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AUDIT AND ACCOUNTING GUIDE

AUDITS OF PROVIDERS OF HEALTH CARE SERVICES

PREPARED BY THE HEALTH CARE COMMITTEE AND THE HEALTH CARE AUDIT AND ACCOUNTING GUIDE TASK FORCE

Second Edition

Including
STATEMENTS OF POSITION
ISSUED BY THE ACCOUNTING STANDARDS DIVISION

Note: This edition includes the audit and accounting guide *Audits of Providers of Health Care Services* as it was originally published in 1990; Statement of Position (SOP) 89-5, *Financial Accounting and Reporting by Providers of Prepaid Health Care Services*, issued by the Accounting Standards Division in 1989; and SOP 90-8, *Financial Accounting and Reporting by Continuing Care Retirement Communities*, issued by the Accounting Standards Division in 1990. In using this guide, readers should refer to SOPs 89-5 and 90-8, both of which provide guidance on financial accounting and reporting matters for providers of health care services.

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Preface

Applicability

This guide has been prepared to assist the independent auditor in auditing and reporting on financial statements prepared in accordance with generally accepted accounting principles and pertaining to entities whose principal operations consist of providing health care services to individuals. It describes relevant matters and procedures unique to those entities. Health care entities to which this guide applies include the following:

- Clinics, medical group practices, individual practice associations, individual practitioners, and other ambulatory care organizations
- Continuing care retirement communities
- Health maintenance organizations and similar prepaid health care plans (see appendix B, which contains AICPA Statement of Position (SOP) 89-5, *Financial Accounting and Reporting by Providers of Prepaid Health Care Services*)
- Home health agencies
- Hospitals
- State and local government-owned health care entities that use enterprise fund accounting and reporting
- Nursing homes that provide skilled, intermediate, and less intensive levels of health care
- Organizations whose primary activities are the planning, organization, and oversight of entities providing health care services, such as parent or holding companies of health care providers

A health care entity may be a part of another organization, such as a government, a medical school or a university, or a subsidiary of a corporation. The recommendations contained in this guide apply to the separate financial statements of (1) investor-owned and not-for-profit health care entities and (2) state and local government-owned health care entities that use enterprise fund accounting and reporting. When separate financial statements are

prepared for a state or local government-owned health care entity that uses enterprise fund accounting and reporting, the accounting, reporting, and disclosure requirements set forth in this guide and by pronouncements of the Governmental Accounting Standards Board (GASB) apply (see chapter 3 for a discussion of the application of generally accepted accounting principles).

This guide is based on the assumption that the readers are generally expert in accounting and auditing. It focuses on specific problems of auditing, accounting and reporting with respect to the financial statements of the health care entities considered; however, the guide does not discuss the application of all generally accepted accounting principles and auditing standards as they pertain to the preparation and auditing of such financial statements. The nature, timing, and extent of auditing procedures are matters of professional judgment and will vary according to the size of the entity, the organizational structure, the independent auditor's assessment of the level of risk and other factors.

The appendixes to this guide include (1) illustrations of the form and content of financial statements for the health care entities considered, (2) SOP 89-5, and (3) AICPA Current Industry Developments *Health Care Industry Developments—1989*.

This guide supersedes the AICPA Industry Audit Guide *Hospital Audit Guide* (6th ed. 1987) and the following statements of position:

- *Clarification of Accounting, Auditing, and Reporting Practices Relating to Hospital Malpractice Loss Contingencies* (1978)
- SOP 78-1, *Accounting by Hospitals for Certain Marketable Equity Securities*
- SOP 81-2, *Reporting Practices Concerning Hospital-Related Organizations*
- SOP 85-1, *Financial Reporting by Not-for-Profit Health Care Entities for Tax-Exempt Debt and Certain Funds Whose Use Is Limited*
- SOP 87-1, *Accounting for Asserted and Unasserted Medical Malpractice Claims of Health Care Providers and Related Issues*

Effective Date and Transition

The provisions of this guide are effective for audits of financial statements for periods beginning on or after July 15, 1990.

The following schedule outlines the accounting and reporting recommendations and practices that are changed by this guide, and the recommended treatment for their initial adoption.

Changes	*Paragraph*	*Treatment for Initial Adoption*
• Reporting net service revenue	2.3, 12.11	Reclassification and disclosure for all years presented.
• Accounting for donated property and equipment	2.6	Reclassification and disclosure for all years presented.
• Application of FASB Statement 95, *Statement of Cash Flows*, to not-for-profit health care entities	3.25	Restatement for earlier years presented is encouraged but not required.
• Reporting charity care and resulting reduction of receivables and valuation allowance	2.3	Reclassification and disclosure for all years presented.
• Reporting bad debts	7.2, 12.14	Reclassification and disclosure for all years presented.
• Netting of revenue and expenses is inappropriate	12.1	Reclassification and disclosure for all years presented.
• Application of FASB Statement No. 12, *Accounting for Certain Marketable Securities*, to not-for-profit health care entities.	6.6–6.17	If the initial application of this guide requires the establishment of a valuation allowance, previously issued financial statements should not be restated. If the establishment of a valuation allowance is required for a marketable equity securities portfolio included in current assets in general funds, the effect of the change should be included in the determination of the excess of revenue over expenses for the period of the change in accordance with the provisions of APB Opinion No. 20. If the establishment of

(*continued*)

Changes	*Paragraph*	*Treatment for Initial Adoption*
		a valuation allowance is required for a marketable equity securities portfolio included in noncurrent assets in general funds or assets in restricted funds, the effect of the change should be presented in the statement of changes in fund balance. If this change has a material effect on the financial statements, an explanatory paragraph (following the opinion paragraph) should be included in the independent auditor's report.

