 3	BS	Balance Sheet	Assets
9,444.57	0-00-1000-08	Bank Account 4	BS	Balance Sheet	Assets

F9 User Balance Issues

F9 users should be familiar with the Analyze function. Performing the Analyze on the Trial Balance tab will quickly identify accounts that are not counted twice (magic number for all accounts). You can do a copy paste from the Analyze results tab to the Account Lineup tab to assist with updating the MA. **The most common balance issue is from adding a new account on your Trial Balance but not including it on the Account Lineup tab.**

Hello David,
~
Thank you for submitting your Upload! It has been processed with our Alerts utility and the following items were flagged. Items starting with "EXCLUDED" have NOT been loaded and will NOT appear on your BA reports. EXCLUDED items with a zero amount are present where we recommend having detail. It is common for a hospice to have EXCLUDED amounts when first starting the system.

We appreciate you keeping your hospice information up to date!
-
Period submitted: YTD December 2015
-
- _____FINANCIAL AMOUNTS_____
- EXCLUDED - DME Palliative Care NPR = 10.80% Net Revenue. Exceeds High Parameter.
- EXCLUDED - Hospice Aide Inpatient Unit NPR = 0.13% Net Revenue. Below Low Parameter.
- EXCLUDED - Linen Inpatient Unit NPR = 0.00% Net Revenue. Below Low Parameter.
- Ambulance Palliative Care NPR = 0.37% Net Revenue. High amount.
- Bereavement Palliative Care NPR = 14.45% Net Revenue. High amount.
- Dietary Inpatient Unit NPR = 1.16% Net Revenue. This number exceeds the normal range.

Validator Results

When MVIB receives your email Upload file we process it with our Alerts Utility, email comments back to you and load the accepted data to the Master Data Set within two business days. The email consists of comments on line items that are high and low as well as items that are too high or low for us to load without verifying the accuracy. In these cases the line item will begin with the text "EXCLUDED". In the sample above Linen Inpatient Unit is "Excluded" at $0 but will have no impact on your BA reports. However, Hospice Aide IP Unit at NPR = 0.13% will not appear on your BA reports so you will want to investigate the amount, and notify MVIB should you feel it is accurate. Initially there will be some cleanup process associated with reviewing your hospice amounts on the BA reports. The Alerts email should then be forwarded to other staff members using the BA. The Excluded amounts will also be shown on the bottom of the Executive Dashboard report.

Account Lineup and Allocation Tabs

This tab is a critical one as it determines where every account is being represented on the reports. Although we will perform the initial lineup it is critical that you are comfortable with this area and review it for accuracy!

Account Lineup

Paste the account number and description columns starting at column B and C row 9 respectively. Using the drop-down boxes, select the classifications that are most appropriate. The classifications are Origin, Category, Type and Sub-Type. All classifications must be completed for each account. To facilitate the classification process, you may separate your accounts by segment and paste them into columns H through N. Use Excel Filter functions to sort by segments. The classifications determine where each account is calculated in the system. Use this area to troubleshoot misclassified accounts.

Account to Columns

Account	Description	Orig	Category	Type	Sub-Type	Seg 1	Seg 2	Seg 3	Seg
0-00-0500-00	Petty Cash	BS	Balance Sheet	Assets	Petty.Cash	0	00	0500	00
0-00-1000-00	Operating Account	BS	Balance Sheet	Assets	Operating.Accounts	0	00	1000	00
0-00-1000-05	Bank Account	BS	Balance Sheet	Assets		0	00	1000	05
0-00-1000-06	Bank Account 2	BS	Balance Sheet	Assets	Operating.Accounts	0	00	1000	06
0-00-1000-07	Bank Account 3	BS	Balance Sheet	Liabilities	**Operating.Accounts**	0	00	1000	07
0-00-1000-08	Bank Account 4	BS	Balance Sheet	Assets	Operating.Accounts	0	00	1000	08
0-00-1000-09	Bank Account 5	BS	Balance Sheet	Assets			00	1000	09
0-00-1010-00	Payroll Account - 1	BS	Balance Sheet	Assets			00	1010	00
0-00-1020-00	Savings Account - 2	BS	Balance Sheet	Assets			00	1020	00
0-00-1200-00	Accounts Receivable-Patient	BS	Balance Sheet	Assets			00	1200	00
0-00-1250-00	Allowance for Doubtful Accou	BS	Balance Sheet	Assets			00	1250	00
0-00-1320-00	Pledges Receivable	BS	Balance Sheet	Assets			00	1320	00
0-00-1321-00	Pledges Receivable Eowmen	BS	Balance Sheet	Assets			00	1321	00
0-00-1330-00	Other Receivable	BS	Balance Sheet	Assets			00	1330	00

Petty.Cash
Operating.Accounts
Accounts.Receivable-Patient.Accoun
Grants.Receivable
Pledges.Receivable
Other.Receivable
Allowance.for.Doubtful.Accounts

Account Lineup Tab

The cells are formatted to assist identify problem areas. On the sample above row 11 is missing the Sub-Type and as such the account will not be represented on the MA. Row 13 illustrates that there are no Operating Accounts for the Type of Liabilities. Switching row 13 Liabilities to Assets will automatically clear out the alert. Row 15 is an illustration of the options available when Assets is chosen. New accounts may be added by inserting a new row or adding to the bottom of the list. Classification cells can be updated quickly by using Copy/Paste functions and by using the filters to work on a specific area of your Chart of Accounts. The Account to Columns button will automatically perform a Text to Columns function on your Account Column to the Segments Columns. This will help facilitate filtering on a specific segment. The Definitions of Account Sub-Types sheet is an excellent reference when getting familiar with the MA and we highly recommend having a copy on hand when working on the MA.

Tracable Indirect and Centralized Direct Cost Allocations to Segments

					Hospice			Palliative		
Allocate Line?	Description	Allocation Base	Costs	Control %	Allocation Percent	Allocation Amount	Account Lineup	Allocation Percent	Allocation Amount	Account Lineup
Yes	Admissions Labor	*Number of Admissions*	239.18	100.00%	100.0%	239.18	239.18	0.0%	-	-
Yes	Bereavement Labor	*Bereavement Hours*	168,127.79	100.00%	100.0%	168,127.79	168,127.79	0.0%	-	-
Yes	Physician Labor	*Physician Hours*	-	100.00%	100.0%	-	-	0.0%	-	-
Yes	Triage Labor	*Triage Hours*	-	100.00%	100.0%	-	-	0.0%	-	-
Yes	Volunteers Labor	*Volunteer Hours*	86,668.00	100.00%	100.0%	86,668.00	75,177.86	0.0%	-	-
Yes	DME Labor and Other	*Number of Deliveries*	-	100.00%	100.0%	-	-	0.0%	-	-
Yes	Pharmacy Labor and Other	*Number of Orders Filled*	-	100.00%	100.0%	-	-	0.0%	-	-
Yes	Therapies Labor	*Therapist Hours*	-	100.00%	100.0%	-	-	0.0%	-	-
Yes	Administration Labor	*Time Estimate*	237,116.10	100.00%	100.0%	237,116.10	232,167.36	0.0%	-	-
Yes	Clinical Management Labor	*Time Estimate*	517,475.76	100.00%	100.0%	517,475.76	480,031.19	0.0%	-	-
Yes	Compliance/QI/Education Labor	*Number of Visits*	-	100.00%	100.0%	-	-	0.0%	-	-

Allocation Table Main Setup

This tab historically can be the most confusing in the MA until the hospice truly understands its purpose. The purpose of this tab is to take Indirect and a few Direct Costs and allocate the amount between the Hospice, Palliative Care, IP Unit and Other Programs segments. This tab is not a factor for the "pure" hospice (one with no home health, IP/Residential Unit or Other Programs). For a pure hospice, the first column is ALWAYS 100%. Example: Sunny Day Hospice may have $500,000 going to Clinical Management Labor and on their Trial Balance it hits one account. However, in reality 10% of that Labor cost should go to their IP Unit segment. To achieve this they will say "Yes" to allocate the line item and put 90% in Hospice and 10% to IP Unit. The typical thought process to this will be as follows:

Is the line item already being allocated on my Trial Balance?

- If you answer yes then set the "Allocate Line" item to "No" and the system will take the amount directly as you have setup on the Account Lineup tab (notice the Account Lineup grey column for reference).
- If you answer no then set the "Allocate Line" item to "Yes" and enter the percent to be allocated to each segment using the Allocation Base column as a reference for our recommended allocation basis. If you have a lot of Other Programs please keep in mind that you can also allocate amounts to the Other Program segment.

Physician/Medical Director Allocation

No	Allocate Physician/Med Director?	Account Lineup	Allocated
30%	Physician Percent	-	-
70%	Medical Director Percent	61,004.79	61,004.79
100%	Total	**61,004.79**	**61,004.79**
25%	Physician Factor		

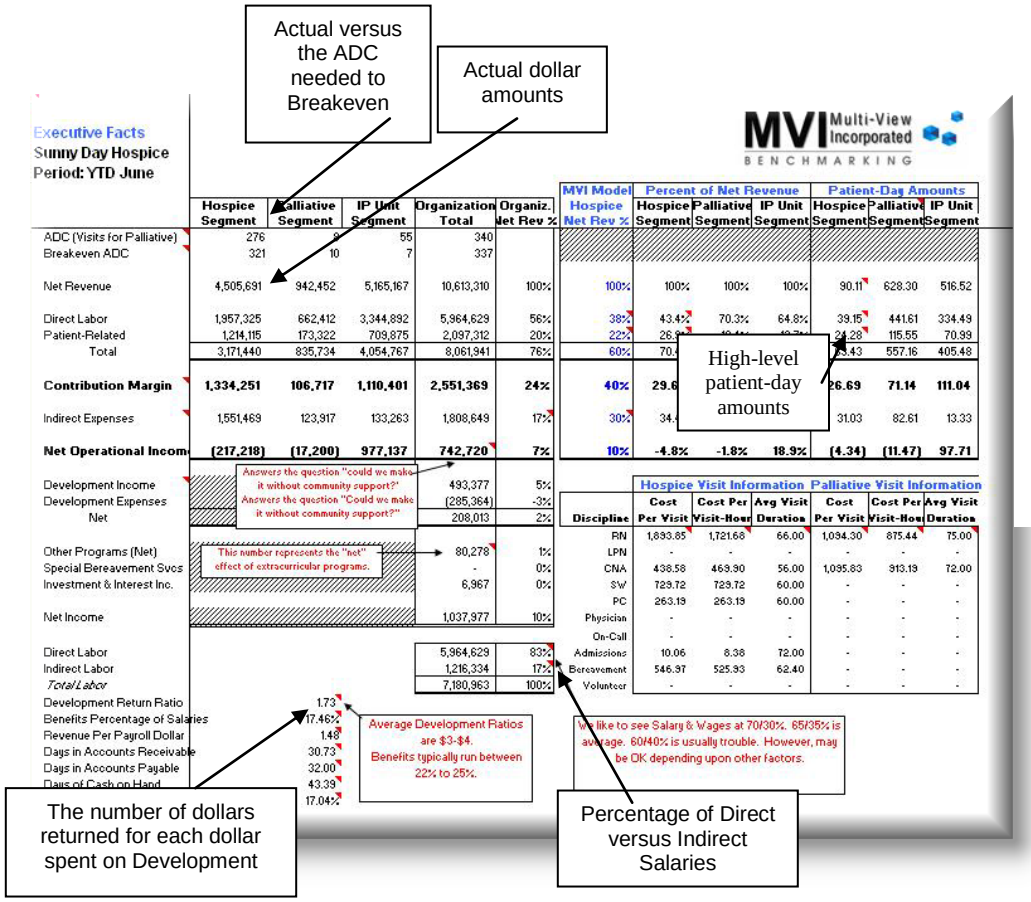
Additional Allocation Options

Many hospices have a Physician that performs both direct patient visits (Physician Percent) and Corporate functions (Med Director Percent). This area allows you to allocate the amounts between the two if you are not already separating on your Trial Balance. The Physician Factor will typically be set between 25-50% and **will affect only the visit reports** where we are automatically allocating Indirect Costs based on Payroll Dollars. Since Physicians command high wages, this area allows us to reduce the amount of Indirect Costs allocated to them.

Primary Reports

All of the reports on the MA have detail comments available by doing a mouse-over the report header. The best way to become familiar with the reports is to take a little time to review your amounts on the reports. When getting started we recommend that you become familiar with several Primary Reports.

Executive Facts – a very popular summary report that brings data from many of the detail reports.
Breakeven (BE) and Contribution Margin (CM) Report - This report provides some information contained in the Executive Facts report, but includes several MAJOR calculations that materially impact a hospice's operations.
Cost % of Net Revenue – excellent view of Direct Expenses by segment including view of Costs as a percent of Net Revenue.
Allocated IS – extremely useful for reviewing your amounts in detail after the Account Lineup and Allocation Table have been set up.
Lineup Summary – represents results from the Account Lineup **without** any Allocation Table calculations.
Indirect Analysis – Indirect Labor, Operations and Facility Related costs are broken out in detail.
Patient-Days – excellent view of Direct Expenses by segment including Patient-Day amounts.



Executive Facts

This report is great for the CEO or for the "astute" board that really wants to understand hospice financials. Most of the major elements are summarized in this report. High level Actual and Patient-Day amounts are displayed as well as Cost Per-Visit by Discipline, Benefits Percentage, Development Return Ratio, Mix between Direct to Indirect Salaries, etc.

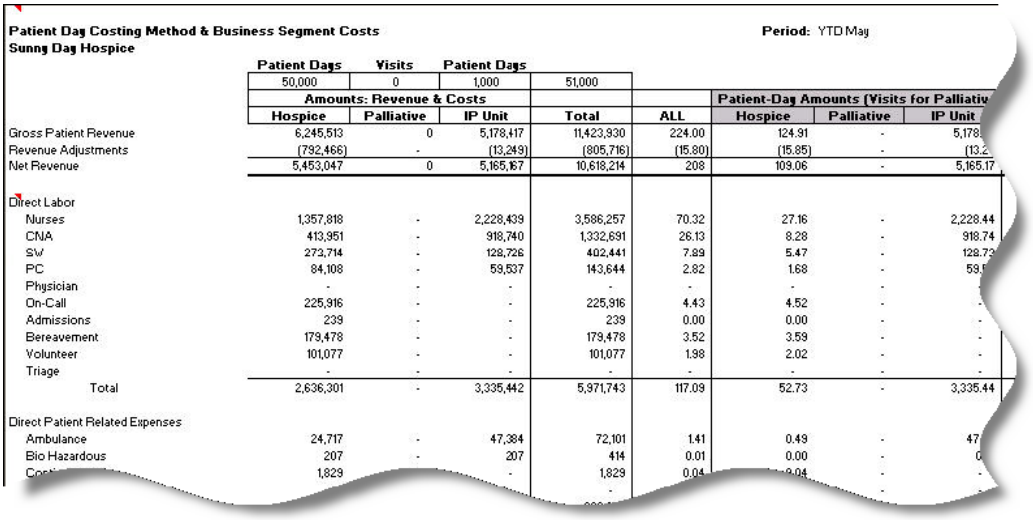
Average Net Revenue	
Average Net Hospice Homecare Revenue Per Patient-Day	95.63
Average Net Hospice Unit Revenue Per Patient-Day	0.00
Average Net Home Health Revenue Per-Visit	0.00
Weighted Average Net Revenue Per Unit	95.63
Variable Costs	
Average Variable Costs Per Hospice Homecare Patient-Day	57.01
Average Variable Costs Per Hospice Unit Patient-Day	-
Average Variable Costs Per Home Health Visit	-
Weighted Average Variable Costs Per Unit	57.01

Variable Costs are critical to good margins and breakeven. Try to keep this in the $50-$62 range for Hospice Homecare and IP should be in the $165-$280 range.

Breakeven and Contribution Margin Report

It is the "spread" between your Average Net Revenue and your Average Variable Costs that matters. The larger the spread, the healthier your hospice is from an operational standpoint. The smaller the spread, the more you will need community support. If your variable costs exceed your Average Revenue, you're in serious trouble and your survival is questionable unless you have incredible funding sources other than Patient Revenue.

Example: In the illustration shown above, Average Net Hospice Homecare Revenue is $95.63 per day. Average Variable Costs per Hospice Homecare Day are $57.01. If you subtract the revenue from the costs, you get $38.62. This is a great number by our standards. Then by dividing your fixed costs by this number, you will know the number of patient-days to "breakeven". In this case, it is 5,290 patient days. Divide 5.290 by 90 (the number of days in Year to Date March) and you have your Breakeven Average Daily Census. If you want to make 5%, add 5% to your fixed costs, divide the total by the $38.62 and you'll have your number.



Patient Day Costing Method & Business Segment Costs — **Period:** YTD May
Sunny Day Hospice

	Patient Days	Visits	Patient Days					
	50,000	0	1,000	51,000				
	Amounts: Revenue & Costs					Patient-Day Amounts (Visits for Palliativ		
	Hospice	Palliative	IP Unit	Total	ALL	Hospice	Palliative	IP Unit
Gross Patient Revenue	6,245,513	0	5,178,417	11,423,930	224.00	124.91	-	5,178
Revenue Adjustments	(792,466)	-	(13,249)	(805,716)	(15.80)	(15.85)	-	(13.2
Net Revenue	5,453,047	0	5,165,167	10,618,214	208	109.06	-	5,165.17
Direct Labor								
Nurses	1,357,818	-	2,228,439	3,586,257	70.32	27.16	-	2,228.44
CNA	413,951	-	918,740	1,332,691	26.13	8.28	-	918.74
SW	273,714	-	128,726	402,441	7.89	5.47	-	128.73
PC	84,108	-	59,537	143,644	2.82	1.68	-	59.5
Physician	-	-	-	-	-	-	-	
On-Call	225,916	-	-	225,916	4.43	4.52	-	-
Admissions	239	-	-	239	0.00	0.00	-	-
Bereavement	179,478	-	-	179,478	3.52	3.59	-	-
Volunteer	101,077	-	-	101,077	1.98	2.02	-	-
Triage	-	-	-	-	-	-	-	-
Total	2,636,301	-	3,335,442	5,971,743	117.09	52.73	-	3,335.44
Direct Patient Related Expenses								
Ambulance	24,717	-	47,384	72,101	1.41	0.49	-	47
Bio Hazardous	207	-	207	414	0.01	0.00	-	0
Co	1,829		-	1,829	0.04	0.04	-	-

Patient-Day Report

Even though most hospices measure costs using patient-days, realize that it is not advisable for a hospice to totally depend upon patient-day costs for comparison. Percentage of Net Revenue provides a superior view. Multiple perspectives are needed and the MA provides these additional views. For example, you could have great patient-day costs for clinical staff, but it does not mean that patients are being visited! Also, some patient-day costs vary by region and cost as a percentage of net patient revenue is probably more meaningful. Cost per visit is another important indicator as it provides insight into clinical productivity. Again, patient-days are a good measure, but recognize their limitations.

