

the problem with perceived high hospital prices is the result not of hospital behavior, but rather the payment policies of both government and major commercial payers.

#### Four Pricing Conclusions

We can draw the following conclusions:

- > Hospital pricing should not be a major public concern. For the most part, hospital prices are not unreasonable and are a direct result of the hospital's payer mix and payer contractual terms.
- > While prices for services to the medically uninsured are significantly higher than average payment received from most third-party payers, very few medically uninsured patients actually pay at a level approaching average payment levels of most third-party payers. The vast majority of the bill is written off either as charity care or bad debt expense.
- > Any policy change that restricted hospital pricing or limited charges to medically uninsured patients undermine already thin hospital profits. Forcing hospitals to limit pricing would require comparable increases in payments from other third-party payers, such as Medicare, Medicaid, and other commercial carriers, which would be unlikely in the current economic environment.
- > Hospitals that fail to set prices to recover their true financial requirements, including a profit factor to permit replacement of capital assets and to finance working capital, will erode their financial position and shift the financial burden to the next generation of patients. This strategy does not appear to be economically sound or equitable.

Hospitals should use a methodology similar to that employed here to assess the reasonableness of their own prices. ☞

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## Estimating the Space Required for Inpatient Nursing Units

The following guidelines can be used to develop an "order of magnitude" space estimate prior to detailed operational and space planning. The department gross square feet (DGSF) represents the "footprint" of the nursing unit and includes the net square feet of the individual rooms as well as the space occupied by internal circulation corridors, walls/partitions, and minor utility columns. To estimate the actual floor gross square feet for a bed tower, an additional 15 percent to 20 percent more space will be required (factor of 1.15 to 1.20) to account for shared public lobbies, elevator banks, stairwells, major mechanical spaces, and the space occupied by the building's exterior wall.

Nursing Unit Type	Department Gross Square Feet (DGSF)	Comments
Acute medical/surgical (all private patient rooms)	450 to 700 DGSF per bed	Lower range assumes standard-sized patient rooms and typical support space on the unit; higher range assumes more ample-sized patient rooms, enhanced patient/visitor amenities, and expanded point-of-care diagnostic services on the unit.
Acute medical/surgical (mix of private and semi-private patient rooms)	350 to 575 DGSF per bed	Lower range assumes a high percentage of semi-private patient rooms; higher range assumes more private patient rooms, more ample-sized patient rooms, enhanced patient/visitor amenities, and expanded point-of-care diagnostic services on the unit.
Pediatric unit	500 to 700 DGSF per bed	Lower range assumes a mix of private and semi-private patient rooms; higher range assumes all private patient rooms, more ample-sized patient rooms, and enhanced family amenities.
Intensive care unit	600 to 700 DGSF per bed	Higher range assumes more ample-sized patient cubicles, enhanced patient/visitor amenities, and expanded point-of-care diagnostic services on the unit.
Rehabilitation/skilled nursing/subacute unit	500 to 650 DGSF per bed	Lower range assumes a mix of private and semi-private patient rooms; higher range assumes all private patient rooms, more ample-sized patient rooms, and/or expanded patient/family amenities.
Psychiatric unit	400 to 500 DGSF per bed	Lower range assumes mostly semiprivate patient rooms; higher range assumes more private patient rooms and expanded activity and therapy space.

Source: *SpaceMed: A Space Planning Guide for Healthcare Facilities* (www.spacemed.com). Used with permission.

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