Health Care Committee
July 1990

Executive Summary

The basic financial statements of not-for-profit and governmental health care entities consist of a balance sheet, a statement of revenue and expenses of general funds, a statement of changes in fund balances, and a statement of cash flows of general funds (and restricted funds of governmental health care entities). The basic financial statements of investor-owned health care entities are similar to those of other investor-owned entities.

Aggregated (combined fund) and disaggregated (layered fund) balance sheets are acceptable alternatives to reporting financial position of not-for-profit health care entities and governmental hospitals. However, state or local government-owned health care entities should not change their reporting practices for presenting aggregated or disaggregated balance sheets as a result of this guide.

FASB Concepts Statement No. 6, *Elements of Financial Statements*, provides a useful conceptual framework for preparers of financial statements to distinguish among financial statement elements for purposes of display of revenue, expenses, gains, and losses. In applying this conceptual framework, activities associated with the provision of health care services constitute the ongoing major or central operations of providers of health care services. Revenue, expenses, gains, and losses arising from those activities are classified as "operating." Gains and losses from transactions that are peripheral or incidental to the provision of health care services and from other events stemming from the environment that may be largely beyond the control of the entity and its management are classified as "nonoperating."

In the statement of revenue and expenses, service revenue is reported net of contractual adjustments and other adjustments. In accordance with FASB Concepts Statement No. 6, charity care is not included in gross revenues. However, the entity's policy for provision of charity care should be disclosed in the financial statements. In addition, the level of charity care provided is

disclosed and may be measured based on the provider's rates, costs, units of service, or other statistics.

Donated assets are reported at fair market value as of the date of the gift. Voluntary and governmental health care entities report donated assets, other than property and equipment, in the statement of revenue and expenses of general funds if unrestricted or as an addition to the appropriate restricted fund balance if restricted. Donations to voluntary or governmental entities of property and equipment, or of assets received to acquire property or equipment, are reported in restricted funds. A transfer to the general fund balance is reported when the donated property or equipment is placed in service, or when the donated assets are used to acquire property or equipment.

Donated services are reported as an expense, and a corresponding amount reported as contributions, if the services are significant and measurable and the entity controls the employment and duties of the service donors.

Unrestricted gifts, bequests, grants, tax support, and other subsidies from governmental or community agencies are reported as gains or revenue depending on their relationship to the provider's ongoing major or central operations.

The effect of timing differences related to reimbursement programs that become permanent is reported in the financial statements in the period in which it is determined that they will not be recovered or realized.

Agency funds held by a health care entity are reported in the financial statements as an asset, and a corresponding amount is reported as a liability.

Investments are initially recorded at acquisition cost or, if received as a donation or a gift, at fair market value at the date of the gift. Marketable equity securities are reported at the lower of aggregate cost or market value in accordance with the requirements of FASB Statement No. 12, *Accounting for Certain Marketable Equity Securities*. Debt securities are reported at amortized cost if there is the intent and ability to hold to maturity or at the lower of cost or market value if not intended to be held to maturity. The market value method is used to equitably allocate investment income and gains and losses on pooled investments. Investments accounted for on the equity method of accounting are reported in accordance with Accounting Principles Board Opinion No. 18,

The Equity Method of Accounting for Investments in Common Stock.

Advances from third-party payors are reported as liabilities unless the right of setoff against a related receivable applies.

Contingencies, such as those relating to pending appeals under rate-setting systems and to state waivers under Medicare, are accounted for in accordance with FASB Statement No. 5, *Accounting for Contingencies*, as amended and interpreted.

Uncollected premiums and amounts recoverable from stop-loss insurance (reinsurance) are reported as receivables, net of appropriate valuation allowances.

Bad debts are to be reported as expenses in accordance with generally accepted accounting principles.

Receivables for health care services do not include charges related to charity care and are reported net of appropriate valuation allowances.

Pledges are reported in the period in which they are made, net of an allowance for uncollectible amounts.

Depreciation and amortization of property and equipment is reported in conformity with generally accepted accounting principles.

Obligations incurred in advance refundings of debt, or for the purpose of early retirement or extinguishment of debt, are reported in accordance with FASB Statement No. 4, *Reporting Gains and Losses From Extinguishment of Debt*, as amended, and FASB Statement No. 76, *Extinguishment of Debt*.

A liability should be reported by a continuing care retirement community (CCRC) recognizing the obligation to provide future services to, and use of facilities by, current residents without additional compensation for the term of the contracts or the lives of the residents. (In January 1989 the AICPA exposed for public comment a proposed statement of position, *Accounting by Continuing-Care Retirement Communities for Fees and the Obligation to Provide Future Services and the Use of Facilities, and for Initial Direct Costs of Acquiring Continuing-Care Contracts*. The SOP is intended to provide additional accounting guidance to CCRCs.)

The ultimate cost of medical malpractice claims is reported in the period during which the incidents that give rise to the claims occur, if it is probable that liabilities have been incurred and the amounts of the losses can be reasonably estimated.

Certain information of related entities should be disclosed in the notes to the financial statements if such entities are not consolidated or combined in accordance with ARB No. 51, *Consolidated Financial Statements*, as amended.

AICPA Statement of Position 89–5, *Financial Accounting and Reporting by Providers of Prepaid Health Care Services*, included as appendix B of this guide, provides guidance on applying generally accepted accounting principles for health care costs, contract losses, stop-loss insurance, and contract acquisition costs of providers of prepaid health care services.