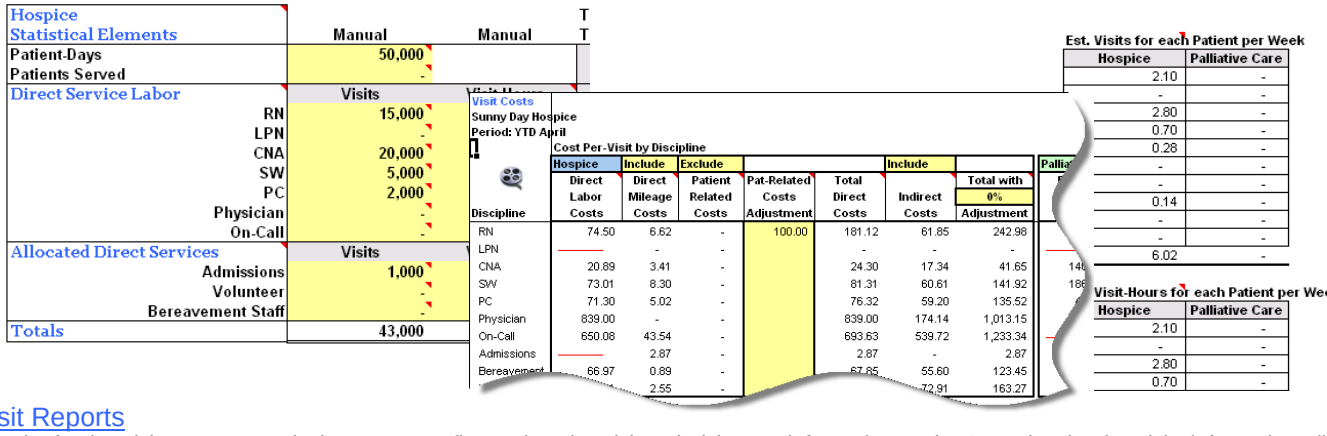
Cost Composition Report - Based on Net Revenue — **Period:**
Sunny Day Hospice

	Hospice Costs	Palliative Costs	IP Unit Costs	Total Costs	Total % of Revenue	Hospice Actual %
Net Revenue	5,453,047	(0)	(0)	5,453,047	100.0%	100.0%
Direct Labor						
Nurses	1,327,325	-	-	1,327,325	24.3%	24.3%
CNA	404,655	-	-	404,655	7.4%	7.4%
SW	267,568	-	-	267,568	4.9%	4.9%
PC	82,219	-	-	82,219	1.5%	1.5%
Physician	-	-	-	-	0.0%	0.0%
On-Call	220,842	-	-	220,842	4.0%	4.0%
Admissions	239	-	-	239	0.0%	0.0%
Bereavement	177,775	-	-	177,775	3.3%	3.3%
Volunteer	85,706	-	-	85,706	1.6%	1.6%
Food Services	2,986	-	-	2,986	0.1%	0.1%
Total	2,569,316	-	-	2,569,316	47.1%	47.1%
Direct Patient Related Expenses						
Medical Supplies	107,944	-	-	107,944	2.0%	2.0%
Pagers	4,256	-	-	4,256	0.1%	0.1%
Mobile Phone	18,171	-	-	18,171	0.3%	0.3%
Therapies	95,588	-	-	95,588	1.8%	1.8%
Outpatient	2,977	-	-	2,977	0.1%	0.1%
DME Re	313,602	-		313,602	5.8%	5.8%
	-				0.0%	0.0%

Net Revenue % Report

Cost Composition Based on Net Revenue is extremely useful for gauging your costs as they relate to what you are being paid. It encourages a hospice to live within its net patient revenue. This report is probably the best for comparing hospice operations, much better than the Patient-Day Report because it takes into account the differences in regions, especially relating to Direct Labor. Normally, an area with high Direct Labor costs will also have higher reimbursement. Therefore, as a percentage of net patient revenue, the percentage will be much more comparable.

In this report the MA creates a percentage for each amount in the Patient-Day Report. It helps us understand our cost composition and how much cost goes into each specific area. One of the key elements is the Indirect Costs. Indirect Costs constitute 35% of the average hospice. In our opinion, this is too high. When you can get below 30%, you are really doing something right (as long as work is getting done and patients are being seen)!



Hospice Statistical Elements	Manual	Manual	T
Patient-Days	50,000		
Patients Served	-		
Direct Service Labor	**Visits**		
RN	15,000		
LPN	-		
CNA	20,000		
SW	5,000		
PC	2,000		
Physician	-		
On-Call	-		
Allocated Direct Services	**Visits**		
Admissions	1,000		
Volunteer	-		
Bereavement Staff	-		
Totals	43,000		

Visit Costs
Sunny Day Hospice
Period: YTD April

Cost Per-Visit by Discipline

Discipline	Hospice Include Direct Labor Costs	Include Direct Mileage Costs	Exclude Patient Related Costs	Pat-Related Costs Adjustment	Total Direct Costs	Include Indirect Costs	Total with 0% Adjustment	Pallia
RN	74.50	6.62	-	100.00	181.12	61.85	242.98	
LPN	-	-	-		-	-	-	
CNA	20.89	3.41	-		24.30	17.34	41.65	146
SW	73.01	8.30	-		81.31	60.61	141.92	186
PC	71.30	5.02	-		76.32	59.20	135.52	
Physician	839.00	-	-		839.00	174.14	1,013.15	
On-Call	650.08	43.54	-		693.63	539.72	1,233.34	
Admissions	-	2.87	-		2.87	-	2.87	
Bereavement	66.97	0.89	-		67.85	55.60	123.45	
		2.55	-			72.91	163.27	

Est. Visits for each Patient per Week

Hospice	Palliative Care
2.10	-
-	-
2.80	-
0.70	-
0.28	-
-	-
-	-
0.14	-
-	-
-	-
6.02	-

Visit-Hours for each Patient per Week

Hospice	Palliative Care
2.10	-
-	-
2.80	-
0.70	-

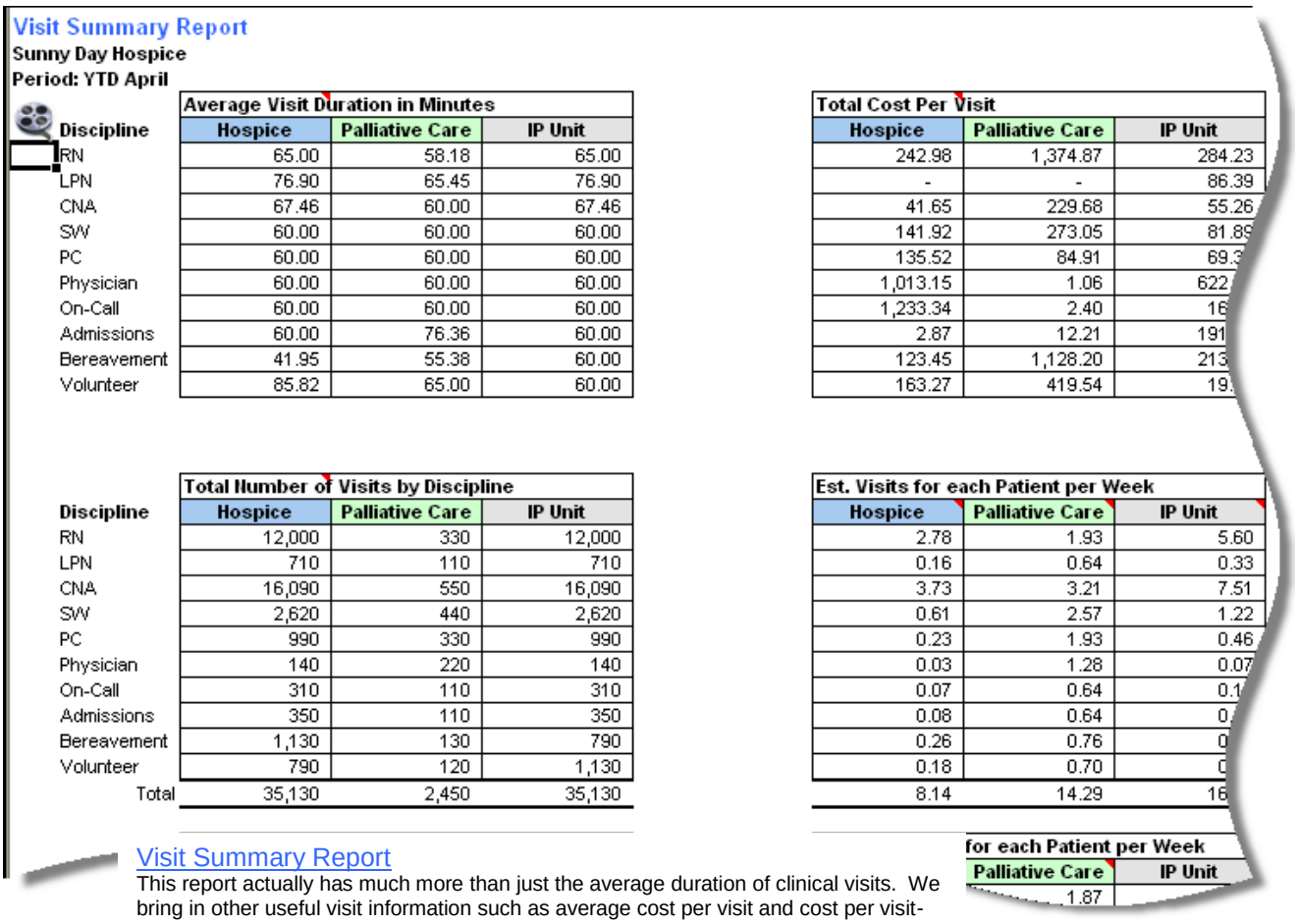
Visit Reports

In order for the Visit Reports to calculate you must first update the Visit and Visit-Hour information on the Controls tab. The Visits information will always reflect the same time period as your Trial Balance. Detailed comments are included to walk a hospice through the calculation logic.

Visit Costs – Calculates the Cost per Visit by discipline including an optional Allocation of Indirect Costs; Allocation of Direct Costs; Adjustment Column and Percentage Adjustments. The combination provides flexibility in a hospice to include or exclude specific columns of their choosing for a highly customizable calculation of the Visit Cost.

Visit Hours – Calculates the Cost per Visit-Hour by discipline including the same flexibility of cost calculations present in the Visit Cost Report.

Visit Summary – Includes calculations on Average Visit Duration in Minutes, Total Cost per Visit and Visit-Hour, Estimated Visits for each Patient per Week.



Visit Summary Report
Sunny Day Hospice
Period: YTD April

Average Visit Duration in Minutes

Discipline	Hospice	Palliative Care	IP Unit
RN	65.00	58.18	65.00
LPN	76.90	65.45	76.90
CNA	67.46	60.00	67.46
SW	60.00	60.00	60.00
PC	60.00	60.00	60.00
Physician	60.00	60.00	60.00
On-Call	60.00	60.00	60.00
Admissions	60.00	76.36	60.00
Bereavement	41.95	55.38	60.00
Volunteer	85.82	65.00	60.00

Total Cost Per Visit

Hospice	Palliative Care	IP Unit
242.98	1,374.87	284.23
-	-	86.39
41.65	229.68	55.26
141.92	273.05	81.89
135.52	84.91	69.3
1,013.15	1.06	622
1,233.34	2.40	16
2.87	12.21	191
123.45	1,128.20	213
163.27	419.54	19

Total Number of Visits by Discipline

Discipline	Hospice	Palliative Care	IP Unit
RN	12,000	330	12,000
LPN	710	110	710
CNA	16,090	550	16,090
SW	2,620	440	2,620
PC	990	330	990
Physician	140	220	140
On-Call	310	110	310
Admissions	350	110	350
Bereavement	1,130	130	790
Volunteer	790	120	1,130
Total	35,130	2,450	35,130

Est. Visits for each Patient per Week

Hospice	Palliative Care	IP Unit
2.78	1.93	5.60
0.16	0.64	0.33
3.73	3.21	7.51
0.61	2.57	1.22
0.23	1.93	0.46
0.03	1.28	0.07
0.07	0.64	0.1
0.08	0.64	0
0.26	0.76	0
0.18	0.70	0
8.14	14.29	16

for each Patient per Week

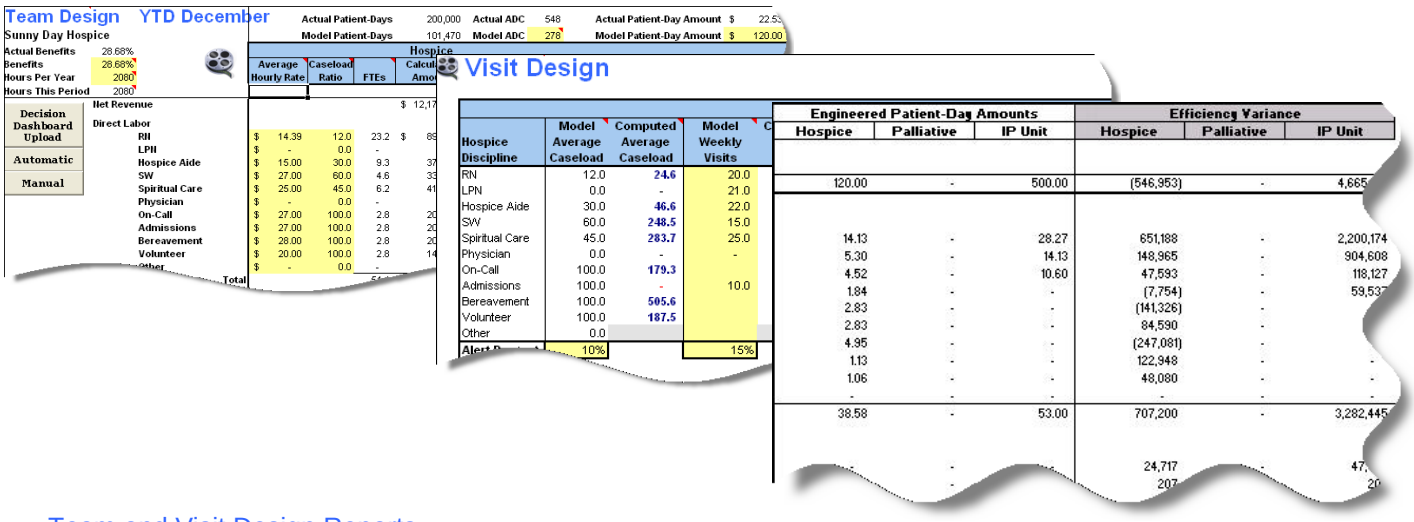
Palliative Care	IP Unit
1.87	

Visit Summary Report

This report actually has much more than just the average duration of clinical visits. We bring in other useful visit information such as average cost per visit and cost per visit-hour by discipline.

The instructions contained in the text box on the report are the key to obtaining your costs by diagnosis, payer type, referrals source, age, etc. Here are our recommendations:

- At the end of every quarter, load your visit-hour costs by discipline into your patient-management system.
- Run a "recalculation" function, if one exists in your patient-care system. This will transpose your "currently attainable" costs onto historical activity. This will be helpful for making decisions NOW…IN THE PRESENT TIME. Decisions based on current conditions are what we are interested in. The past is past. Now and the future are what is important today.



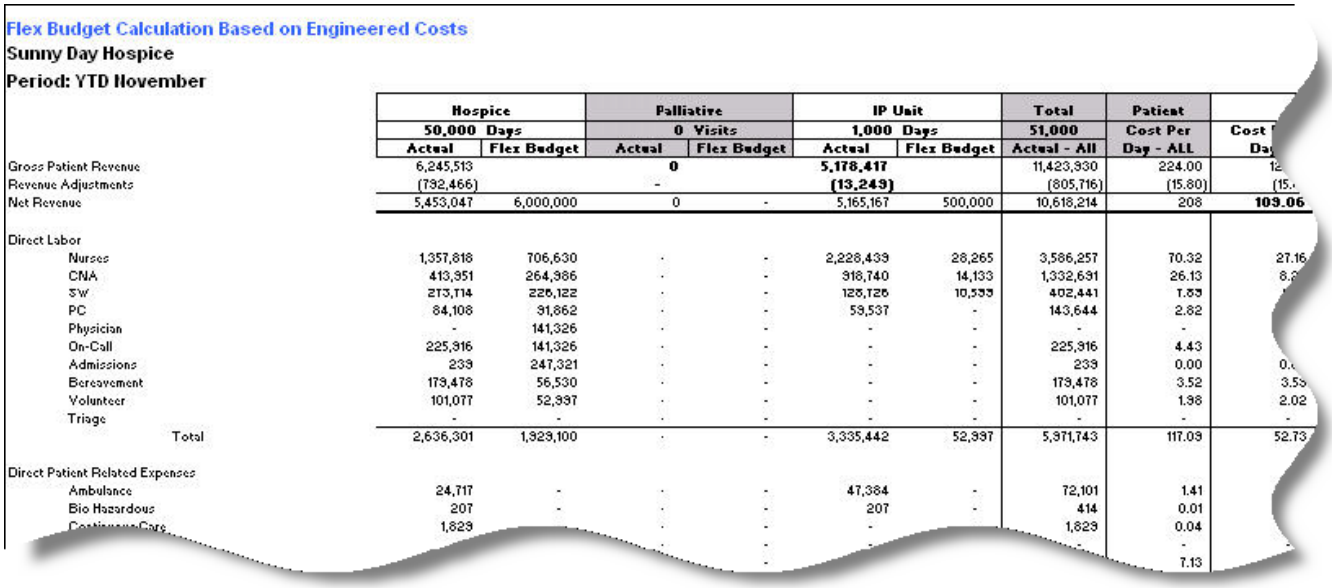
Team and Visit Design Reports

One of the unique features of the system is where the hospice can Model its financial amounts by creating a Flex-Budget. The results of the Team Design will also update the Patient-Day, Net Revenue % , Flex Model and Executive Dashboard Reports.