Chapter 1

Introduction

Health Care in the United States

1.1. Medical care expenditures in the United States increased from 4.4 percent of the gross national product in 1950 to over 11 percent in 1988. Extensive changes in medical practice and health care delivery, increased demands for access to health care services, and legislative and public interest group initiatives have all been factors leading to this significant growth in the health care industry.

1.2. The federal government was not extensively involved in providing or financing health care in the United States before 1965. The few exceptions to this included the financing of medical facility construction and modernization with federally sponsored grants, loans or loan guarantees under the Hill-Burton Act, and the provision of care for veterans and dependents of military personnel. Amendments to the Social Security Act in 1965, however, established the Medicare and Medicaid programs. Medicare, a health insurance program operated by the federal government, provides health care coverage for eligible individuals, primarily those age 65 and over. Medicaid, a health care assistance program operated by state governments within federal guidelines, provides financing of medical care for needy individuals.

1.3. The health care industry includes a broad and complex array of endeavors. Health care services may be provided by (*a*) individual practitioners of medicine, (*b*) public and private universities, (*c*) voluntary organizations, (*d*) medical service and retirement institutions, (*e*) commercial enterprises, and (*f*) governmental institutions.

1.4. Because of the nature of health care, the demand for services is usually not directly related to consumers' disposable income. However, the industry historically has experienced slowdowns during economic downturns because, among other factors,

employers have discontinued or curtailed health insurance coverage and nonemergency health care services have been postponed.

Parties to Health Care Transactions

1.5. As many as four or more parties might be involved in arranging for health care services, including—

a. The person who receives care.

b. The physician who determines the nature and duration of services to be provided to the person.

c. The health care entity that provides institutional or other services to the person.

d. The third-party payor (insurer) that provides payment to the health care entity on behalf of the person. (Some third-party payors, however, may make payments only to the person for some or all of the health care services for which benefits are available.)

1.6. Third-party payors (such as Blue Cross and other commercial insurance companies, Medicare, Medicaid, and state and local government general assistance programs) pay for a significant portion of health care services. The involvement of third-party payors began in the 1920s with the introduction of health insurance plans, notably Blue Cross and Blue Shield. In some regions of the United States today, third parties pay as much as 90 percent of hospital-provided health care services.

Classification of Health Care Entities

1.7. Health care entities may be classified by sponsorship or legal structure within three broad categories: voluntary (not-for-profit), governmental, and investor- (or operator-) owned.

1.8. Voluntary, or not-for-profit, health care entities operate under the direction of governing boards that may be self-perpetuating or elected by corporate members or sponsoring organizations. Such organizations may be further classified as—

a. Community-based (that is, organized, sponsored, or operated by a community). The governing board generally is composed of local business, medical, civic, and religious leaders.

b. Religious-affiliated (that is, organized, sponsored, or operated

by a religious group). The governing board and administration usually include members of the religious group.

c. University-sponsored, institutionally affiliated (that is, organized, sponsored, or operated by a private university or medical school that may govern the entity directly or appoint a separate governing board).

1.9. Voluntary health care entities are usually exempt from federal and state income taxes if they are operated exclusively for religious, charitable, scientific, or educational purposes and if no part of their net earnings inures to the benefit of any private shareholder or individual. They may be subject to income tax, however, on taxable income that is derived from activities not related to exempt purposes. Operations may generate an excess of revenue over expenses to be used to meet financial obligations, improve patient care, expand facilities, and advance the charitable purposes of the entity (for example, research, training, and education). Some voluntary health care entities may receive support from religious and fraternal organizations, individuals, corporations, and other donors and grantors.

1.10. Governmental health care entities (often called *public health care entities*) are owned and operated by federal, state, city, or county governments or other political subdivisions. The governmental unit may govern the entity directly or appoint its governing board. Governments may also control health care entities that are operated as voluntary not-for-profit organizations. Such entities receive varying levels of financial support from federal, state, or local governments and may provide medical treatment for specific diseases or assist the chronically ill. This guide applies to the separate financial statements of state and local government-owned health care entities that use enterprise fund accounting and financial reporting (hereinafter "governmental health care entities").

1.11. Investor- or operator-owned entities may be stock corporations, partnerships, or sole proprietorships.

Clinics and Other Ambulatory Care Organizations

1.12. The essential characteristic of a clinic or other ambulatory care organization is that services are performed on an *outpatient* basis rather than on an *inpatient* basis; that is, patients do not

require overnight accommodations. Ambulatory services include minor emergency aid, outpatient surgery, and other diagnostic and treatment assistance.

Continuing Care Retirement Communities

1.13. Continuing care retirement communities (CCRCs) (also referred to as *life-care retirement communities* or *residential care facilities*) offer facilities and programs to provide health care services that can range from emergency nursing care to skilled or intermediate care over extended periods in a nursing home facility. Other services usually include basic housing, food service, laundry, housekeeping, and social activities.

Home Health Agencies

1.14. Home health agencies provide health and supportive services in the person's home. These services may include nursing, nutritional, and therapeutic aid (such as physical therapy and dialysis) and the rental and sale of durable medical equipment.

Hospitals

1.15. Hospitals provide short-term, acute-care services, although some specialize in long-term care, such as rehabilitative and psychiatric services. Health care services provided by hospitals include the following three levels of care:

a. Primary care—rendered in an ambulatory fashion, such as in emergency rooms, outpatient clinics, and other outpatient departments.

b. Secondary care—rendered to inpatients in hospitals that offer short-term, acute-care services of either a general or specialized nature.

c. Tertiary care—rendered in hospitals that possess the personnel, equipment, and expertise to handle complex cases.

Nursing Homes

1.16. Nursing homes provide health care services directed generally toward rehabilitation, maintenance of patients with chronic conditions, and provision of health care and related services

to elderly and other patients who may not be able to live independently. Nursing home health care usually is classified by the level of care, as follows:

a. *Skilled nursing facility (SNF) services.* These (1) are needed on a daily basis and are provided on an inpatient basis, (2) are ordered by and provided under the direction of a physician, and (3) require the skilled services of technical or professional personnel.
b. *Intermediate care facility (ICF) services.* These are health-related services provided to a person who does not require hospital or SNF care but whose mental or physical condition requires services that are above the level of room and board and that can be made available only through institutional facilities.
c. *Custodial or personal care services.* These are usually residential services and are provided by persons who are (1) qualified to provide the services, (2) supervised by a registered nurse, and (3) not members of the recipient's family.

Ownership and Organization

1.17. Most health care entities are independently owned and operated. However, since the inception of the Medicare and Medicaid programs in 1965, some health care entities have become subsidiaries of other corporations or members of controlled groups of corporations. In addition, some hospitals have acquired other hospitals, nursing homes, retirement communities, or home health agencies. Some health care entities have also created separate organizations (frequently referred to as "foundations") to raise and hold funds for hospitals, nursing homes, and other health care entities. The reporting entity and issues relating to consolidated and combined financial statements are discussed in chapter 13.

Legislation and Regulation

1.18. Significant aspects of health care entity operations are affected by government legislation and regulation. Much of that legislation and regulation has been designed to provide minimum standards for quality of care, to ensure reasonable access to health care services for the public, and to control health care providers'

revenue and costs as well as the level of participation in those costs by government programs. Some of the significant legislation and regulation affecting the health care industry is discussed in the following paragraphs; however, the regulatory environment in which the industry operates is characterized by continuous and often significant change.

Licensure

1.19. States have adopted laws and regulations governing the granting of operating licenses to various health care providers. Criteria for licensure typically include physical facility requirements, the scope of services offered, the education and training standards for medical staff and employees, and minimum safety and staffing requirements.

Accreditation

1.20. Various independent organizations and governmental agencies evaluate programs and services of health care entities to determine compliance with their standards. The Joint Commission on Accreditation of Healthcare Organizations, for example, periodically evaluates programs and services of hospitals. This process is usually important to hospitals because accreditation satisfies one of the conditions for participation in the Medicare program.

Medicare and Medicaid

1.21. As part of the Social Security Amendments of 1965 (Public Law 89-97), Congress enacted a three-part program for medical care for the aged and needy. The Social Security Act (U.S. Code title XVIII) provides health insurance protection to qualified individuals under part A (hospital insurance) and part B (voluntary supplementary medical insurance). Those two parts are collectively known as Medicare.

1.22. Part A is financed largely through a portion of social security (FICA) taxes imposed by the Internal Revenue Code. It provides certain benefits for hospital care, nursing home care, home health care, and related health care services. This program is officially called "Hospital Insurance Benefits for the Aged," although it includes more than hospital benefits and covers disabled persons under age 65, as well as people who have chronic renal disease.

1.23. Participation in part B is voluntary. Part B supplements part A by covering, subject to defined limits, physician services, outpatient services, and certain other services and items not covered by part A. It is financed largely by monthly premiums from enrollees and matching contributions from the federal government. Part B is officially called "Supplementary Medical Insurance Benefits for the Aged." Together, parts A and B are referred to as "Health Insurance for the Aged."

1.24. The third part of the program, Medicaid, was enacted as title XIX of the Social Security Act and provides assistance to the needy under a joint federal and state program. The federal government shares in the cost of the Medicaid program, which is state-administered and varies by state.

1.25. Both the Medicare and Medicaid programs set forth various administrative and technical requirements covering provider participation and payment mechanisms as well as individual eligibility and benefit provisions. For fiscal years that began before October 1, 1983, Medicare payments to hospitals for covered services rendered to program beneficiaries were generally based on allowable costs incurred, as defined. In April 1983 the federal government adopted the Medicare Prospective Payment System (PPS), which pays predetermined and generally fixed payment rates per Medicare inpatient discharge. The PPS became effective with fiscal years of affected hospitals beginning on or after October 1, 1983. Payment rates vary according to a classification system based on patient diagnostic, clinical, and other factors called diagnosis-related groups (DRGs). Certain allowable costs incurred by hospitals subject to PPS continue, at least temporarily, to be reimbursed by Medicare on a reasonable-cost basis, subject to specific limitations. Such allowable costs include outpatient, capital (depreciation, interest on debt incurred for property and equipment acquisitions, rents, and other capital-related costs), and costs of defined medical education programs. Some hospitals and hospital units (for example, rehabilitation hospitals and those units meeting defined criteria) are specifically excluded from the PPS by law. Medicare continues to reimburse excluded hospitals and units for covered services that are rendered to program beneficiaries, based on allowable cost incurred, subject to specific limitations.

1.26. Medicare reimbursement to nursing homes and home health agencies is based on the allowable cost incurred, subject to specific limitations. For those providers, however, the federal

government has expressed a desire to replace cost-based reimbursement with a prospective type of payment system.

1.27. Medicare payments for covered physician services are determined on the basis of the lowest of "customary charges," "prevailing charges," or actual physician charges. Customary and prevailing charge limits are established on a periodic basis by the Medicare program.