Team Design – includes a Direct Labor area that helps a hospice arrive at its Percent of Net Revenue amount by entering in Hourly Rate, Hours per Year and Caseload Ratio fields. The Direct Expenses area allows a hospice to simply enter the amount they determine to be the standard Percent of Net Revenue amounts for their Hospice, Palliative Care and IP Unit(s) areas.

Visit Design – taking the results for Direct Labor from the Team Design tab, this report allows a hospice to compare its Calculated Direct Cost per Visit with Actual results from the Visit Cost tab. Although this calculation is an estimate it is often an eye opener for productivity. Calculating productivity for the clinical disciplines can be difficult. MVI's favorite method is Number of Visits Based on an 8-Hour Day or whatever your typical working day is. However, another useful method can be calculated via the GL. The application has a tab that allows a hospice to input the Expected Average Visits per Day and the Number of Annual Working Days. With this information, a Calculated Average Visits per Day can be calculated. If the numbers appear weird, perhaps the number of visits are inaccurate, the GL amounts for Salaries are not pure, or a combination of these two. However, if these are even close to being right and your number is still low, you have productivity problems.

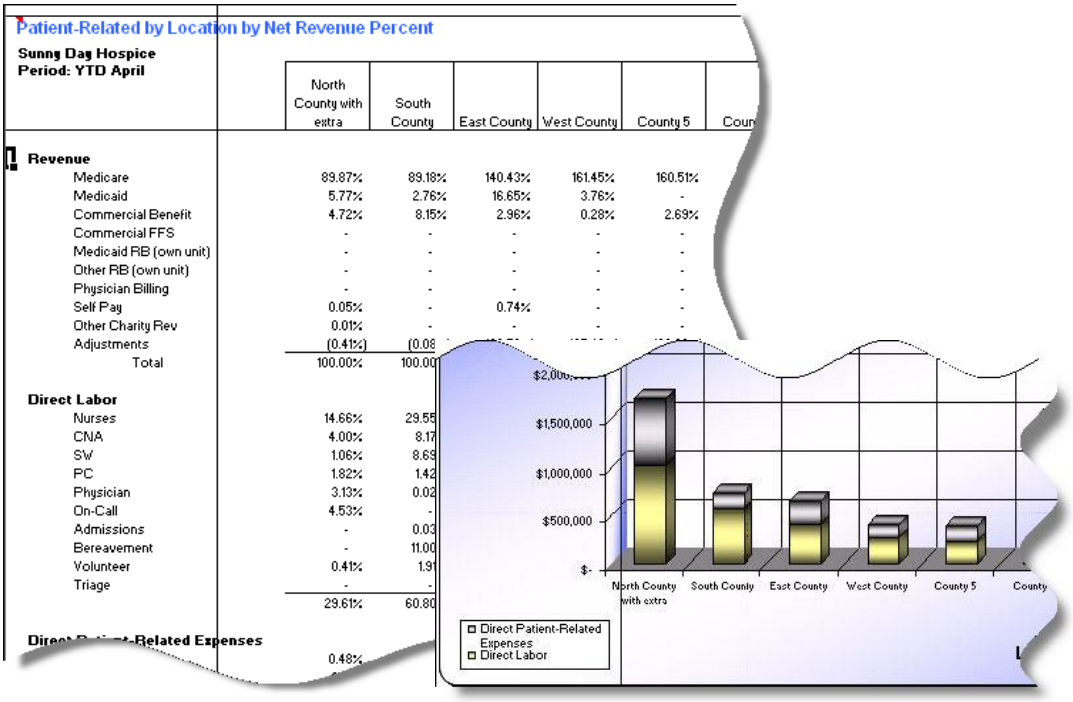
Flex Model Report - This report is actually more useful than the Patient-Day Report as it not only provides patient-day amounts, but it also computes a Flex or Variable budget based on your standards in the Cost Engineering tab. This allows a hospice to compare its actual performance against its goals.



Flex Model Report

The most financially successful hospices use flex budget systems because they increase and decrease with changes in patient volume. A static budget is good for planning, but they become irrelevant when there are substantial deviations from budget. Because a Flex budget is based on "standard costs" based on your operational ideals, it does not matter if your census increases 50%. The Model approach to the budget will automatically adjust. Then you will be able to easily see if you are "in the model" or "out of the model".

In the partial report view above, you see actual patient-day amounts and the standard costs in the right columns. In the left columns you see the actual amounts compared with the amounts computed based on your standards. Large deviations would indicate that your hospice is NOT operating within its own standards.



Patient-Related by Location by Net Revenue Percent

Sunny Day Hospice
Period: YTD April

	North County with extra	South County	East County	West County	County 5	Coun
Revenue						
Medicare	89.87%	89.18%	140.43%	161.45%	160.51%	
Medicaid	5.77%	2.76%	16.65%	3.76%	-	
Commercial Benefit	4.72%	8.15%	2.96%	0.28%	2.69%	
Commercial FFS	-	-	-	-	-	
Medicaid RB (own unit)	-	-	-	-	-	
Other RB (own unit)	-	-	-	-	-	
Physician Billing	-	-	-	-	-	
Self Pay	0.05%	-	0.74%	-	-	
Other Charity Rev	0.01%	-	-	-	-	
Adjustments	(0.41%)	(0.08				
Total	100.00%	100.00				
Direct Labor						
Nurses	14.66%	29.55				
CNA	4.00%	8.17				
SW	1.06%	8.69				
PC	1.82%	1.42				
Physician	3.13%	0.02				
On-Call	4.53%	-				
Admissions	-	0.03				
Bereavement	-	11.00				
Volunteer	0.41%	1.91				
Triage	-	-				
	29.61%	60.80				
Direct Patient-Related Expenses						
	0.48%					

Locations Reports

The Locations reports are available to all clients at no additional charge and may also be used for internal team reporting. However, if you desire to load each location results to the Master Data Set with subsequent BA reporting, there is an additional charge. The first criterion for using the Locations reports is the ability to identify the locations clearly on your Chart of Accounts. If you can point to a specific segment of your Chart of Accounts and identify the Location then you should be able to use this area. However, hospices that have greater complexity such as "My first location is Segment One equaling Number 4 but not for accounts with Segment Two containing a 60" will not be able to use the locations. Of course in order for you to have value from the locations reports you must be separating Patient-Related expenses in detail on your Trial Balance for each of your locations.

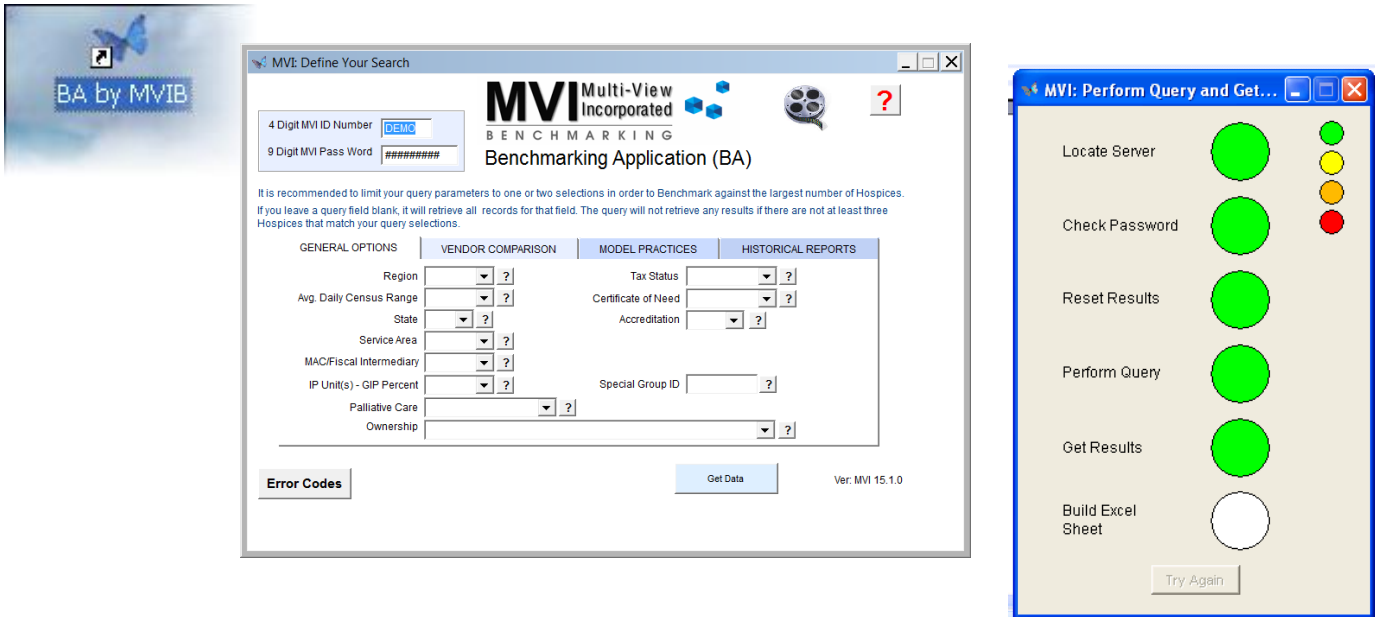
Locations Report – The primary report has yellow cells on the top to properly identify each segment. Whole dollar amounts for Patient-Related items are broken out.

Locations Revenue Percent – This report presents each location with its Patient-Related items represented as a Percent of Net Revenue.

Locations Per Patient Day – This report presents each location in a Per Patient-Day comparison.

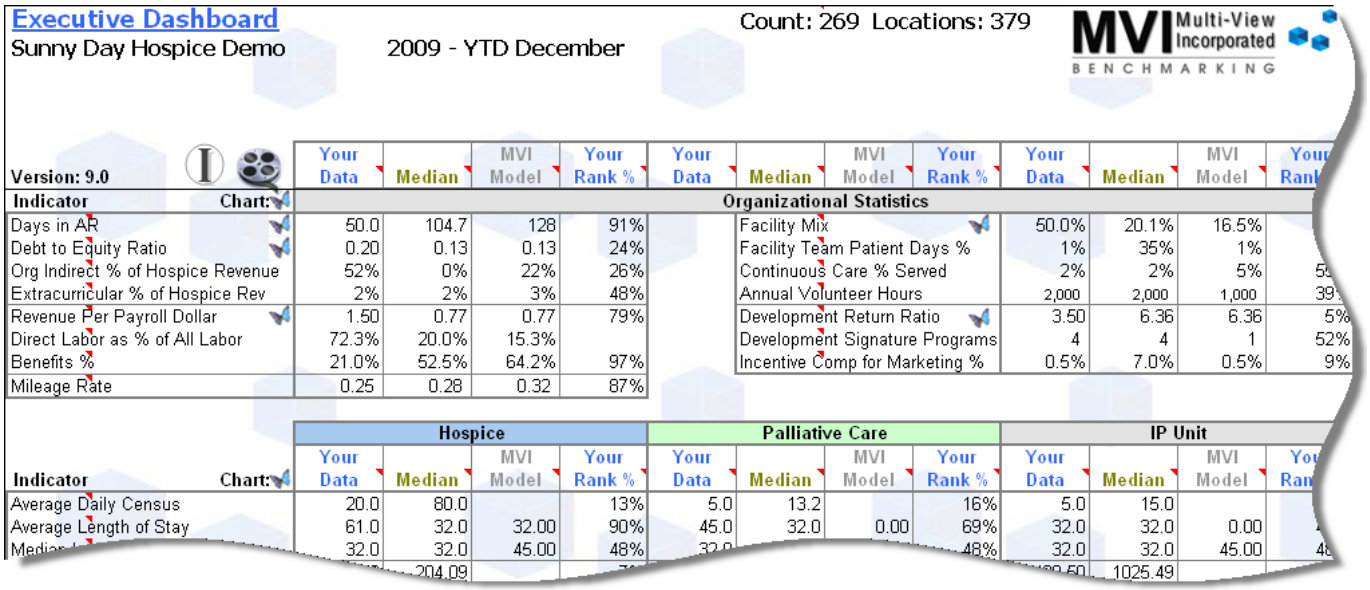
Using the Benchmarking Application (BA)

The BA is installed on each user's pc to allow a hospice to compare its data to other hospices based on the criteria specified. The application offers summary reporting called Benchmarking that allow a hospice to see its operations compared to other hospices in an attractive graphical representation. When a user specifies criteria in the BA, the application accesses the Master Data Set via the internet to produce the results of your most recent email Upload submission. The results of the query are reported and saved. Each query is saved for additional analysis. During the initial training of the system our staff will typically install the BA to your PC. However, a hospice can go to http://www.mvib.net/download-ba selecting the "Download BA" button and follow the instructions to get the BA installed on your local PC. *(Note: if installed previously select "REPAIR" during the MyODBC Setup process. All other options will be the default.)* The BA must always be installed to your local C drive.



Running the Benchmarking Application (BA)

After installing the BA to your local PC there will be a "BA by MVIB" icon on your desktop. Selecting the icon will produce the "Define Your Search" window. Here you will enter your unique ID and Password as provided by MVIB. Leaving the ID to DEMO will allow you to get familiar with the BA report layout by reviewing Demonstration data (note: running the DEMO company will not pull real hospice amounts)! We recommend running the reports first against ALL Regions and ALL ADC Ranges… as this will provide comparison with the greatest amount of hospices. Of course you can also run against specific parameters but keep in mind there are four Regions and 8 ADC Sizes, so if you select parameters for both, you will end up with around one thirty-second of the total hospices in the count.



Executive Dashboard

Sunny Day Hospice Demo — 2009 - YTD December — Count: 269 Locations: 379

MVI Multi-View Incorporated BENCHMARKING

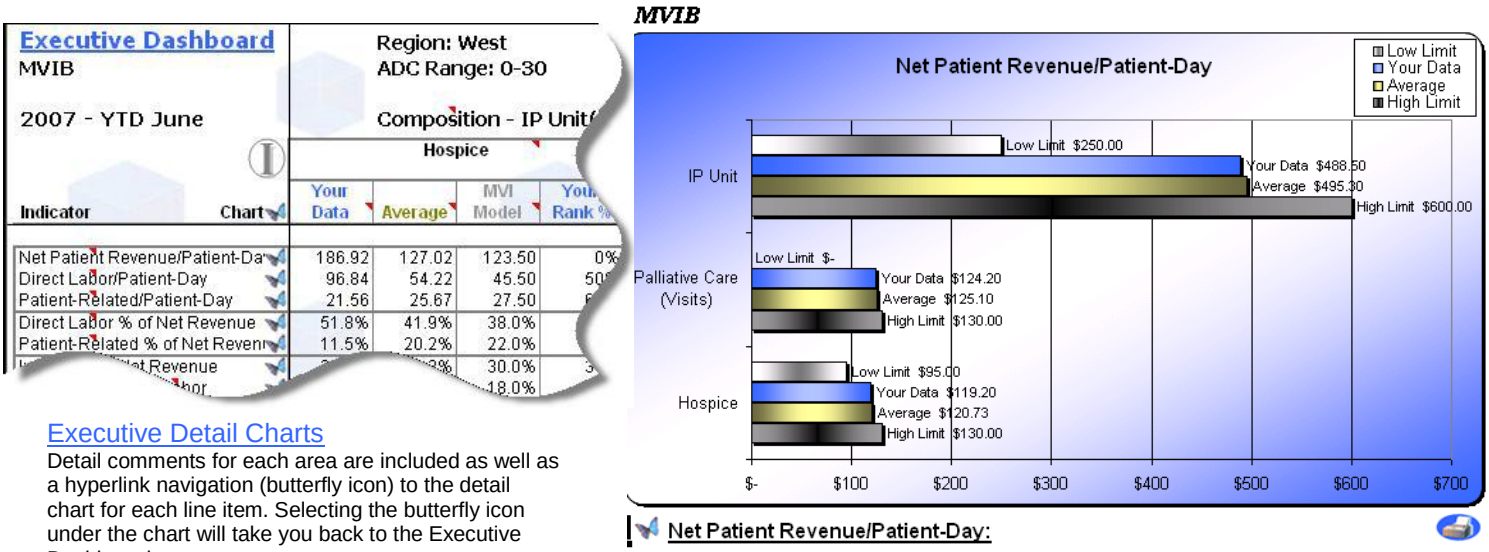
Version: 9.0 / Indicator (Chart:)	Your Data	Median	MVI Model	Your Rank %
Organizational Statistics				
Days in AR	50.0	104.7	128	91%
Debt to Equity Ratio	0.20	0.13	0.13	24%
Org Indirect % of Hospice Revenue	52%	0%	22%	26%
Extracurricular % of Hospice Rev	2%	2%	3%	48%
Revenue Per Payroll Dollar	1.50	0.77	0.77	79%
Direct Labor as % of All Labor	72.3%	20.0%	15.3%	
Benefits %	21.0%	52.5%	64.2%	97%
Mileage Rate	0.25	0.28	0.32	87%

	Your Data	Median	MVI Model	Your Rank %
Facility Mix	50.0%	20.1%	16.5%	
Facility Team Patient Days %	1%	35%	1%	
Continuous Care % Served	2%	2%	5%	5
Annual Volunteer Hours	2,000	2,000	1,000	39
Development Return Ratio	3.50	6.36	6.36	5%
Development Signature Programs	4	4	1	52%
Incentive Comp for Marketing %	0.5%	7.0%	0.5%	9%

Indicator (Chart:)	Hospice Your Data	Hospice Median	Hospice MVI Model	Hospice Your Rank %	Palliative Care Your Data	Palliative Care Median	Palliative Care MVI Model	Palliative Care Your Rank %	IP Unit Your Data	IP Unit Median	IP Unit MVI Model	IP Unit Your Rank
Average Daily Census	20.0	80.0		13%	5.0	13.2		16%	5.0	15.0		
Average Length of Stay	61.0	32.0	32.00	90%	45.0	32.0	0.00	69%	32.0	32.0	0.00	
Median	32.0	32.0	45.00	48%	32.0			48%	32.0	32.0	45.00	4
		204.09								1025.49		

Executive Dashboard

The Executive Dashboard report is a summary report that enables a decision-maker to get a quick picture of the current status of the hospice. This report was designed for CEOs and other top hospice management. It shows performance measures in both numeric and graphical representations. Selecting the Butterfly Icon next to each data point will provide a detailed graph for that specific data point.