1.28. Some physicians accept assignment of benefits from Medicare beneficiaries entitling those physicians to bill the program for covered services. They are referred to as *participating physicians*. In such circumstances, payment from the Medicare program plus the applicable deductible and coinsurance due from the beneficiary are accepted as payment in full, and physicians may not bill the Medicare beneficiary for any amount in excess of the allowable charge established by the Medicare program. Physicians who do not accept assignment of benefits for Medicare beneficiaries (that is, nonparticipating physicians) bill the beneficiary directly for services provided.

1.29. States use various methods to pay health care providers for covered services under Medicaid. Some use principles of reimbursement adopted by the Medicare program and some have adopted other methods. The payment method adopted by each state must be approved by the federal government.

1.30. The Medicare program and state-administered Medicaid programs have adopted various cost-reporting principles and forms to determine reimbursable costs. Hospitals included in the PPS must use cost-reporting principles and forms to determine reimbursement for costs not covered by the predetermined, fixed-payment rates.

State Waivers From Medicare

1.31. Some states have received exemptions (waivers) from the federal government to use methods different from those used by the federal Medicare program to determine payment to health care providers for covered services rendered to Medicare beneficiaries. Paragraph 7.14 discusses additional considerations regarding Medicare waiver arrangements.

Other Legislation and Regulation

1.32. The following section summarizes certain legislation and regulations affecting health care entities.

- *Hospital Survey and Construction Act of 1946 (Public Law 79-725).* Often referred to as the Hill-Burton Act, Public Law 79-725 provided grants for construction, renovation, and modernization of not-for-profit hospitals and required provision of uncompensated care.
- *Social Security Amendments of 1972 (Public Law 92-603).* Significant provisions of these amendments include—
  - — Establishing limits on reimbursable operating expenses of health providers. Such limits are designed to impose a financial penalty for inefficient delivery of health services. "Inefficiency" is determined by comparison with other providers.
  - — Providing that reimbursement for defined services cannot exceed the lesser of customary charges or reasonable cost. As a result, "reasonable costs" will not be paid if customary charges are lower than the cost for those services.
  - — Requiring that a federal board be established to provide an independent review of decisions resulting from certain reimbursement disputes.
  - — Providing that individual states may determine the reasonable costs of inpatient services to Medicaid beneficiaries. As a result, Medicaid program reimbursement varies by state.
- *HMO Act of 1973 (Public Law 93-222).* This act was designed to encourage health maintenance organization (HMO) development and provide support for federally qualified HMOs. The following are significant provisions of the act:
  - — Under certain conditions, employers are required to offer an HMO option to their employees in their benefit packages.
  - — Grants and loans may be provided to HMOs serving medically underserved populations.
- *Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95-142).* Significant provisions of this act include—
  - — Penalties for defrauding the Medicare and Medicaid programs.
  - — A requirement for a comprehensive study and review of the administrative structure for processing Medicare claims.
- *Omnibus Reconciliation Act of 1980 (Public Law 97-12).* This act required certain changes to the Medicare cost-reporting forms and modified the treatment of certain items for Medicare reimbursement purposes. Significant provisions include—

— Requiring access to books and records of subcontractors. Providers must include a clause binding subcontractors to make their books and records available for federal government inspection of all contracts for more than $10,000 and in excess of twelve months duration.

— Providing the legislative basis for limiting outpatient reimbursement to an amount paid to perform similar procedures in a physician's office.

- *Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248).* This act, in addition to directing the Secretary of Health and Human Services to develop a viable prospective payment system by December 31, 1982, changed the reimbursement system by—
  - — Introducing two different cost-per-case limits on inpatient cost reimbursement.
  - — Providing, under specific conditions, incentive payments (or penalties) to hospitals whose rates of increase in inpatient reimbursement fall below (or exceed) certain target limits.
  - — Narrowing the definition of allowable Medicare costs.
  - — Authorizing the Secretary of Health and Human Services to enter into risk-based contracts with HMOs and competitive medical plans (CMPs) for providing comprehensive medical care to Medicare beneficiaries.
- *Social Security Amendments of 1983 (Public Law 98-21).* This law overhauled the social security program and completely restructured the system for reimbursing hospital inpatient services to Medicare beneficiaries by creating the Medicare PPS. Significant provisions include—
  - — Establishing the concept of paying a fixed price per discharge for a series of medical categories (diagnosis-related groups [DRGs]).
  - — Repealing the cost-per-case limits established under Public Law 97-248 as they pertain to hospitals covered by the PPS.
  - — Introducing peer review organizations (PROs) to monitor portions of PPS.
- *Deficit Reduction Act of 1984 (Public Law 98-369).* (This act includes the Medicare and Medicaid Budget Reconciliation Amendments of 1984.) One of the more significant provisions of this act is the prohibition of Medicare reimbursement of capital

costs resulting from an increase in the basis of assets after an acquisition or a merger.

- *Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272).* This act primarily addresses Medicare PPS issues and certain physician payment matters.
- *Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509).* Among other things, this act provides that ambulatory surgery services be reimbursed under a prospective payment method.
- *State rate-setting programs.* Some states have legislated programs to review and approve, modify, or deny rate increase requests by health care entities. Some states require budgetary review and approval and apply penalties for noncompliance with their decisions.
- *Financing authorities.* Some state and local governments have enacted laws creating financing authorities to assist health care providers in their jurisdictions to obtain financing for construction projects, equipment acquisitions, and other purposes. These authorities normally issue tax-exempt bonds, the proceeds of which are used by health care providers. The bonds issued are usually not an obligation of the financing authority and are collateralized by the revenues and defined assets of the benefited health care providers.
- *Other Medicare legislation and regulations.* Laws and regulations modifying or updating the Medicare program are enacted on a frequent basis. Examples of such laws and regulations include the following:

  — The Secretary of Health and Human Services is required to issue rules annually to update the Medicare PPS.

  — Changes to other aspects of the Medicare program in general are proposed and implemented continuously.

  — Congress has enacted substantial changes to the Medicare program in conjunction with annual federal budget legislation, and may continue to do so in the future. In addition, federal legislation already enacted requires that the Secretary of Health and Human Services promulgate legislation to replace (beginning on October 1, 1991) cost-based reimbursement for capital costs under the Medicare PPS with a prospective payment method.

Chapter 2

Unique Operating Considerations of Health Care Entities

Fiduciary Responsibilities (Fund Accounting)

2.1. Many health care entities are charitable not-for-profit organizations. As with other charitable organizations, donors and grantors often place terms and conditions on how their support may be used by a health care entity. This places a fiduciary responsibility on the health care entity to comply with the specific restrictions. To account for resources received from donors and grantors and to satisfy fiduciary responsibilities, some not-for-profit and governmental organizations use fund accounting. The application of this method of accounting and reporting by health care entities is described in the section titled "Fund Accounting" (paragraphs 3.2–3.3).

Revenue From Health Care Services

2.2. A significant portion of a health care entity's revenue is usually received in whole or in part from third parties (that is, Medicare, Medicaid, Blue Cross, other health insurance carriers, and prepaid health care plans). Some of these third parties pay health care entities according to allowable costs or a predetermined (prospective) contractual rate rather than according to the health care entity's established rates for service. Many health care entities have therefore adopted the practice of reporting allowances or contractual adjustments in their financial statements to recognize the difference between the established rates for covered services and the amount paid by third parties.

2.3. In general, gross service revenue is recorded in the accounting records on an accrual basis at the provider's established rates, regardless of whether the health care entity expects to collect that amount. Provisions recognizing *contractual adjustments*

and other adjustments (see examples in paragraph 7.3) are recorded on an accrual basis and deducted from gross service revenue to determine net service revenue. For financial reporting purposes, gross revenue does not include charity care (see discussion in paragraph 7.2) and service revenue is reported net of contractual and other adjustments in the statement of revenue and expenses. Accounting and auditing issues related to receivables and revenue from health care services are discussed in chapters 7 and 12.

2.4. Management's policy for providing charity care is disclosed in the financial statements. The level of charity care provided should be disclosed in the financial statements. Such disclosure is made in the notes to the financial statements and measured based on the provider's rates, costs, units of service, or other statistics.

Third-Party Payor Considerations

2.5. Some third-party payors retrospectively determine final amounts reimbursable for services rendered to their beneficiaries based on allowable costs. These payors reimburse the health care entity on the basis of interim payment rates until the retrospective determination of allowable costs can be made. In most instances, the accumulation and allocation of allowable costs and other factors result in final settlements different from the interim payment rates. Final settlements are determined after the close of the fiscal periods to which they apply and may materially affect the health care entity's financial position and results of operations. Consequently, a reasonable estimate of the amount receivable from or payable to these payors should be made in the same period that the related services are rendered. Accounting and auditing issues related to receivables from third parties are discussed in chapter 7.

Donated Assets

2.6. Donated assets are reported at fair market value as of the date of the gift.[1] Voluntary and governmental health care entities report the receipt of donated assets, other than property and equipment, in the statement of revenue and expenses of general

1. The FASB is considering recognition and measurement issues associated with receiving or making contributions (restricted and unrestricted) or pledges for future contributions of cash or other goods or services.

funds if unrestricted or as additions to the appropriate fund balance if restricted. Unrestricted donated assets are reported as operating gains or revenue or nonoperating gains depending on whether the donations constitute the entity's ongoing major or central operations or are peripheral and incidental to the entity's operations (see chapter 12). Donations to a voluntary or governmental entity of property and equipment, or of assets received to acquire property or equipment, are reported in a restricted fund. A transfer to the general fund is reported when the donated asset is placed in service or used for the specific operating purpose for which it was intended.

Donated Services

2.7. The nature and extent of donated services received by not-for-profit health care entities vary and range from the limited participation of many people in fund-raising activities to active participation in the entity's service programs.[2] Because it is difficult to place a monetary value on such services, their values are usually not recorded. If all of the following conditions exist, the estimated value of donated services is reported as an expense and a corresponding amount reported as contributions. (Financial presentation of revenues, gains, expenses and losses is discussed in chapter 12.)

a. The services performed are significant and form an integral part of the efforts of the entity as it is presently constituted; the services would be performed by salaried personnel if donated services were not available for the entity to accomplish its purpose; and the entity would continue this program or activity.

b. The entity controls the employment and duties of the service donors and is able to influence their activities in a way comparable to the control it would exercise over employees with similar responsibilities. This includes control over time, location, and nature and performance of donated or contributed services.

c. The entity has a clearly measurable basis for the amount to be recorded.

2. See note 1.

2.8. Participation of volunteers in philanthropic activities generally does not meet the foregoing criteria because there is no effective employer-employee relationship.

Unrestricted Grants and Subsidies

2.9. Grants, tax support, and other subsidies from governmental or community agencies may be received for general support of health care entities. These items are reported as operating gains or revenue or nonoperating gains depending on whether they constitute the entity's ongoing major or central operations or are peripheral and incidental to the entity's operations (see chapter 12).