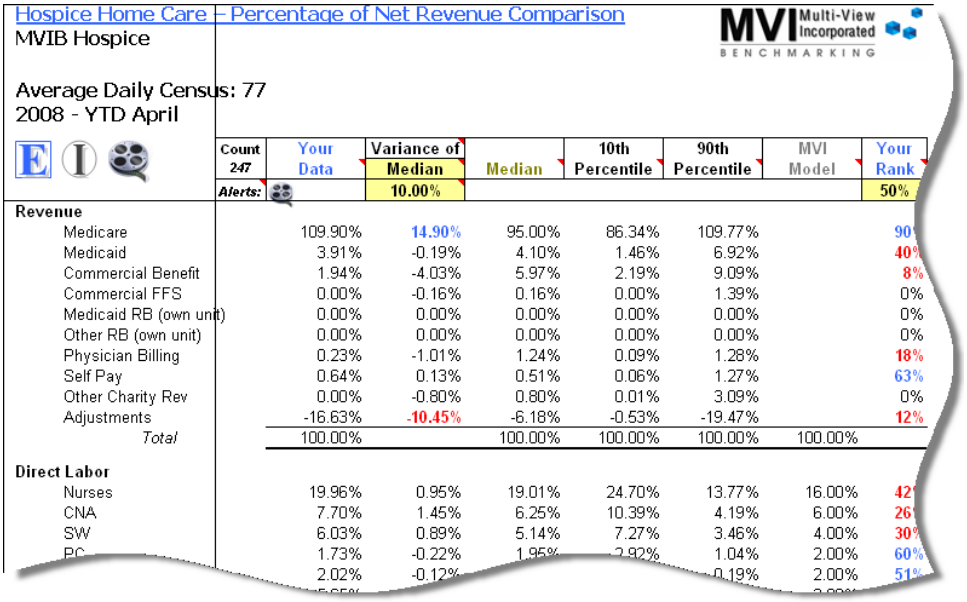


Executive Detail Charts

Detail comments for each area are included as well as a hyperlink navigation (butterfly icon) to the detail chart for each line item. Selecting the butterfly icon under the chart will take you back to the Executive Dashboard.

Net Patient Revenue/Patient-Day:

Typically, this Net Revenue amount is approximately 95% of your Medicare Routine rate. Factors that affect this number are (1) Medicare MSA rates, (2) Write-offs, and (3) your "payer mix." This revenue is a product of the number of visits multiplied by the associated rates for the services. It varies from entity to entity and its vision of Palliative Care.Typically, this Net Revenue amount is approximately 95% of your Medicare Acute rate. Factors that affect this number are (1) Medicare MSA rates, (2) Write-offs, (3) "payer mix," or (4) mix of residential patients.



Detail Patient-Related Reports

There are detail reports for Hospice, Palliative Care and IP Unit in both Per Patient-Day and Percent of Net Revenue amounts. The layout of columns and rows is identical for all six reports. Totals may not be a mathematical sum if part of your data is excluded during the Validation process. In some cases a hospice will submit an Upload that will have an amount Excluded but the Total will be accepted so adding up the line items will not total for the Your Data column. The hospice will always be notified on our Alerts Results email that the Exclusion took place. Another consideration when reviewing the Average, Minimum, and Maximum column, each line, including total lines, is an independent calculation representing the results of the query for that specific data point. Therefore, a total is not a mathematical sum, but an independent calculation of the reported totals for a category.

% Variance Column

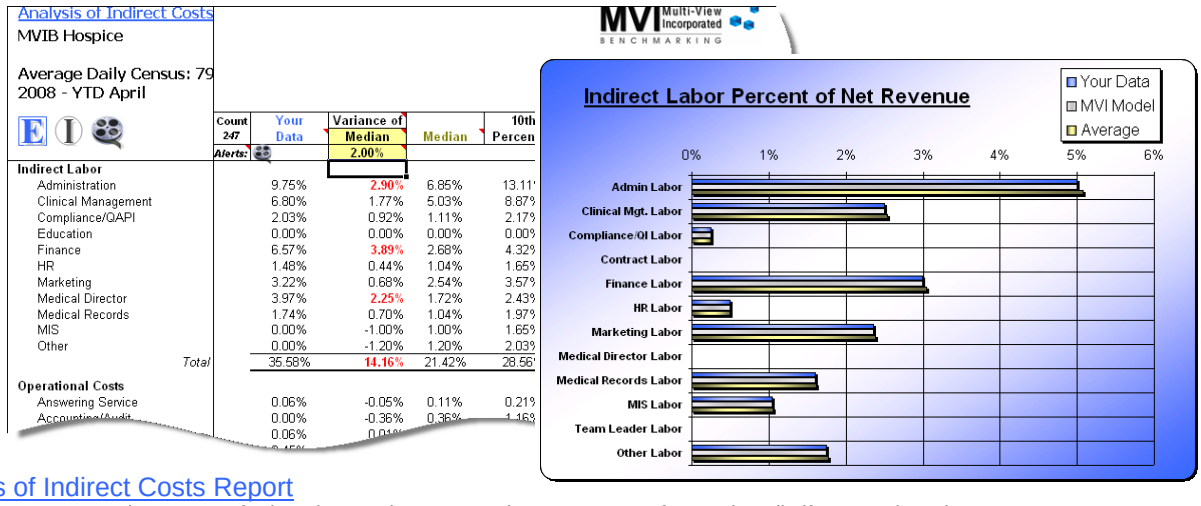
The % Variance Column is used to compare "Your Data" with a column of your choosing by dividing Your Data by the column you are comparing with. Use the yellow Percentile Cell drop-down to choose your comparison column. Then update the yellow percent cell. Amounts better than your Limit will format to BLUE, amounts worse than your Limit will format to RED.

The 10th and 90th Percentile columns represent the low and high markers for each data point to help you compare with other hospice programs. The 10th Percentile always represents the poor performers (both Revenue and Expense). The 90th Percentile represents the top performers.

Your % Rank

The Your Rank Column is designed to help identify where your hospice "ranks" among other hospice programs. We use a "100% is best" approach where you should strive toward the 100% mark for both Revenue and Expense line items.

If there are 100 hospice programs being evaluated and your Nurses line item has the 20th lowest cost Nurses would be 80%. The Rank % cell allows you to establish your own alerts with Blue always being Good and Red always being bad.



Analysis of Indirect Costs Report

Indirect Costs are a major concern for hospices. It is one area that can go out of control easily if not monitored. Indirect Costs are always displayed as a percentage of Net Patient Revenue. This provides comparability among hospice programs. Controlling Indirect Cost is one of the major challenges for hospices. It is the most difficult category of cost to control or design. Many times, the difference between a profitable hospice and an unprofitable hospice lies in the Indirect Cost category. Our best advice is to "draw a line in the sand" and say "this is ALL we are going to spend (on a percentage of revenue basis) on Indirect Costs". And then, hold it! Over time, Indirect Costs creep upward and they must constantly be forced back behind the line you've drawn.

Caseload

	Hospice				Palliative Care				IP Unit			
	Your Data	Your Model	Median Model	MVI Model	Your Data	Your Model	Median Model	MVI Model	Your Data	Your Model	Median Model	MVI Model
RN	10.5	13.0	13.0	10.5	8.0	15.0	13.0	0.0	6.0	13.0	13.0	6.0
LPN	10.5	14.0	14.0	10.5	8.0	15.0	15.0	0.0	6.0	14.0	15.0	6.0
Hospice Aide	8.0	10.0	9.0	8.0	4.0	10.0	10.0	0.0	6.0	10.0	10.0	6.0
SW	35.0	41.0	42.0	35.0	4.0	41.0	41.0	0.0	15.0	42.0	41.0	15.0
Spiritual Care	65.0	39.0	45.0	65.0	8.0	39.0	45.0	0.0	65.0	45.0	45.0	65.0
Physician	125.0	145.0	120.0	125.0	4.0	145.0	120.0	0.0	120.0	120.0	120.0	0
On-Call	50.0	75.0	55.0	50.0	8.0	75.0	66.0	0.0	66.0	66.0	66.0	0
Admissions	50.0	42.0	55.0	50.0	3.0	55.0	55.0	0.0	40.0	42.0	55.0	40
Bereavement	100.0	89.0	102.0	100.0	3.0	102.0	89.0	0.0	102.0	89.0	89.0	0
		96.0	103.0	100.0	3.0				88.0	96.0	96.0	0.0

Model

The Model amounts come from work done in the MA where a hospice intentionally designs key expectations for clinical staff. Caseload, Hourly Rate, Weekly Visits and Visit Durations are presented. Your Data represents actual performance to be compared with the Your Model, Median Model and MVI Model. Again, the Model amounts are not actual performance as seen on other BA reports but are “goals” for each area.

Interpreting the Results–Some Top Indicators of Performance

Here are some of the top financial indicators that a hospice needs to monitor. All of them are calculated in the MA, except for ADC for Nursing Home Patients. This should be derived from a correctly configured and utilized patient-management system.

- Average Daily Census (Regular & Nursing Homes)
- Breakeven Average Daily Census
- Days in Accounts Receivable
- Direct Costs as a Percentage of Net Patient Revenue
- Patient-Day Costs
- Variable Costs
- Indirect Costs as a Percentage of Net Patient Revenue
- Average Visits Per Day by Discipline
- Fully-Absorbed Visit-Hour Costs by Discipline
- Return on Development Ratio

Average Daily Census & Breakeven Average Daily Census

Location: Executive Facts; Breakeven and Contribution Margin Report.

This is the #1 financial indicator as it impacts everything. Low census dictates a different course of action than a high census. Be able to segregate your regular hospice homecare from your nursing home ADC. Attack nursing homes with full force and be IMPRESSIVE at it. This will be the area you will get the best financial returns and at the same time block or impede penetration by competitors.

When you see your Breakeven ADC and it is much higher than your actual census, it can be disheartening. If your breakeven number is high, first look at the spread between your average revenue and your variable costs. If it is tight, then you know you have problems. It also can be that your fixed costs are excessive. OR, it could be a combination of high variable AND fixed costs.

Other Resources: Marketing & OutReach – Revisited (audio CD); MVI Document Marketing Plan for a Hospice; MVI and MVIB Website; Designing the Perfect Hospice (audio CD series); Open Access – An Interview with Carolyn Cassin (Audio CD)

Days in Accounts Receivable

Location: Balance Sheet Analysis.

Out of cash…out of business! If you are not collecting your Accounts Receivable, you're likely to be running on reserves. Cash is the lifeblood of any business. When you can't pay the bills, you're done.

So what does the number mean? It is the average number of days it takes for you to collect on a claim or billing.

Here are some general guidelines to help you judge your Days in AR.

- 40-50 Days – Excellent
- 51-60 Days – Average
- 61-70 Days – Start Getting Nervous
- 71-80 Days – Take Aggressive Action
- 90+ Days – Heads Roll

The payer mix in your service area affects the number of days in AR. If you have a high percentage of commercial payers, your "ideal" number of days in AR will be higher. Most hospices run 70+% Medicare…therefore, these guidelines are good for most of the hospices in the country.

Other Resources: MVI Document Is Your AR in Good Shape?; MVI and MVIB Website; The Need for Benchmarking, Key Indicator, & Benchmark Reporting (Audio CD)

Direct Costs as a Percentage of Net Patient Revenue

Location: Percentage of Net Revenue Reports

This is one of the best hospice measurements. It is good for comparability for all areas of the country as it reflects all costs in proportion to the revenue generated. Thus, if you have high Medicare reimbursement rates for your MSA, then your labor costs will tend to be high as well. BUT THE PERECENTAGE OF NET PATIENT REVENUE WILL BE SIMILAR TO OTHER HOSPICES. That is, you will spend approximately the same proportion as a hospice in a low Medicare reimbursement MSA.

The calculation is simply dividing the cost of an area by the Net Patient Revenue for that business segment. It is easy to compute and is arguably more relevant than the patient-day measurement. The most astute hospice CFOs use this measure.

It is wise for a hospice to create a "model of care" with each category of cost reflected with the associated cost and computed percentage of Net Patient Revenue. The MA has Team and Visit Design Tools to aid you with the development of this Model. A hospice can know its "ideal" number in about 15 minutes. Without this consciousness, a hospice is shooting in the dark. You could be working towards an ideal that might put you out of business or that is unattainable in your market. A hospice must work with intention and purpose. With this tool, you can "design" your care, at least from a financial perspective. So if you want to beef up CNA services to provide a higher standard of care or just to run another hospice out of business, you can engineer your costs to be congruent with that goal.

Use this measurement for Labor costs as well as Patient-Related costs such as Medications, Medical Supplies, DME, Therapies, etc. Here it would be wise to look at our benchmarking information. Look at the averages and the best. Then construct a way to get there through modification of clinical practice, better contracts, or a combination of the two.

Indirect Costs are always measured as a percentage of Net Patient Revenue. See the section below that specifically relates to this area of cost.

Other Resources: MVI Cost Engineering Tool; Quick Budget System Version 1.0; Hospice Budget Tool Version 6.0; Basic Hospice Accounting (audio CD); Profitability (Audio CD); How to Make Your Hospice a Financial Success! (Audio CD); Pharmacy, DME, & Medical Supplies – An Interview with Grant Faubion (Audio CD)

Patient-Day Costs

Location: Patient-Day Reports; Executive Facts

This is the most common hospice measurement. It is good for comparability, but is limited regarding measuring productivity. It is calculated by dividing the cost of an area by the number of patient-days in that same period of time.

The first category MVI looks at is Direct Labor. Using the Team Design Tool, a hospice can know its "ideal" number in about 15 minutes. Without this consciousness, a hospice is shooting in the dark. You could be working towards an ideal that might put you out of business or that is unattainable in your market. A hospice must work with intention and purpose. With this tool, you can "design" your care, at least from a financial perspective. So if you want to beef up CNA services to provide a higher standard of care or just to run another hospice out of business, you can engineer your costs to be congruent with that goal.

The second category MVI looks at is Patient-Related costs (Medications, Medical Supplies, DME, Therapies, etc.). Here it would be wise to look at our benchmarking information. Look at the averages and the best. Then construct a way to get there through modification of clinical practice, better contracts, or a combination of the two.

The third category MVI looks at is Indirect Costs. This is the most difficult area to judge. But if your Direct Labor and your Patient-Related are OK…and you are still having problems…then by elimination you know that your Indirect Costs are bad.

Other Resources: MVI Cost Engineering Tool; Quick Budget System Version 1.0; Hospice Budget Tool Version 6.0; Basic Hospice Accounting (audio CD); Profitability (Audio CD); How to Make Your Hospice a Financial Success! (Audio CD); Pharmacy, DME, & Medical Supplies – An Interview with Grant Faubion (Audio CD)

Variable Costs

Location: Breakeven and Contribution Report

Variable costs are the KEY to successful hospice financial operations. If this is out of control, it will be impossible for a hospice to do well from an operational perspective regardless of how many patients you serve. You could have an ADC of 1,000 and still be losing your shirt! This area is covered in the explanation of the Breakeven and Contribution Margin Report as well. Variable costs increase as your census increases. For example, over the course of a year, if your ADC increases from 50 to 100, you will need more RNs and use more medications. This makes these types of costs variable. In the same illustration, you wouldn't necessarily need another Executive Director or to increase Rent. These would be largely "fixed" in behavior.

What is important about variable costs is the "spread" between your Average Net Revenue and your Average Variable Costs. The larger the spread, the healthier your hospice is from an operational standpoint. The smaller the spread, the more you will need community support. If your variable costs exceed your Average Revenue, you're in serious trouble and your survival is questionable unless you have incredible funding sources other than Patient Revenue.

Average Net Revenue		
	Average Net Hospice Homecare Revenue Per Patient-Day	95.63
	Average Net Hospice Unit Revenue Per Patient-Day	0.00
	Average Net Home Health Revenue Per-Visit	0.00
	Weighted Average Net Revenue Per Unit	95.63
Variable Costs		
	Average Variable Costs Per Hospice Homecare Patient-Day	57.01
	Average Variable Costs Per Hospice Unit Patient-Day	-
	Average Variable Costs Per Home Health Visit	-
	Weighted Average Variable Costs Per Unit	57.01

Variable Costs are critical to good margins and breakeven. Try to keep this in the $50-$62 range for Hospice Homecare and IP should be in the $165-$280 range.

Example: In the illustration shown above Average Net Hospice Homecare Revenue is $95.63 per day. Average Variable Costs Per Hospice Homecare Day is $57.01. If you subtract the revenue from the costs, you get $38.62. This is a great number by our standards. Then by dividing your fixed costs by this number, you will know the number of patient-days to "breakeven". In this case, it is 5,290 patient days. Then by dividing 5.290 by 90 (the number of days in Year to Date March), you have your Breakeven Average Daily Census. If you want to make 5%, then add 5% to your fixed costs. Divide the total by the $38.62 and you'll have your number.

Now this is a simple example. When you start to include a different "mix" of services such as home health and/or an Inpatient/Residential Unit, the calculations become much more complex.

Other Resources: MVIB Benchmarking information; MVI and MVIB Website; Profitability (Audio CD); How to Make Your Hospice a Financial Success! (Audio CD)

Indirect Costs as a Percentage of Net Patient Revenue

At the time of this printing, the average hospice's Indirect Costs as a percentage of Net Patient Revenue was 35%. This is too high in our opinion. A better target is 30%. Most of the time, it is Indirect Labor that throws a hospice into financial problems and not Operational or Facility-Related indirect costs. This is a major area where hospices get into trouble and have difficulty fixing. Often we react to the situation and do a quick RIF (Reduction In Force) only to have the same positions come back in the next year. Why? Because we got rid of the people, but not the "work". When we hire these positions back, we are still "thinking" about the work being done in the same way as before. The fix is WORKING SMARTER. This means using technology, training people better, and expecting more. Often, when you provide a clear expectation, you will be surprised at people's ingenuity and capacity for innovation. Expect people to become experts and master skills. It works for MVI and it will work for any hospice. Like we say, allow staff to take one-half day per month to work on specific skills that would help them in their positions. An hour spent learning a computer technique could return you 80 hours of labor over the course of a year…no kidding. Taking the time to write this manual will save MVI staff *hundreds* of hours a year. If your hospice will take training seriously, you will derive similar payoffs.

Automation and knowledge can save your organization a lot of money. One hospice can have 1 employee handle payroll for 3,000 employees whereas another takes 10. With such drastic differences, it is hard to say always what is best regarding Indirect costs. This is why MVI uses percentages to benchmark the Indirect areas. It is comparable.

Other Resources: MVI Website – Training Topics; CYMA & F9 Knowledge System; The Five Things Your Hospice Needs to do NOW (audio CD); MVI & MVIB Website; Profitability (Audio CD); How to Make Your Hospice a Financial Success! (Audio CD)

Average Visits Per Day by Discipline

Location: Executive Facts; Visit Summary Report; Cost Per Visit by Discipline Report

This measurement is needed to supplement the Patient-Day perspective. It not only provides us a FBS to know how much to charge per-visit payer sources, but it also can tell us about the productivity level of our clinicians.

As said in the explanation of the Cost Per Visit by Discipline Report, look closely at Direct Labor Costs per visit. This is where you can gauge your organization's productivity. By taking the average salaries & benefits for a discipline and dividing them by the expected annual visits for that discipline, you will know what your average direct cost per visits should be. If you expect 4 visits a day from an RN and the Direct Labor Costs is double what you calculate, your RNs are averaging 2 visits per day!

The "P" word is a dirty word for many hospices. The "benchmark setting hospice" always monitors productivity very, very closely. Here are our suggestions for each discipline:

- RN – 4 visits per day (20 per week) (not 3, not 5…but 4!)
- Hospice Aide – 4 to 4.5 per day (20 to 22 per week)
- SW – 3 per day (15 per week)
- PC – 4 to 5 per day (20 to 25 per week)

Other Resources: MVI Document How to Get Productivity Up to Standard; Designing the Perfect Hospice (audio CD series); TRUST – The Foundation of a Great Corporate Culture (audio CD); Leadership (audio CD); MVI Document Master System Plan for a Hospice; MVI & MVIB Website; How to Get Your Costs by Diagnosis, Payer, and Other Demographics (Audio CD); Profitability (Audio CD); How to Make Your Hospice a Financial Success! (Audio CD)

Fully Absorbed Visit-Hour Cost by Discipline

Location: Executive Facts; Visit Summary Report; Cost Per Visit by Discipline Report

Fully absorbed is somewhat of a misleading term. The fully absorbed costs that we refer to include elements of all costs EXCEPT patient-related costs such as DME, Medications, Medical Supplies, Therapies, etc. Therefore, it includes some of the rent, depreciation, office supplies, administrative salaries, etc.

The fully absorbed visit-hour cost is the cost that enables a hospice to get its cost by diagnosis, referral type, patient type, payer, age, sex, physician, etc. Most hospices do not have this information and are not conscious of what this information can do. If you are unknowingly or semi-consciously getting "dumped on" by a more sophisticated referral source, it could be costing your other patients resources. Wouldn't you like to know if the relationship is costing you $2,500 or $250,000 a year?

So how do you use the fully absorbed visit-hour?

- At the end of every quarter, load your visit-hour costs by discipline into your patient-management system.
- Run a "recalculation" function if you wish. This will transpose your "currently attainable" costs onto historical activity. This will be helpful for making decisions NOW! - IN THE PRESENT TIME! We are not interested so much in history here as to what state our hospice is in NOW. The past is past. Now and the future are what is important today.
- By loading this information into your patient-management systems, you can use the power of the relational database to get views of your costs and operations that would not be possible in any accounting system.

Other Resources: Designing the Perfect Hospice (audio CD series); MVI Document and Lecture Understanding Your Product and Service Costs; MVI Document Hospice Cost Accounting; MVI Document Master System Plan for a Hospice; Profitability (Audio CD); How to Make Your Hospice a Financial Success! (Audio CD)

Return on Development Ratio

Location: Executive Facts; Breakeven and Contribution Margin Report

Since community support is an important element or even a competitive edge for many hospices, it needs attention. The average hospice gets 3 to 4 dollars in return for every dollar spent in the Development function. However, some hospices get 20! This ratio simply takes the income from community support and divides it by the costs in the Development area. This provides an "effectiveness" measurement. It is not that we are saying that every fundraising activity or function needs to provide an incredible return, because a hospice can get some mileage (PR value) out of many activities. However, with that said, too many hospices waste tremendous effort and exhaust their staff on bake sales, yard sales, spaghetti suppers, fashion shows, and other small- time efforts. It seems to us, that such effort could be used to get a lot more value.

There is a trend in hospice. Every year hospices set new records in both the number and the amounts of gifts. Hospices do this in the face of ever increasing competition for support dollars. The hospice with a high degree of integrity, that can clearly communicate the cause, and that can clearly communicate the use of the funds can get incredible bequests and contributions. The key is credibility and trust. Both come with a price…the price of time and follow-through. It comes by living up to the promises we make and becoming people of high personal quality. That's what people give to…

Other Resources: Becoming a Great Hospice Board Member (audio CD); TRUST – The Foundation of a Great Corporate Culture (audio CD); Designing the Perfect Hospice (audio CD series); Profitability (Audio CD); How to Make Your Hospice a Financial Success! (Audio CD)

Examples of Statistical Accounts

Statistical Accounts

Here are some of the accounts that MVI uses. We incorporate more for use in the CAR (Critical Activities Reporting) departmental reporting system to help organizations focus on the major things that need to be accomplished. In essence a Statistical Account is an account that houses statistical information so it may be used by different reports that require statistics in their calculations. The amounts are imported or manually entered just like one would for doing a Journal Entry. As soon as the entry is posted all F9 reports will automatically pull the updated statistical amount during the normal calculation.

Long Account	Short Account	Description	Used
01-6000-9000-00-00	1-60-9000-00	Number Of Days In Period	No
01-6000-9003-00-00	1-60-9003-00	ALOS-All	No
04-6000-9005-00-00	4-60-9005-00	Average Daily Census-All	Yes
04-6000-9007-00-00	4-60-9007-00	Patients Served-Total	Yes
04-6001-9100-00-00	4-61-9100-00	RN Visits-Hospice	No
04-6002-9100-00-00	4-62-9100-00	LPN Visits-Hospice	No
01-4200-9100-00-00	1-I0-9100-00	Admission Visits-Hospice	No
04-6005-9100-00-00	4-65-9100-00	CNA Visits-Hospice	No
04-6006-9100-00-00	4-66-9100-00	SW Visits-Hospice	No
04-6007-9100-00-00	4-67-9100-00	PC Visits-Hospice	No
01-4600-9100-00-00	1-V8-9100-00	Volunteer Visits-Hospice	No
01-4400-9100-00-00	1-B0-9100-00	Bereavement Contacts	No
04-6001-9110-00-00	4-61-9110-00	RN Direct Time-Hospice	No
04-6002-9110-00-00	4-62-9110-00	LPN Direct Time-Hospice	No
04-6005-9110-00-00	4-65-9110-00	CNA Direct Time-Hospice	No
04-6006-9110-00-00	4-66-9110-00	SW Direct Time-Hospice	No
04-6007-9110-00-00	4-67-9110-00	PC Direct Time-Hospice	No
01-4600-9110-00-00	1-V8-9110-00	Vol Direct Time-Hospice	No
01-4400-9110-00-00	1-B0-9110-00	Bereavement-Direct Time	No

How to Calculate Fully-Absorbed Costs Using Allocations

MVI has developed a time-proven method to calculate fully-absorbed costs. It is a rational, logical and practical way to approximate costs. When these costs are used in conjunction with a patient management system with cost fields, cost views by diagnosis, payer, age, sex, referral source and other demographics are possible.

Calculation of Direct Cost amounts is not difficult. It is a matter of segregating each category of cost and dividing it by operating statistics such as patient-days, visits, or visit-hours. The following demonstrates the computation of direct costs on a unit basis:

Direct Cost Category	Amount	Patient-Days	Visits	Visit-Hours	Cost Per Patient-Day	Direct Cost Per Visit	Direct Cost Per Visit-Hour
Direct Labor *							
RN	$ 60,000	2,500	750	750	24.00	80.00	80.00
LPN	$ 5,000	2,500	75	75	2.00	66.67	66.67
CNA	$ 20,000	2,500	825	780	8.00	24.24	25.64
SW	$ 10,000	2,500	100	125	4.00	100.00	80.00
SC	$ 2,500	2,500	75	40	1.00	33.33	62.50
Admissions	$ 7,000	2,500	50	100	2.80	140.00	70.00
Bereavement	$ 2,500	2,500	40	50	1.00	62.50	50.00
Total	$ 107,000		1,915	1,920			
Patient-Related							
Medications	$ 25,000	2,500	N/A	N/A	10.00	N/A	N/A
DME	$ 12,000	2,500	N/A	N/A	4.80	N/A	N/A
Medical Supplies	$ 5,000	2,500	N/A	N/A	2.00	N/A	N/A
Therapies	$ 8,000	2,500	N/A	N/A	3.20	N/A	N/A
Mileage	$ 9,000	2,500	N/A	N/A	3.60	N/A	N/A
Total	$ 59,000						
Total Direct Costs	$ 166,000						

Calculation of Direct Costs is relatively easy. However, calculation of Indirect Cost per unit is much more difficult. It involves a two-step process.

Step 1 divides a category of Indirect Cost by segment (Hospice Homecare, Palliative Care, Inpatient Units and Other Programs). An allocation base should be selected that most closely represents actual resource consumption for each segment. Allocation bases can be patient-days, time studies, square footage, estimates, number of transactions, number of deaths, number of admissions, etc.

Indirect Area	Allocation Base	Amount	Hospice Homecare	Hospice IP Unit	Palliative Care
Administration	Time Study	$ 100,000	$ 70,000	$ 20,000	$ 10,000
Operational	Resource Consumption	$ 50,000	$ 35,000	$ 10,000	$ 5,000
Facility	Square Footage	$ 10,000	$ 4,000	$ 5,000	$ 1,000
		$ 160,000	$ 109,000	$ 35,000	$ 16,000

Hospice Homecare

RN	LPN	CNA	SW	SC	Admissions	Bereavement	Total
$ 61,121	$ 5,093	$ 20,374	$ 10,187	$ 2,547	$ 7,131	$ 2,547	$ 109,000

Step 2 takes the amount allocated in Step 1 to each segment and then “sub-divides” it based on Payroll Dollars. Indirect Costs are only allocated in Step 2 to clinical disciplines. In Step 2, Indirect Costs are not allocated to patient-related costs. Time studies have shown a close approximation to Payroll Dollars in terms of an allocation base. To actually arrive at a fully-absorbed cost, Direct Costs and Indirect Costs are simply summed.

Direct Cost Category	Direct Cost Amount		Indirect Cost Applied		Fully Absorbed Cost
Calculation of Fully-Absorbed Cost Per Visit					
Direct Labor *					
RN	80.00	+	$ 81.50	=	$ 161.50
LPN	66.67	+	$ 67.91	=	$ 134.58
CNA	24.24	+	$ 24.70	=	$ 48.94
SW	100.00	+	$ 101.87	=	$ 201.87
SC	33.33	+	$ 33.96	=	$ 67.29
Admissions	140.00	+	$ 142.62	=	$ 282.62
Bereavement	62.50	+	$ 63.67	=	$ 126.17
Calculation of Fully-Absorbed Cost Per Visit-Hour					
Direct Labor *					
RN	80.00	+	$ 81.50	=	$ 161.50
LPN	66.67	+	$ 67.91	=	$ 134.58
CNA	25.64	+	$ 26.12	=	$ 51.76
SW	80.00	+	$ 81.50	=	$ 161.50
SC	62.50	+	$ 63.67	=	$ 126.17
Admissions	70.00	+	$ 71.31	=	$ 141.31
Bereavement	50.00	+	$ 50.93	=	$ 100.93

On a quarterly basis, update the cost fields in your Patient Management System.

Applying currently attainable costs to historical activity provides the most conservative estimates of cost.

Calculation of Fully-Absorbed Patient Day Cost

		Divide by Patient Days	
Total Segment Direct Patient-Day Costs	$ 166,000	2,500	$ 66.40
Allocated Indirect Costs from Step 1	$ 109,000	2,500	$ 43.60
	$ 275,000	2,500	$ 110.00

Fully Absorbed Costs

So what do you do with a fully-absorbed cost amount? On a quarterly basis, update the cost fields in your patient-management system. Applying currently attainable costs to historical activity provides the most conservative estimates of cost.

Many patient-management systems can produce reports similar to the one shown below. This example is an "ideal" report containing most everything a hospice needs.

Revenue & Expense Analysis

For the Period from 3/1/05 to 3/31/05

This could be payer source, physician, referral source, staff member, individual patient, age, sex, zip code, as well as diagnosis or diagnosis group.

Diagnosis: Lung Cancer

	Amounts	Cost Per Patient-Day	Number of Visits	Visit-Hours: Direct Time	Visit-Hours: Indirect Time	Visit-Hours: Travel Time	Visit-Hours: Total Time	Fully Absorbed Costs
Revenue	57,615.00	115.23						
Direct Labor								
RN	22,166.95	44.33	155	116.3	11.6	32.6	160.5	138.13
LPN	1,977.60	3.96	16	13.0	1.2	5.0	19.2	103.00
CNA	10,174.01	20.35	170	132.4	12.8	44.7	189.9	53.59
SW	5,507.76	11.02	22	14.5	1.7	5.5	21.7	254.40
PC	3,840.84	7.68	17	13.8	1.3	4.3	19.3	198.75
Intake	4,685.33	9.37	11	22.6	0.8	2.8	26.2	179.00
Bery	812.49	1.62	7	5.5	0.5	1.8	7.8	104.50
Total	49,164.98	98.33	398	318.05	29.85	96.55	444.45	
Patient-Related								
Medications	7,425.00	14.85						
DME	2,375.00	4.75						
Medical Supplies	1,050.00	2.10						
Therapies	2,250.00	4.50						
Mileage	1,875.00	3.75						
Total	14,975.00	29.95						
Total Costs	64,139.98	128.28						
Net Income	(6,524.98)	(13.05)						

Using the power of the relational database, we are able to transpose currently attainable costs onto historical activity. This provides a hospice the most conservative view of its costs.

We recommend that cost fields in patient management systems be updated quarterly.

Number of Patient-Days: 500 Number of Patients: 25

Revenue and Expense Analysis

Revenue and Expense Analysis or other similar reports can usually be run for individual patients or patient groups. At this point, you are taking advantage of the relational database of the patient-management system.

Sometimes summary reports can be created that can help a hospice quickly locate patients and trends in the patient-management system. Below are examples of Top 10 Lists for High and Low cost patients. Both should be of interest to a hospice as one group is receiving a disproportionate amount of resources and the other group is receiving very little.

Top Ten List - Highest Costs

		Number of Visits	Number of Visit-Hours	Direct Labor Costs	Patient Related Costs	Total Costs
1	Betty Jones	48	68.6	13,049.94	12,457.54	25,507.48
2	Billy Ford	42	65.3	7,453.37	14,678.78	22,132.15
3	Melissa Smith	41	60.4	9,240.79	11,265.81	20,506.60
4	Emma Blue	38	58.2	10,321.66	7,934.72	18,256.38
5	Rodney Conrad	36	55.8	6,159.78	6,721.27	12,881.05
6	Julie Brown	35	48.5	4,028.81	6,976.47	11,005.28
7	Suzie Dillingham	30	45.7	4,862.17	3,767.78	8,629.95
8	Jack Zittelman	33	39.3	6,135.39	1,743.90	7,879.29
9	Mary Mohahan	27	37.2	5,333.68	1,295.39	6,629.07
10	John Winter	29	36.6	5,600.43	903.53	6,503.96

Run Summary Services Report for all patients if you can't create a report that can pick out the top 10 most costly and top 10 least costly patients.

Review Monthly.

Top Ten List - Lowest Costs

		Number of Visits	Number of Visit-Hours	Direct Labor Costs	Patient Related Costs	Total Costs
1	Larry Carr	0	0.0	-	55.08	55.08
2	Mel Howe	1	0.5	62.56	-	62.56
3	Jeff Veck	1	0.6	59.63	15.44	75.07
4	Eric Clap	2	1.2	104.25	45.88	150.13
5	Kelly Johnson	2	1.4	87.16	87.99	175.15
6	Sue Wreck	3	1.6	90.62	109.56	200.18
7	Gene Simmons	4	2.0	128.79	121.43	250.22
8	Henry Williams	4	2.5	213.70	99.08	312.78
9	Jed Dorr	4	3.0	209.57	165.76	375.33
10	Jim Morrison	5	3.7	315.14	147.77	462.91

This is a form of “exception” reporting. Anytime you can let the system locate unusual or potentially problem situations without having to review all individual records, you are using your system efficiently.