Donor-Restricted Resources

2.10. Not-for-profit health care entities report resources received from donors or grantors that bear restrictions on their use in donor-restricted funds. Those funds include (*a*) specific-purpose funds, (*b*) property and equipment funds, (*c*) term endowment funds, (*d*) endowment funds, and (*e*) annuity and life income funds. Accounting, reporting, and disclosure considerations for these funds are discussed in chapter 3.

Chapter 3

Accounting Principles of Measurement and Disclosure

Application of Generally Accepted Accounting Principles

3.1. Financial statements of health care entities should be prepared in conformity with generally accepted accounting principles. Financial Accounting Standards Board (FASB) Statements of Financial Accounting Standards and FASB Interpretations, Accounting Principles Board (APB) Opinions, and AICPA Accounting Research Bulletins (ARBs) are applicable to financial statements prepared by health care entities. Health care entities operated by state and local governments are subject to statements and interpretations of the Governmental Accounting Standards Board (GASB) and those other pronouncements of the FASB, APB, and others that the GASB has made applicable to those government entities.

Fund Accounting

3.2. Fund accounting is an accounting technique used by some not-for-profit and governmental health care entities for purposes of internal recordkeeping and managerial control. Governmental health care entities also use fund accounting to demonstrate compliance with legislative or other restrictions. Many individual funds may be established for that purpose. In applying fund accounting, health care entities use general funds to account for resources available for general operating purposes and donor-restricted funds to account for donor-restricted and grantor-restricted resources because of the fiduciary accountability associated with them. Each of the two fund types consists of a self-balancing group of accounts composed of assets, liabilities, and fund balances (net assets).

3.3. FASB Concepts Statement No. 6, *Elements of Financial Statements*, states that although some not-for-profit organizations may choose to classify assets and liabilities into fund groups, information about those groupings is not a necessary part of general-purpose external financial reporting. Issues that affect how, if at all, classifications of assets and liabilities may be displayed in financial statements (for example, by using a columnar presentation and the extent to which aggregation and disaggregation of information is permitted or required) are not addressed in that statement but may be the subject of a future FASB project (see paragraph 3.26). Following is a discussion of the application of fund accounting for external financial reporting purposes.

General Funds

3.4. General funds are used to account for resources not restricted for identified purposes by donors and grantors. They account for all resources and obligations not recorded in donor-restricted funds, including assets whose use is limited, agency funds, and property and equipment related to the general operations of the entity. Assets and liabilities of general funds are classified as current or noncurrent in conformity with generally accepted accounting principles.

Assets Whose Use Is Limited

3.5. Assets whose use is limited are included in general funds and comprise—

- Assets set aside by the governing board for identified purposes. The board retains control over them and may, at its discretion, subsequently use them for other purposes. (These assets are also referred to as board-designated assets.)
- Proceeds of debt issues and funds of the health care entity deposited with a trustee and limited to use in accordance with the requirements of an indenture or a similar agreement.
- Other assets limited to use for identified purposes through an agreement between the health care entity and an outside party other than a donor or grantor. Examples include assets set aside under agreements with third-party payors to meet depreciation funding requirements and assets set aside under self-insurance funding arrangements.

Agency Funds

3.6. Health care entities may receive and hold assets owned by others under agency relationships; for example, they may receive and hold resources for patients, residents, physicians, students, and others. In accepting responsibility for those assets, an entity incurs a liability to the principal under the agency relationship to return them in the future or, if authorized, to disburse them to another party on behalf of the principal. Agency funds are included in general funds. Transactions involving receipt and disbursement of agency funds are not included in the results of operations.

Property and Equipment

3.7. Property and equipment used for general operations, and the related liabilities, are reported in general funds. Property of general funds not used for general operations (for example, property acquired for future expansion or investment purposes) is presented separately in general funds. Property and equipment whose use is restricted (for example, real estate investments of endowment funds) are reported in the appropriate donor-restricted fund.

Donor-Restricted Funds

3.8. Resources restricted by donors and grantors include resources for specific operating purposes, additions to property and equipment, endowments, term endowments, and annuity and life income. Each restricted resource should be accounted for in accordance with the instructions of the donor or grantor placing the restrictions on the resources. Restrictions on many resources are such that the resources can be grouped for reporting purposes even though they may require separate accounting. Restricted resources are generally grouped for reporting purposes in several funds as shown in the following discussion.

Temporarily Restricted Funds

3.9. *Specific-purpose funds.* Specific-purpose funds are used to account for resources restricted by donors and grantors for specific operating purposes. They are recorded as additions to the restricted fund balance when received and are reclassified as revenue of general funds when expenditures are incurred for the purpose intended by the donor or grantor. Examples are resources for

education grants, research grants, or contributions to cover specific operating purposes.

3.10. *Plant replacement and expansion funds.* Resources restricted by donors for additions to property and equipment are considered to be capital contributions and are reported in restricted plant replacement and expansion funds. A reclassification of resources from the plant replacement and expansion fund balance to the general fund balance is reported in the statement of changes in fund balances when expenditures are incurred for the purpose intended by the donor. Examples are resources for building construction, renovation, equipment purchases, and capital debt retirement.

3.11. *Term endowment funds.* Term endowment funds include resources whose principal may be expended after the donor-imposed time or after other restrictions are satisfied. Pertinent information about term endowment funds, such as the term of the endowment and the purposes for which the funds may be used during and after the term of restriction, should be disclosed in the notes to the financial statements. If and when term endowment funds become available for unrestricted purposes, they are reported in the statement of revenues and expenses. If such resources are further restricted under the provisions of the term endowment, they are shown as a reclassification to the appropriate donor-restricted fund in the statement of changes in fund balances.