Benchmarking Type and Sub-Type Logic

Color Code Logic:

Type | Revenue and Income | Salaries/Labor

Sub-Type	Description
Revenue	
Medicare	Use for all forms of Medicare revenue, EXCEPT Physician Billing, which is tracked separately, and Pass-Throughs
Medicaid	Use for all forms of Medicaid revenue, EXCEPT Physician Billing, which is tracked separately, and Pass-Throughs
Commercial Benefit	Commercial or Private Insurance revenue paid predominantly on a per diem basis
Commercial FFS	Commercial Fee-For-Service revenue; this is paid based on number or type of visits or services provided rather than a per diem
Medicaid R&B (own unit)	Use for Medicaid Room & Board revenue. Only use this if you have your own Unit and have indicated the Category as IP Unit
Other/R&B (own unit)	Use for "other" Room & Board revenue. Only use this if you have your own IP Unit and have indicated the Category as IP Unit
Physician Billing	Use for all physician billing EXCEPT consulting physician services, which are Pass-Throughs; use for billing of visits or rounding in IP Units
Self-Pay	Revenue from patients and families
Other/Charity	Pseudo-Revenue for indigent patients, displayed only to demonstrate the value of services provided; not considered collectable
Adjustments	
Contractual Allowances	Use for write-offs where a partial payment or "contractual amount" is anticipated to be collected AT THE TIME OF ADMISSION
Bad Debt	Use for write-offs where the amount of payment expected at the time of admission is denied or is ultimately not received
Reserve Allowance	Use in conjunction with the Allowance for Doubtful Accounts on the Balance Sheet to adjust the valuation
Other/Charity	Commonly used as the "reciprocal" debit amount of the Other/Charity Revenue category; used to offset Other/Charity Revenue
Direct Service including Contract Direct Service Labor & Direct Service Mileage	
RN	Registered Nurse that performs visits and/or has direct patient contact as the DOMINANT part of the work requirement
LPN	Licensed Practical Nurse that performs visits and/or has direct patient contact as the DOMINANT part of the work requirement
Hospice Aide	Certified Nursing Assistant or HHA that performs visits and/or has direct patient contact as the DOMINANT part of the work requirement
SW	Social Worker that performs visits and/or has direct patient contact as the DOMINANT part of the work requirement
Spiritual Care	Pastoral Counselor or Chaplain that performs visits and/or has direct patient contact as the DOMINANT part of the work requirement
Physician	Use for physician that visit and/or has direct patient contact as the DOMINANT part of the work requirement
On-Call	Use for all On-Call labor
Allocated	
Benefits - Health and Wellness	Benefits associated for Health (4110), Dental(4120), Vision Insurance, Long Term Disability Insurance(4125), Wellness(4220), Employee Health(4170) and similar
Benefits - Payroll Taxes	Taxes and mandatory insurance such as Medicare (4130), SUTA (4150), FUTA (4151), Workers Compensation(4160), Local Tax and similar
Benefits - Retirement	Benefits for your Retirement Insurance expense such as the company contribution toward pension plans, IRAs, 403B, 401K(4140) or similar
Benefits - All Other	All Other Benefits such as Employer Paid Life Insurance(4124), Employee Procurement(4200), Tuition Reimbursement(4210), Employee Recognition(4230) and similar
Admissions Labor	Labor associated with performing admissions regardless of discipline
Admissions Contract Labor	Contract Labor associated with performing admissions regardless of discipline
Bereavement Labor	Bereavement Coordinator wages and salaries
Bereavement Contract Labor	Bereavement Coordinator services paid on a contract basis
Volunteers Labor	Volunteer Coordinator wages and salaries
Volunteers Contract Labor	Volunteer Coordinator services paid on a contract basis
Triage Labor	Labor associated with taking clinical calls from patients, families, and outside entities (Can provide advice and care directly over the phone or dispatch clinicians)
Triage Services Contract Labor	Contract Labor associated with taking clinical calls from patients, families, and outside entities (Can provide advice and care directly over the phone or dispatch clinicians)
Mileage Admissions	Mileage costs associated with the admissions function
Mileage Volunteers	Mileage costs associated the Volunteer Coordination function
Mileage Bereavement	Mileage costs associated with the "Hospice" Bereavement function; Community Bereavement mileage would not be classified here
Patient-Related	
Ambulance	Ambulance or any form of patient transportation costs
Bio Hazardous	Hazardous waste disposal
Continuous Care Raw	Cost associated with Continuous (Crisis) Care; most hospices use contract staff; if CC is a major part of your care, then direct ALL CC patient-related and non labor here
Continuous Care Labor	Cost associated with Continuous (Crisis) Care; most hospices use contract staff; if CC is a major part of your care, then direct ALL CC labor here
Continuous Care Other	Cost associated with Continuous (Crisis) Care; most hospices use contract staff; if CC is a major part of your care, then direct ALL CC other costs here
Dietary	The cost of Contract Dietary Specialists
DME Raw	Most hospices will use this for Durable Medical Equipment; use when contracting for DME services
DME Labor	Durable Medical Equipment Labor; use only if you have a DME service which your hospice staffs and operates; this is not used by most hospices
DME Other	The other costs involved with operating a Durable Medical Equipment service; use only if you operate a DME service; this is NOT used by most hospices
ER	Emergency Room
Food	Food expenses should be captured here; this is usually for IP and residential units
Imaging	Imaging Services; example X-rays
Lab	Laboratory and Diagnostics
Linen	Linen; this may be a contracted service or an in-house function
Medical Supplies	Medical Supplies
Mobile Phone	Only use for mobile phone costs of visiting staff; otherwise, use Indirect Costs/Telephone
Other	Try to put as little in this area as possible; it should ONLY be used for items that related to direct patient care
Outpatient	Outpatient services that do NOT fall into any other category are recorded here
Oxygen for Unit Only	Oxygen for IP Unit only. If segregated on your Trial balance
Pagers	Only use for pager costs of visiting staff; otherwise, use Indirect Costs/Pagers
Pharmacy Raw	The cost of medications; most hospices will only use this category as they contract for such services
Pharmacy Labor	Pharmacy Labor; use only if your hospice staffs and operates its own pharmacy; this is NOT used by most hospices
Pharmacy Other	The other costs involved with operating your own pharmacy other than the actual cost of medications; this is NOT used by most hospices
Therapies PT/OT/ST	Cost of Physical, Occupational or Speech Therapy required by COPs. This includes the cost of Contract Labor staff and contracted service providers
Therapies Chemo	Cost of Chemotherapy
Therapies IV/Biol and Other	Includes IV or Biological Therapies, and any other therapy modality not otherwise broken out (radiation therapy for example)
Therapies PT/OT/ST Labor	Cost of PT/OT/ST Staff that receive benefits
Pass-Through-Income	Income where the hospice is the "Fiscal Intermediary" and bills on behalf of other entity; contract GIP, R&B, Respite, Consulting Physicians are examples
Pass-Throughs-Expense	Expense where the hospice pays or "passes through" the money collected on behalf of the entity providing the service; the expense side of Pass-Through Income
Indirect Labor	
Admin Salaries	Administrative salaries & wages such as the CEO, Administrative Assistant, etc.
Admin Contract Labor	Contract Administrative salaries & wages such as the CEO, Administrative Assistant, etc.
Clinical Mgt Salaries	Clinical Management salaries & wages; those that oversee clinical operations (Should include any support staff)
Clinical Mgt Contract Labor	Contract Clinical Management salaries & wages; those that oversee clinical operations
Compliance/QAPI Salaries	Compliance/QI salaries & wages (Should include any support staff)
Compliance/QAPI Contract Labor	Contract Compliance/QI salaries & wages
Education Salaries	Educationl salaries & wages (Should include any support staff)
Education Contract Labor	Contract Education
Finance Salaries	Finance salaries & wages (Should include any support staff)
Finance Contract Labor	Contract Finance salaries & wages
HR Salaries	Human Resource salaries & wages (Should include any support staff)
HR Contract Labor	Contract Human Resource salaries & wages
Marketing Salaries	Marketing salaries & wages; Includes reimbursable and non-reimbursable outreach efforts; Public Relations, Community Awareness, or Promotions and any support staff
Marketing Contract Labor	Contract Marketing salaries & wages; Includes reimbursable and non-reimbursable outreach efforts; Public Relations, Community Awareness, or Promotions
Medical Director Salaries	Medical Director Salaries. Use the Allocation Table to allocate amounts between Physician and Medical Director.
Medical Director Contract Labor	Medical Director Contract Labor. Use the Allocation Table to allocate amounts between Physician and Medical Director.
Medical Records Salaries	Medical Records salaries & wages (Should include any support staff)
Medical Records Contract Labor	Contract Medical Records salaries & wages
MIS Salaries	MIS or IT salaries & wages; these are your computer and network people (Should include any support staff)
MIS Contract Labor	Contract MIS or IT salaries & wages; these are your computer and network people
Other Salaries	Use this only for salaries & wages that will not fit in the above types
Other Contract Labor	Use this for Indirect Contract Labor that will not fit in the above types

Indirect Operating	
Answering Service	Answering Service costs
Accounting/Audit	Accounting/Audit; would include MVI services, audit services, outside accounting services; do not use for internal accounting/finance staff
Bank Service	Bank Service charges and fees
Computer Expenses	Computer Expenses such as toner, lease contracts, maintenance and non-capitalized items/software
Consulting/Professional Fees	Consulting/Professional Fees
Continuing Education	The cost of education including books, resources, all costs for attending conferences (registration, travel, lodging, meals, etc.)
Dues Licenses & Subscript	Dues, Licenses & Subscriptions
Copier Expense	Use for copier expenses including contract costs and all associated expenses
Insurance	Insurance such as Liability, Directors & Officers, Malpractice, Hazard, Property, etc
Interest-Operating	Interest expense for operations, like a line of credit; this is NOT for interest relating to a mortgage or the financing of a building/facility
Lease/Rent Equipment	Leased equipment costs not captured in other accounts
Legal	Legal expenses
Meeting Expense	Meeting Expense such as supplies for meetings and functions, food, travel for predominantly non-continuing educational meetings
Mileage-Non-Patient	Any mileage not related to direct patient care
Minor Equipment	Small office/non-capitalized items such as file cabinets, book shelves, desk lamps, heavy duty staplers, waste cans, etc.
Miscellaneous	Very few costs should go here and nothing with a significant dollar amount
Office Supplies	Office Supplies such as paper, writing materials, folders, binders, tape, pens, notebooks, etc.
Pagers (Non-Patient)	Pager expenses for staff who do not perform direct patient visits as their major responsibility
Postage/Mailings	Postage for non-marketing or fundraising purposes; use for regular correspondence and shipping needs
Printing	Printing for non-marketing or fundraising purposes; use for all other printing
Service Contracts-Operating	Operating Service Contracts; service contracts NOT relating to the service and upkeep of a building or facilities
Telephone	Telephone and telecommunication expenses including mobile phone charges for non-visiting staff
Vehicle Exp-Owned/Lease	Use this for expenses associated with company vehicles
Training-Groups	For expenses relating to the education and training of volunteers; Do not use for the training costs of staff, in that case, use Continuing Education
Marketing Other	Marketing materials and activities such as advertising, brochures, displays, exhibitions, etc.
Other Expenses	Use for expenses that do not fit any other category
Indirect Facility-Related	
Alarm System	Alarm system or security expense
Cleaning & Paper	Cleaning and janitorial expenses; include costs to keep the facilities clean and toilet supplies stocked
Depreciation-Major Moveable	Use for depreciation expense for any non-building related item such as major movables, fixed assets, vehicles, etc.
Depreciation-Building	Use for depreciation expense for building related item such as leasehold improvements, building, etc.
Exterminating	Use for the cost of exterminating insects and pests
Interest-Facility	Use for interest related to buildings and facilities such a mortgage or other financing instruments
Landscaping	Landscaping and grounds keeping expenses; lawn services, plant maintenance, mulching, etc.
Other-Facility	Use for all building-related costs that do not fit any other category;
Maintenance	Maintenance expenses; these include painting, repairs, minor replacement costs, etc.
Maintenance Salaries	Maintenance Salaries and Wages; Paid maintenance staff
Property Taxes	Property Taxes
Rent	Rent or lease costs relating to a building or facility
Service Contracts-Facilities	Use for all service contract costs that related to a build or facility such as garbage removal, inspections, monitoring arrangements, etc.
Utilities	Utilities costs such as water, natural gas, electricity, sewer, etc.
Interest Investment Income	
Interest Income	Income earned from interest on cash and other near-cash assets
Investment Income	Income from investments in bonds, securities, T-Bills, CDs, etc.
Medicare/Medicaid Interest	Interest paid by Medicare or Medicaid for delayed payment
Realized Gain/Loss Disposals	Use for the actual losses from the "disposal" of assets; can be tangible assets like computers or office equipment or money vehicles
Unrealized Gains/Loss	Use for estimated gains or losses from assets if the assets were to be sold or "disposed of" as of the balance sheet date
Other	Other types of investment income not fitting any of the above categories
Development Income	
Contributions	Donations and general community support not associated with specific fundraising events
Memorials	Monies received in memory of the deceased
United Way	Monies received from the United Way
Bequests	Use for amounts left to the organization in wills or other appropriations after the death
Endowment	Monies given to the hospice for perpetuation of the program; can also be designated as special purpose
Grants-Support Only	Use only for grants that are more of a "gift" than to fund a specific program
Fundraising	Monies received from specific fundraising events or functions; examples Tree of Lights, Golf-a-Thon, Bike for Hospice, Galas, etc.
In-Kind Income	Value received in the form of goods and services rather than cash
Other	Use only if the type of Development Income does not fit any of the other categories
Development Costs	
Development Labor	Development or Fundraising Staff salaries & wages
Development Other	The other costs associated with the operation of the Development or Fundraising department
Development-Fundraising	Use for the cost of fundraising events and functions
Special Bereavement/Grief Program	
Special Bereavement Labor	Use for Special and Community Bereavement salaries & wages; these are NOT traditional bereavement for hospice patients but extra
Special Bereavement Other	Use for other costs of operating a Special and Community Bereavement program
Other Program Costs	
Program Labor	Many programs can be established on the Controls Tab; list all extra programs on the Control tab designating labor when applicable for benefit calculations
Program Other	Create your program names on the Controls Tab for selection when lining up your Trial Balance
In-Kind Expense	Use this to offset In-Kind Income; normally In-Kind Income and Expense net to zero unless there were capital In-Kind donations received, these must be depreciated
Board Designated Items	Use for items designated by the Board that would skew financial statements; research & development costs, feasibility studies, etc.
Donor Restricted Items	Use for items designated by the Donor and that might otherwise skew financial statements

Hospice Benchmarking System

Profit and Loss Type and Sub-Type Logic

Version 15 F9V5

MVI Multi-View Incorporated BENCHMARKING

Category	Type	Sub-Type		
Description	**Description**	**Description**	**Description**	**Description**
Hospice	Revenue	***Revenue***	***Indirect Costs***	***Interest / Investment Income***
IP Unit	Adjustments	Medicare	*Labor*	Interest Income
Palliative Care	Direct Service Labor	Medicaid	Admin Salaries	Investment Income
	Direct Service Mileage	Commercial Benefit	Admin Contract Labor	Medicare/Medicaid Interest
	Direct Per Diems	Commercial FFS	Clinical Mgt Salaries	Realized Gain/Loss on Disposals
	Direct Contract Labor	Medicaid R&B (only for own units)	Clinical Mgt Contract Labor	Unrealized Gain/Loss
	Allocated	Other/R&B (only for own units)	Compliance/QAPI Salaries	Other
	Patient Related	Physician Billing	Compliance/QAPI Contract Labor	
	Indirect Costs	Self-Pay	Education Salaries	**Dev Income**
	Interest Investment Income	Other/Charity	Education Contract Labor	Contributions
	Dev Income		Finance Salaries	Memorials
	Dev Costs	***Adjustments***	Finance Contract Labor	United Way
	Special Bereavement Grief Program	Contractual Allowances	HR Salaries	Bequests
	Other Program Costs	Bad Debt	HR Contract Labor	Endowment
		Reserve Allowance	Marketing Salaries	Grants-Support Only
		Other/Charity	Marketing Contract Labor	FundRaising
			Medical Director Salaries	In-Kind Income
		Direct Service Labor	Medical Director Contract Labor	Other
		Direct Service Mileage	Medical Records Salaries	
		Direct Per Diems	Medical Records Contract Labor	**Dev Costs**
		Direct Contract Labor	MIS Salaries	Development Labor
		RN	MIS Contract Labor	Development Other
		LPN	Other Salaries	Development-Fundraising
		Hospice Aide	Other Contract Labor	
		SW	*Operating*	**Special Bereavement Grief Program**
		Spiritual Care	Answering Service	Special Bereavement Labor
		Physician (and Nurse Practitioner)	Accounting/Audit	Special Bereavement Other
		On-Call	Bank Service	
			Computer Expenses	**Other Program Costs**
		Allocated	Consulting/Professional Fees	Community Bereavement
		Benefits - Health and Wellness	Continuing Education	Home Health
		Benefits - Payroll Taxes	Dues, Licenses & Subscriptions	Peds
		Benefits - Retirement	Copier Expense	Program 4
		Benefits - All Other	Insurance	Program 5
		Admissions Labor	Interest-Operating	Program 6
		Admissions Contract Labor	Lease/Rent Equipment	In-Kind Expense
		Bereavement Labor	Legal	Board Designated Items
		Bereavement Contract Labor	Marketing Other	Donor Restricted Items
		Volunteers Labor	Meals & Refreshments	
		Volunteers Contract Labor	Meeting Expense	
		Triage Labor	Mileage (Non-Patient)	
		Triage Contract Labor	Minor Equipment	
		Mileage Admissions	Miscellaneous	
		Mileage Bereavement	Office Supplies	
		Mileage Volunteers	Pagers (Non-Patient)	
			Postage/Mailings	
		Patient Related	Printing	
		Ambulance	Service Contracts-Operating	
		Bio Hazardous	Telephone	
		Crisis Care Raw	Training-Groups	
		Crisis Care Labor	Vehicle Exp-Owned/Lease	
		Crisis Care Other	Other Expenses	
		Dietary	Depreciation-Major Moveable	
		Dietary Labor	Depreciation-Building	
		DME Raw	*Facility Related*	
		DME Labor	Alarm System	
		DME Other	Cleaning & Paper	
		ER	Exterminating	
		Food	Interest-Facility	
		Food/Kitchen Labor	Landscaping	
		Imaging	Maintenance	
		Lab	Maintenance Salaries	
		Linen	Other-Facility	
		Medical Supplies	Property Taxes	
		Mobile Phone	Rent	
		Other	Service Contracts-Facilities	
		Outpatient	Utilities	
		Oxygen for Unit Only		
		Pagers		
		Pharmacy Raw		
		Pharmacy Labor		
		Pharmacy Other		
		Therapies PT/OT/ST		
		Therapies Chemo		
		Therapies IV/Biol and Other		
		Therapies PT/OT/ST Labor		
		Pass-Through-Income		
		Pass-Through-Expense		

These three primary segments are tracked in separate columns on our reports.

All Development Expenses should be set to this area in order to properly capture the Return on Development calculation. The question is "How does the Hospice stand without any community support"?

Almost every hospice has some type of unique program such as a Pediatrics Program. It is important to keep income and expense associated with these programs to the Other Programs area in order not to skew normal hospice amounts.

Any questions? Don't guess!
Call Multi-View Benchmarking at 772-569-9811

This document provides a "roadmap" for the Benchmarking System Type and Sub-Types. We recommend keeping a printed copy available for reviewing the Benchmarking System.

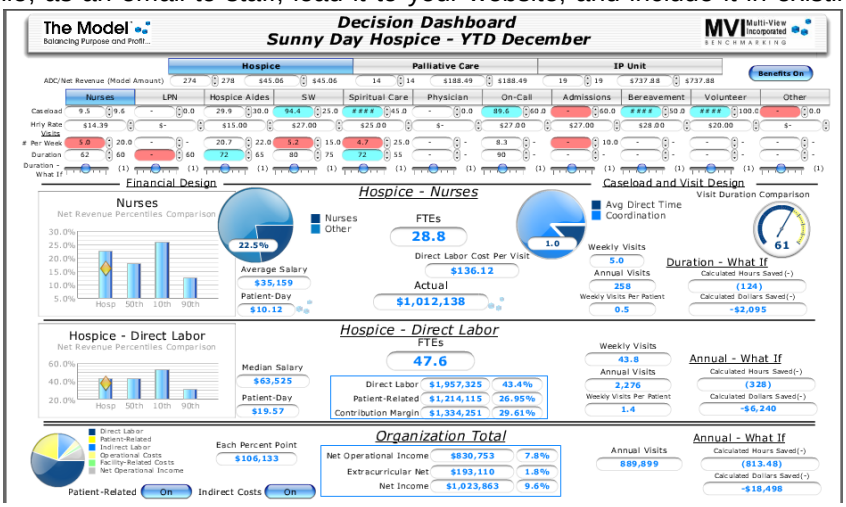
Some items such as DME have several options.

Raw - Most often used. For hospices that do not have their own DME Company.
Labor - Use only if you have a DME Company. All labor with benefits will be included here.
Other - Use only if you have a DME Company. All non-labor expenses will go here.

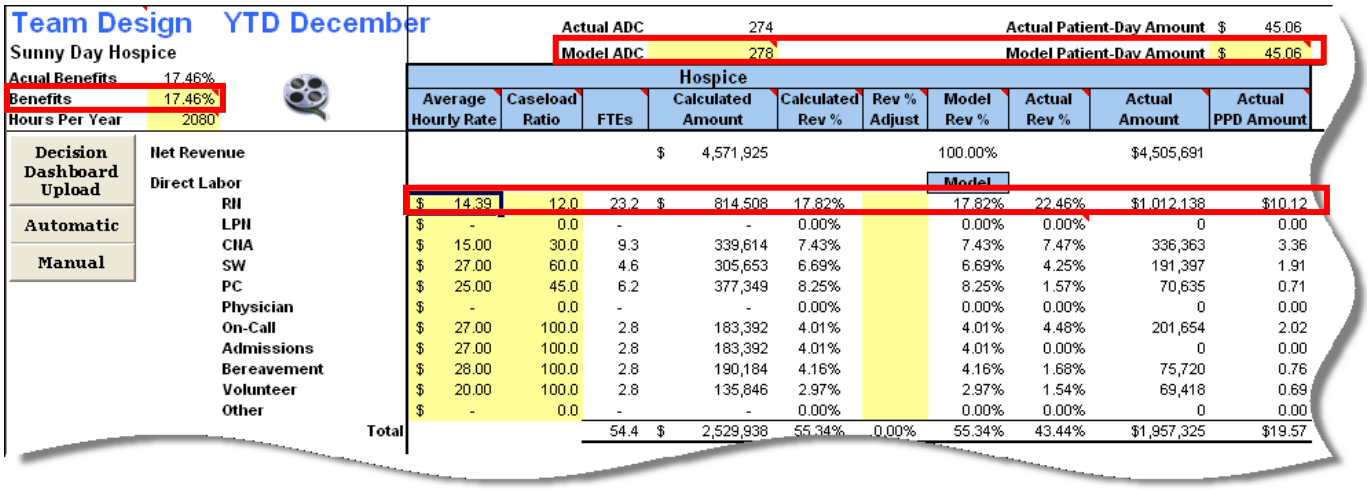
Pass-Through Income and Expense should be grouped here. A Pass-Though is where the hospice acts as the Fiscal Intermediary - **money in and money out.** These items will not net to zero as there are anticipated contractual differences. This is one important for benchmarking as you should want to know what kind of residual other hospices see on Pass-Throughs.

Decision Dashboard – (DD)

The Decision Dashboard (DD) is the most exciting new feature of the Benchmarking System. We now have the ability to capture the results of your Team and Visit Design work from the MA in this interactive flash utility. You can use this file as a stand alone Adobe pdf file, as an email to staff, load it to your website, and include it in existing PowerPoint presentations… The DD has been designed to include a wealth of "what-if" scenarios making it powerful for group discussions. The Team and Visit reports were formerly the Cost and Productivity Engineering but have been modified to emulate MVI's Model Planning Tool logic. This new utility, the Decision Dashboard, has a similar logic as the current process of submitting an Upload file to be loaded to the Master Data Set. Update the MA, review amounts, submit the Decision Dashboard Upload, MVI will create the DD and email it back to you. In this manner you can control submitting your amounts when you are comfortable.



There is a new Decision Dashboard service level that you will need to sign up for to take advantage of this new technology. However, after signing up all the work that you have done on these reports will be able to be taken full advantage of. We encourage hospices not interested in the new DD to still use the Team and Visit Design reports to help manage expectations of clinical staff.



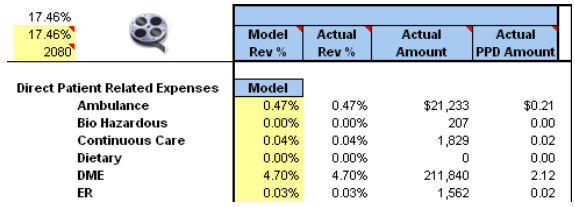
Team Design YTD December

Sunny Day Hospice

Acual Benefits	17.46%			Actual ADC	274			Actual Patient-Day Amount	$	45.06	
Benefits	17.46%			Model ADC	278			Model Patient-Day Amount	$	45.06	
Hours Per Year	2080			Hospice							
		Average Hourly Rate	Caseload Ratio	FTEs	Calculated Amount	Calculated Rev %	Rev % Adjust	Model Rev %	Actual Rev %	Actual Amount	Actual PPD Amount
Decision Dashboard Upload	Net Revenue				$ 4,571,925			100.00%		$4,505,691	
Automatic	Direct Labor							Model			
Manual	RN	$ 14.39	12.0	23.2	$ 814,508	17.82%		17.82%	22.46%	$1,012,138	$10.12
	LPN	$ -	0.0	-	-	0.00%		0.00%	0.00%	0	0.00
	CNA	$ 15.00	30.0	9.3	339,614	7.43%		7.43%	7.47%	336,363	3.36
	SW	$ 27.00	60.0	4.6	305,653	6.69%		6.69%	4.25%	191,397	1.91
	PC	$ 25.00	45.0	6.2	377,349	8.25%		8.25%	1.57%	70,635	0.71
	Physician	$ -	0.0	-	-	0.00%		0.00%	0.00%	0	0.00
	On-Call	$ 27.00	100.0	2.8	183,392	4.01%		4.01%	4.48%	201,654	2.02
	Admissions	$ 27.00	100.0	2.8	183,392	4.01%		4.01%	0.00%	0	0.00
	Bereavement	$ 28.00	100.0	2.8	190,184	4.16%		4.16%	1.68%	75,720	0.76
	Volunteer	$ 20.00	100.0	2.8	135,846	2.97%		2.97%	1.54%	69,418	0.69
	Other	$ -	0.0	-	-	0.00%		0.00%	0.00%	0	0.00
	Total			54.4	$ 2,529,938	55.34%	0.00%	55.34%	43.44%	$1,957,325	$19.57

Team Design – Modeling Caseloads and Hourly Rates

Looking at the demonstration above; the average RN is making $14.39/hr with benefits of 17.46%. There must be 23.2 Full Time Employees needed to cover a census level of 278 when the caseload is 12. This calculates out to $814,508 or almost 18% of Net Revenue. *The Rev% Adjustment column should be used only if quickly updating this report and not if intending to create the DD utility*. The three columns to the right are actual amounts and in the case above there is a significant difference ($200k) in the Calculated and Actual amounts. By engineering these amounts you can use them as your hospice Model amounts (or standards). Both amounts will be seen on your custom DD. You have the flexibility of using actual or Model amounts for Benefits %, ADC and Patient-Day Amounts. Both logics have merit depending on the current focus of the hospice. Example: if you are emulating your budget it would be best to manually enter the ADC amount that the budget is based on. However, if you are using a Flex-Budget approach you will want your Model to change to match actual ADC. This is simply done by referencing the Actual ADC cell in the Model ADC input area. Palliative Care and IP Unit segments have very similar logics with Palliative looking at Average Daily Visits in place of ADC and IP Unit includes the number of FTE's to cover each bed. **For hospices without Palliative Care and IP Units, you should not have amounts entered in any yellow input cells for those segments.** The first two Model amounts to keep in mind are the Caseload and Average Hourly Rate.

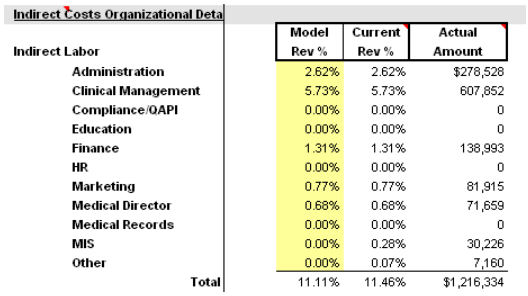


17.46%
17.46%
2080

	Model Rev %	Actual Rev %	Actual Amount	Actual PPD Amount
Direct Patient Related Expenses	Model			
Ambulance	0.47%	0.47%	$21,233	$0.21
Bio Hazardous	0.00%	0.00%	207	0.00
Continuous Care	0.04%	0.04%	1,829	0.02
Dietary	0.00%	0.00%	0	0.00
DME	4.70%	4.70%	211,840	2.12
ER	0.03%	0.03%	1,562	0.02

Direct Patient Related Expenses

Below the Direct Labor area is where the Direct Expenses should be updated. When first starting the Team Design, some hospices simply copy the actual Rev% column amounts over to the Model Rev% column. While this is an easy way to get started, each item should be modeled at your earliest convenience as the Model amount will be represented on various reports in the MA.



Indirect Costs Organizational Deta	Model Rev %	Current Rev %	Actual Amount
Indirect Labor			
Administration	2.62%	2.62%	$278,528
Clinical Management	5.73%	5.73%	607,852
Compliance/QAPI	0.00%	0.00%	0
Education	0.00%	0.00%	0
Finance	1.31%	1.31%	138,993
HR	0.00%	0.00%	0
Marketing	0.77%	0.77%	81,915
Medical Director	0.68%	0.68%	71,659
Medical Records	0.00%	0.00%	0
MIS	0.00%	0.28%	30,226
Other	0.00%	0.07%	7,160
Total	11.11%	11.46%	$1,216,334

Indirect Costs Organizational Detail

Scrolling down on the page the Indirect area has input cells as a Percent of Net Revenue. This is an organizational total and totals will be automatically allocated based on the allocation logic as detailed on the Allocation Table. Again, a copy/paste from actual will quickly get you started but intentional design of each line item should be done at your earliest convenience.

Visit Design

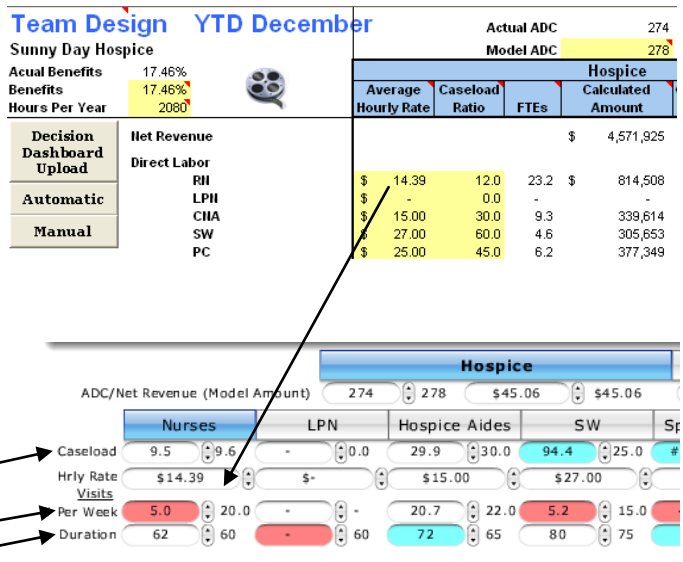
Hospice										
Hospice Discipline	Model Average Caseload	Computed Average Caseload	Model Weekly Visits	Computed Weekly Visits	Model Visit Duration	Computed Visit Duration	FTE Number of Annual Visits	FTEs	Computed Avg Direct Time Per Day	Computed Coordination Time Per Day
RN	9.6	9.5	20.0	5.0	60	62.4	258	29.0	2.2	5.8
LPN	0.0	-	21.0	-	61	-	0	-	0.0	8.0
CNA	30.0	29.9	22.0	20.7	65	72.0	1,076	9.3	1.1	6.9
SW	25.0	94.4	15.0	5.2	75	80.0	269	11.1	0.1	7.9
PC	45.0	236.9	25.0	4.7	55	72.0	242	6.2	0.0	8.0
Physician	0.0	-	-	-		-	0	-	0.0	8.0
On-Call	60.0	89.6		8.3		90.0	430	4.6	0.1	7.9
Admissions	60.0	-	10.0	-	90	-	0	4.6	0.0	8.0
Bereavement	50.0	247.5		-		-	0	5.6	0.0	8.0
Volunteer	100.0	192.9		-		-	0	2.8	0.0	8.0
Other	0.0							-	0.0	8.0
Alert Percent	10%		15%		20%					

Visit Design – Modeling Weekly Visits and Visit Durations

While the Team Design focuses on financial amounts, the Visit Design focuses on the productivity expectations. You will see Caseload calculations from the Team Design are represented first. Next we have Input areas for Weekly Visits and Visit Durations. At the end FTE and Direct Time calculations are present. Looking at the yellow input cells, this is where you establish your Model amounts for each section. The details for calculations are on the comments area for Computed Weekly Visits and Visit Durations. This is a great area to identify problem areas related to counting visits and visit hours that often plague hospice programs. The Alert Percent cells at the bottom allow you to indicate when you want to be alerted to a difference in the Model and Actual amounts. Alerts will flag when the difference between the Model and Actual is greater than your percentage. “Blue is good Red is bad” continues to be the logic through the system. However, even though the Computed Average Caseload for SW (above) is blue at 94.4 there is likely a need to verify the amounts as this would be an unrealistically high amount. The percentages that you establish to “flag” alert colors will carry through to your Model Cards, as well as the DD. Palliative Care and IP Unit business segments are available for those who have such programs; if you are a basic hospice you will want to make sure those yellow areas are cleared out.

Decision Dashboard Upload

After recalculating your work and reviewing the amounts sending a Decision Dashboard Upload is the same as sending the Upload to the Master Data Set. We recommend using the same Automatic or Manual option that you do for the NFDS Upload. Within two business days we will process your DD Upload and email back to you the interactive flash Decision Dashboard. The DD will not have an Alerts/Validator mechanism to eliminate questionable data. This is due to the nature that when first using this area unrealistically high and low amounts are likely but will be more obvious when viewed with the DD compared to the MA. Your DD will include both actual and Model amounts. However, actual amounts can be modified for “what-if” scenarios while the Model amounts are fixed and non-modifiable on the DD.



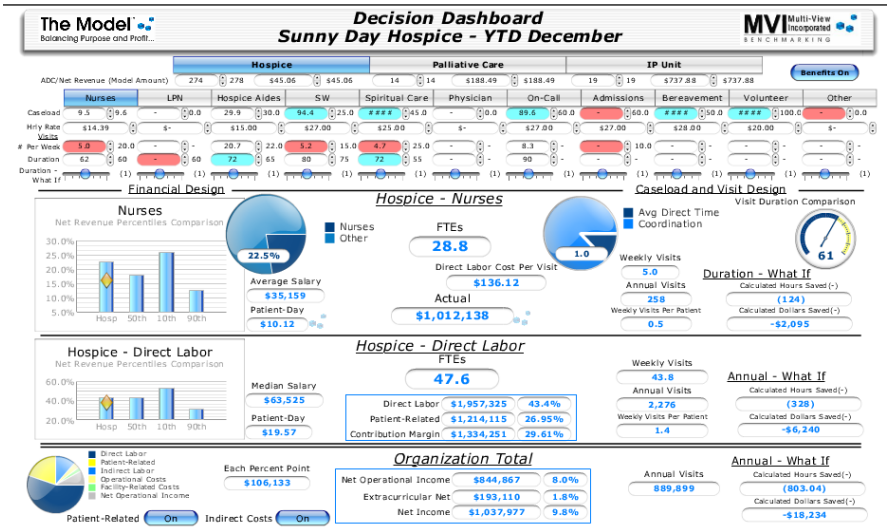
Visit Design

Hospice						
Hospice Discipline	Model Average Caseload	Computed Average Caseload	Model Weekly Visits	Computed Weekly Visits	Model Visit Duration	Computed Visit Duration
RN	9.6	9.5	20.0	5.0	60	62.4
LPN	0.0	-	21.0	-	61	-
CNA	30.0	29.9	22.0	20.7	65	72.0
SW	25.0	94.4	15.0	5.2	75	80.0
PC	45.0	236.9	25.0	4.7	55	72.0

Getting Familiar with the Decision Dashboard - Overview

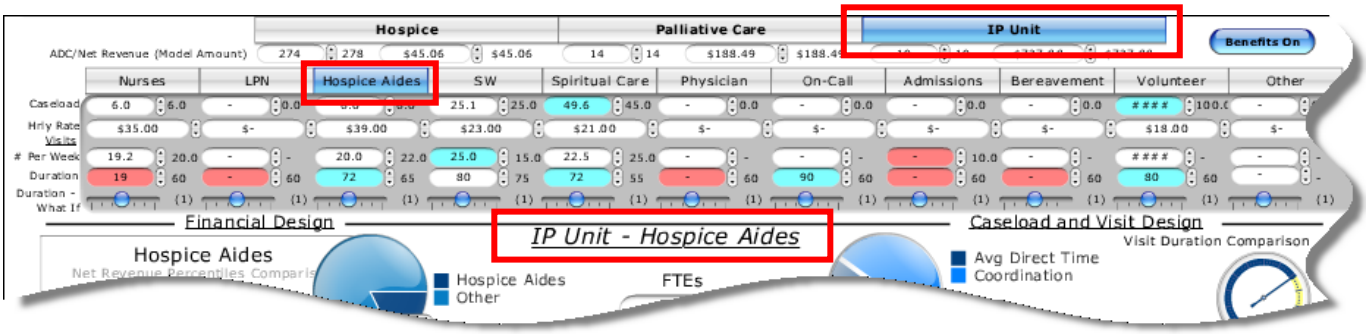
The DD presents a fantastic representation of your actual performance in a way that static reports can never do. It gives you the power to make on the fly changes to see what the predictable outcome may be. What if Census took a nose dive? What if we had to increase benefits to match competition? What if we made changes in our Caseloads?

- First become familiar with the basic layout (Direct Labor Key Performance Indicators - KPI's, Direct Labor Detail by Discipline, Direct Labor Summary by segment, Organization Total). Please notice the two navigation bars on the top. The top bar is the Business Segments navigation bar and the second is the Discipline navigation bar for the 11 disciplines. Start to navigate the DD by selecting various segments and disciplines and notice how the summary areas will display the area that has the current focus (such as IP Unit - CNA).
- Next start with a discipline that you are familiar with and modify the KPI's. You will notice the up/down arrows are one way of making modifications. **Another way is to highlight the amount such as RN Caseload and manually enter the new amount**. It may take some practice to get use to the input controls.
- Next, click on and off the Benefits (top), Patient Related and Indirect (bottom) buttons to gain a feel for turning these detail focus areas on and off. These areas have modifiable fields as well and the Patient Related area works in conjunction with the business segment navigation bar (Hosp, Pal Care, IP Unit). *Make sure to enter percentages in correct decimal format; 5% of Net Revenue would be entered in as .05 and not just 5 as 5 means 500%*.
- Clicking on each KPI header such as Caseload will produce a detailed chart for the respective area. Also, the MVI Cubes are placed in strategic locations for pop-up style charts. Try this by clicking the Cubes on and off for Patient-Day amounts under the Direct Labor detail area.



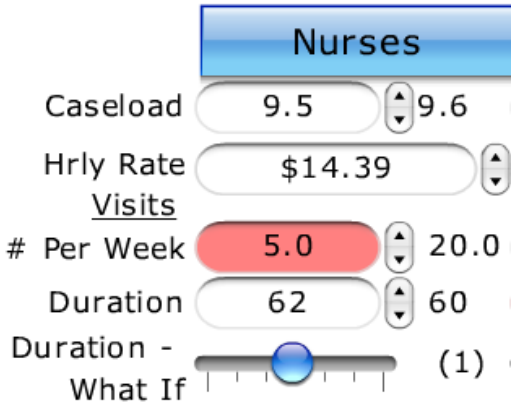
Words to the Wise

- The DD comes loaded with defaults from your MA so look back to the MA for questions on specific amounts. This includes alerts ranges.
- When changing the KPI amounts keep the perspective that you are not changing your Model but doing What-If scenarios on real amounts.
- **Modifications to the DD will not be saved when you close out.** However, if doing a specific study, make the changes and do a Print Screen to capture the results of your work. Since you cannot break the DD, play play play…
- Model amounts are present only for reference purposes and cannot be changed on the DD.
- If presenting on an area that is hard to see in Adobe, use your zoom button.



Navigation Bars

The sample above illustrates having the IP Unit and Hospice Aides selected. As such both bars highlight to blue and the detail area headers change appropriately. Also, notice the KPI area has a grey background when IP Unit is selected. All through the DD the Model amount will follow the actual amount. Notice that under Hospice the Actual ADC is 274 but the Model ADC is 278. However, the Net Revenue per Patient-Day is the same for both as the Model on the MA was set to be the same as actual. (Glad this is demo data with a low $45 amount!) Changes to these amounts will be reflected through the DD making great predictors for census and reimbursement changes.

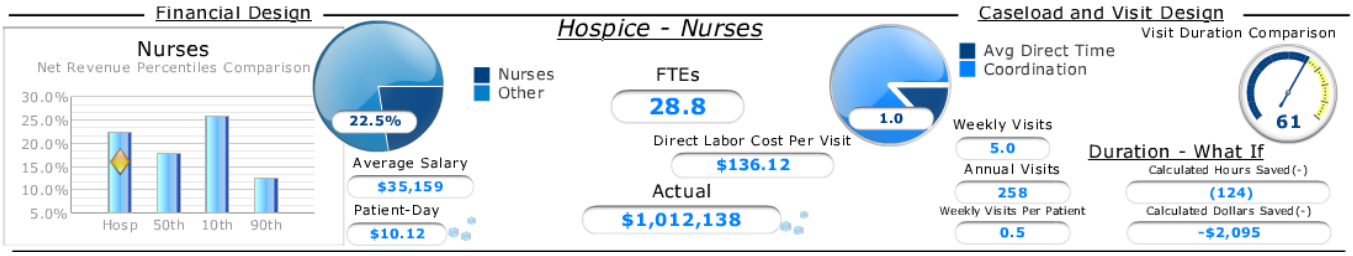


Discipline Bar and KPI's

Zooming in on the Discipline Bar and KPI's we see that there are four KPI's that can be modified. To the right of each is the static Model amount as a reference. The last item is a Duration What If that only impacts the Calculated Hours and Dollars saved fields. The exact same series is present for all 11 disciplines. Since these amounts come directly from the MA calculations you only need to make changes in effort to evaluate impacts of projected changes.

Probably the most noticeable field in the illustration is the Red - # Visits Per Week at 5.0. The alert color automatically will change when the Actual amount is different then the Model amount and by the Alert Percentage as setup in the MA. So if 20 is our Model and the Alert is at 10% the color will turn to Red below 18 and to blue above 22. In this manner you can completely control what areas flag and how quickly. With ongoing use the alerts are more relevant and will help identify not just issues but at what point something should become an issue. Staff should be drawn toward the blue colors as they tend to indicate great productivity in comparison with the Model.

Clicking on the header (Caseload, Hrly Rate…) will bring up the detail chart for each.

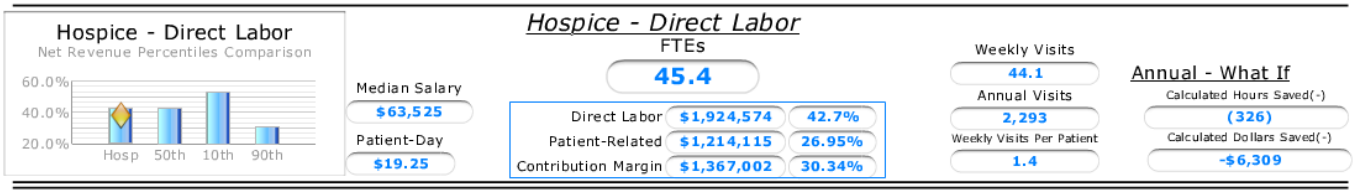


Direct Labor Detail by Discipline

Here we are focused in on Hospice Nurses. Starting on the left side, the bar chart presents your current % Net Revenue amount in the first bar (Hosp) the diamond marker indicates where you have established your Model to be. The other three bars indicate the 50th (aka median), 10th and 90th Percentiles to illustrate how your hospice compares to other programs. In the illustration the 22.5% is very high and close to the 10th Percentile or poor financial performers in this area. It is quite obvious that the Model is below the 50th Percentile indicating there is work to do for Nurses. The Pie Chart quickly illustrates that Nurses is a big piece of the pie.

These amounts along with the Average Salary and Patient-Day amounts will change as the KPI's are changed. It may take some logical reasoning as to what should change. As an example, if the Caseload changes most fields will update but the Average Salary does not. This makes sense in that it does not matter how many patients a RN takes care of, unless the salary amount changes, the Average Salary will remain the same. Changing the Hourly Rate will impact most fields but not the # of FTE's. This also makes senses in that it matters not how much pay changes, if we have a census of 100 and Caseload of 10 we will always need 10 RN's regardless of how much their pay may go up or down.

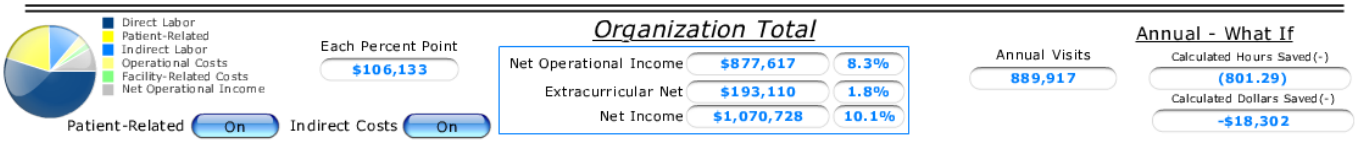
The # Visits per Week and Visit Duration primarily impact the right section. However, the Direct Labor Cost per Visit is impacted by both financial as well as productivity changes. Lastly is the Duration – What If. Changes to this slider will only impact the Duration - What If and not financial amounts. We default the sliders to a reduction of one minute for ease or use. The hours and dollars represent Direct Time and do not include any Indirect Time that would always be present with a FTE. You could also simply modify the visit duration but the What If is designed to keep the Duration to actual or a new projected amount but still allow you to see further impacts of reduced or increased visit times.



Direct Labor Summary

If you understand the previous section, this area is very basic. In a similar fashion to the majority of Income Statements that have line items for detail (like RN) and a summary for Direct Labor, we have emulated that logic. Also, like on the Benchmarking Application we encourage a review of summary data first and then a more detailed look at line items. Some hospices struggle in classification between RN, On-Call and Admissions but the Total for Direct Labor should include all such items.

The Blue Summary Box illustrates the financial standing for this Business Segment. To look at the total for IP Unit you would use the Segment Bar to choose IP Unit. The header will also change to IP Unit – Direct Labor.

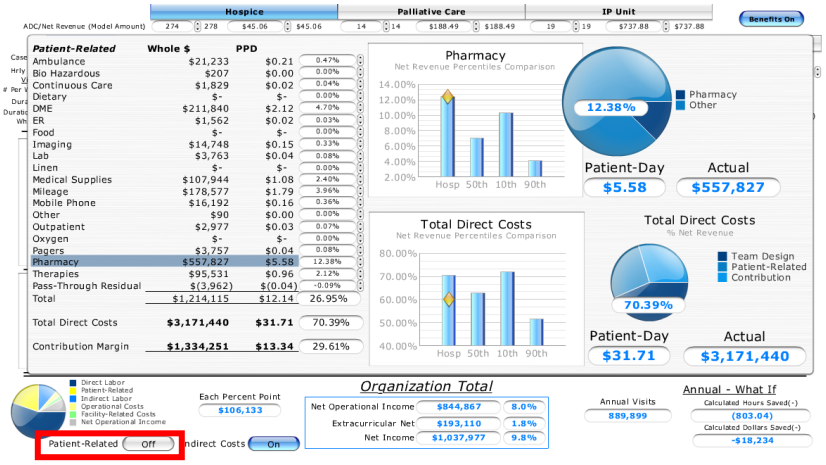


Organization Total

On the bottom of the DD and on the left is the Organization Pie Chart. Doing a mouse-over, the pie will provide amounts that are represented. It is very meaningful when looking at hospice in the light of % of Net Revenue to know what each percent point represents. Every hospice should have a specific Model or goal for the Net Operational Income. 10% is a good starting place and very realistic as it does not include any extra programs that are unique to the individual program. The Net Income should tie out with your financials unless modifications have been made to the DD.

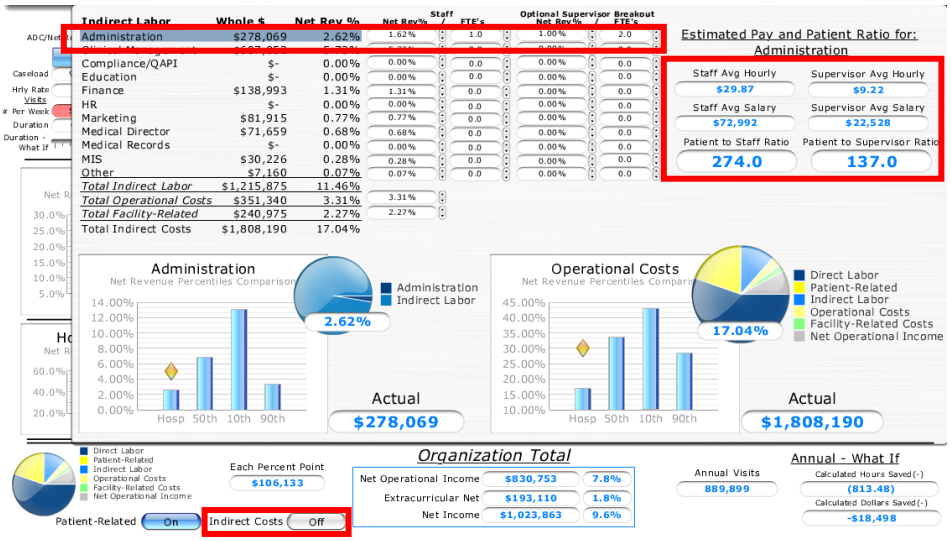
Basic Setup

By selecting the Benefits On/Off button the Basic Setup window will display. These amounts also come over from the MA setup but also allow you to perform on the fly calculations. Changes to benefits can have a large impact and the results can be seen quickly by modifying this area.



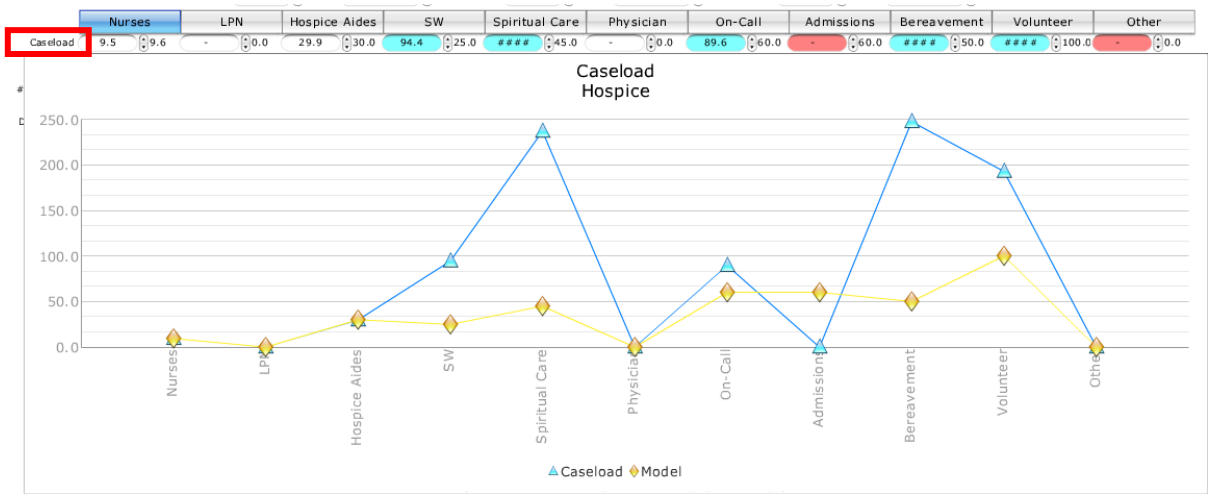
Patient-Related

By selecting the Patient-Related button (located on the bottom of the DD) a detail Income Statement type layout will be represented. Since Patient-Related costs are specific to each business segment, you can use the Segment Navigation bar in conjunction with this area. Most of the elements in this view are similar to the main display but you can click on the line item to produce detail amounts such as we have done on the illustration with Pharmacy. Since we Model our Patient-Related costs by % of Net Revenue amounts, you can adjust that column to see the impact on the Organization Total.



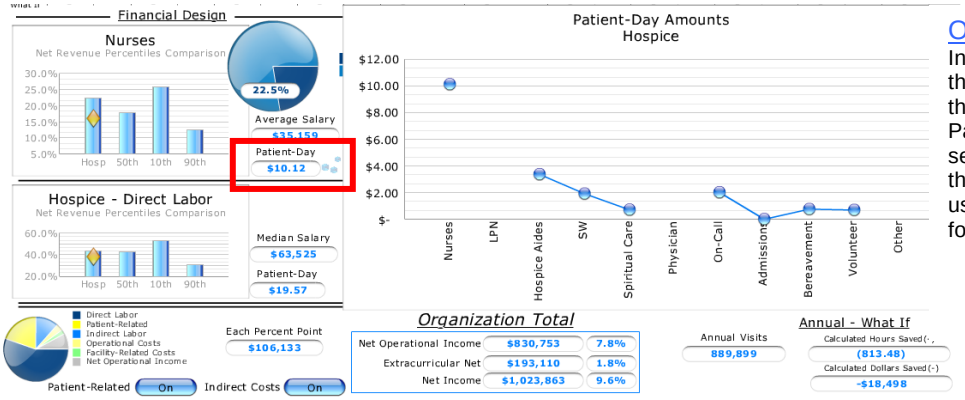
Indirect Costs

The Indirect Costs button is also located on the bottom of the DD. These costs are for the Organization and as such will not have breakout between the business segments (Hospice, Palliative, IP Unit). The line item navigation is similar to the Patient-Related area but also includes a built in Estimated Pay and Patient Ratio for Indirect Labor. This calculator does not produce default amounts as Indirect Labor FTE's are not captured in the MA. However, we include it here to assist with Flex Budget calculations as often departments will have Supervisors and normal staff in one department. In the sample we split the % of Net Revenue amount between Supervisor and Staff but the combined amount 2.62% is still represented on the Net Rev % column.



KPI Detail Charts

"A picture is worth a thousand words" and the detail chart above quickly illustrates differences between the Caseload Calculated and Caseload Model amounts. Click on the header for any of our four KPI's (Key Performance Indicators – Caseload, Hourly Rate, # Visits per Week and Visit Duration). Click on the header again to turn the chart off. Please notice the Spiritual Care amounts. The Model is always illustrated by the yellow diamond and shows 45.0 in both the text box as well as the chart. However, the text box for Actual Caseload for Spiritual Care is shown as "####" indicating an unrealistically high number that is too large to be seen. This is where the chart is very helpful. You may find that highlighting the "####" amount may make it visible.



Other Detail Charts

In other places you will see the MVI Cubes that will provide detail charts upon clicking on them. In the example the cubes next to the Patient-Day amount of $10.12 has been selected. Clicking on the cubes again will hide the chart. Try leaving the chart displayed while using the Business Segment Navigation bar for a quick comparison of the segments.

Presenting Options and Required Software

There are three primary software options when presenting the DD; Adobe Reader, PowerPoint and Internet Explorer. It is nice having the flexibility of choosing your preferred software as the control functionality remains the same for all options. However, since this is leading edge technology it is required to be on a fairly new version of any of the three options. The easiest way to know if you have the needed version is to simply run the software as it will either run or it won't. With any of the options if you are using old flash software you may need to install the free Adobe FlashPlayer at www.adobe.com/support/flashplayer/downloads.html.

Otherwise, here are some points to consider:

- Adobe Reader (version 8 or newer) - Cost is free and the install is simple at http://get.adobe.com/reader. Adobe reader is very common and preloaded on most pc's built in the past few years. It pulls up the DD utility quickly and has an easy to use zoom feature.
- PowerPoint (version 2000 or newer) – Cost can be expensive but it is likely packaged with MS Office. Office 2007 has enhanced security that will prevent the DD from functioning unless the patch from Adobe is installed at www.adobe.com/support/flashplayer/downloads.html The DD can be quickly pasted to existing presentations and illustrated when in presentation mode.
- Internet Explorer (version 6 or newer) – Cost is free and it is likely already installed on your pc and likely set as your default internet browser. It is always nice to work in a familiar environment with zoom features and slider controls. Internet Explorer will likely be your default program to open any flash file.

Notes:_____

Notes:_____