3.12. *Other donor-restricted funds.* Other donor-restricted funds may include annuity and life income funds.

Permanently Restricted Funds

3.13. *Endowment funds.* Endowment funds include resources whose principal may not be expended. The donor may or may not stipulate how the investment income is to be used.

Donated Funds Held in Trust

3.14. Resources that are held in trust by others under a legal trust instrument created by a donor independent of the reporting entity, and that are neither in the possession of nor under the control of the entity but are held and administered by outside fiscal agents with the entity deriving income from such funds, are not reported in the balance sheet with funds administered by the entity; however, their existence should be disclosed. The resources

contemplated by this paragraph are those for which the reporting entity is not the remainderman in the trust.

3.15. Distributions from the trustee are reported on an accrual basis; that is, distributions are reported when the trustee is required to make distributions to the health care entity. Furthermore, the right to future income and the principal held in trust may be disclosed in the notes to the financial statements if appropriate. If the distribution that the trustee makes to the entity is discretionary, the entity reports the distribution in accordance with the terms of the trust or agreement with the trustee.

3.16. If the reporting entity is the remainderman in the trust, then, depending on the terms of the trust document, the donated funds may be reported as assets of the reporting entity.

Timing Differences

Third-Party Reimbursement

3.17. Transactions may enter into the determination of accounting income either before or after they become determinants of reimbursement. These timing differences are recognized in the periods in which the differences arise and in the periods in which the differences reverse. Permanent differences do not affect other periods; thus, interperiod reimbursement allocation is not appropriate for such differences.

3.18. The effect of timing differences recorded under existing reimbursement programs may become permanent because of changes in the programs or regulations. In addition, some reimbursement program provisions (such as limits on increases in reimbursable costs and the implementation of prospective payment systems) may affect the recoverability of deferred debits and the realization of deferred credits recorded for reimbursement timing differences. The effect of timing differences related to reimbursement programs that become permanent is reported in the period when it is determined that they will not be recovered or realized.

3.19. The following reimbursement timing differences are examples of those that may be encountered:

- Expenses for deferred compensation or sick pay benefits recorded under the accrual method for accounting purposes but reported as paid for reimbursement purposes
- Depreciation reported over different periods or using different methods for reimbursement and accounting purposes (for ex-

ample, the use of an accelerated method of depreciation for reimbursement purposes and the straight-line method for accounting purposes)

- Interest expense reported for reimbursement purposes that differs from amounts reported for financial reporting purposes (for example, the use of the method required for Medicare reimbursement purposes and FASB Statement No. 34, *Capitalization of Interest*, for financial reporting purposes)
- Amounts of losses from uninsured medical malpractice claims recorded under the accrual method for financial reporting purposes and amounts paid into certain trust funds established under self-insurance programs that, under Medicare or other third-party requirements, are reported for reimbursement purposes
- Recording gains or losses from the early extinguishment of debt immediately for financial reporting purposes and in future periods for reimbursement purposes

Reporting Entity and Related Organizations

3.20. The FASB is presently studying the concept of a reporting entity and issues related to consolidations, the application of the equity method of accounting, and accounting for various types of joint ventures. The GASB is also studying issues related to the financial reporting entity. Accordingly, pending resolution by the FASB and GASB, those matters are not within the scope of this guide.

3.21. Other organizations (such as foundations, auxiliaries, and guilds) frequently assist, and in many instances are related to, health care entities. Accounting and reporting matters with respect to those relationships are addressed in chapter 13.

Health Care Entities as a Part of Other Organizations

3.22. A health care entity may be a part of another organization, such as a government, a medical school or a university, or a subsidiary of a corporation. The recommendations contained in this guide apply to the separate financial statements of (*a*) investor-owned and not-for-profit health care entities. and (*b*) state and local government-owned health care entities that use enterprise fund accounting and reporting. These governmental health care entities are subject to statements and interpretations of the GASB

and those other pronouncements of the FASB, APB, and others that the GASB has made applicable to those governmental entities. Therefore, when separate financial statements are prepared for a governmental health care entity that uses enterprise fund accounting and reporting, the accounting and disclosure requirements set forth by GASB pronouncements and this guide apply.

Other Principles of Measurement and Disclosure

3.23. The following are other significant accounting principles of measurement and disclosure that are discussed in separate chapters of this guide:

- Display of revenues, expenses, gains, and losses (chapter 12)
- Investments and investment income (chapters 6 and 12)
- Service revenue and receivables (chapters 7 and 12)
- Malpractice loss contingencies, risk contracting, and accounting by providers of prepaid health care services (chapter 10 and appendix B)

Financial Statements

3.24. The basic financial statements of not-for-profit and governmental health care entities consist of a balance sheet, a statement of revenues and expenses of general funds, a statement of changes in fund balances, and a statement of cash flows of general funds (and restricted funds of governmental health care entities). The basic financial statements of investor-owned health care entities are similar to those of other investor-owned entities. Illustrative financial statements are included in appendix A.

3.25. FASB Statement No. 95, *Statement of Cash Flows*, and GASB Statement No. 9, *Reporting Cash Flows of Proprietary and Nonexpendable Trust Funds and Governmental Entities That Use Proprietary Fund Accounting*, established standards for cash flow reporting for investor-owned organizations and governmental entities, respectively. FASB Statement No. 95 excludes not-for-profit organizations from its scope; however, not-for-profit health care entities should apply the provisions of FASB Statement No. 95 to ensure that their financial statements are comparable with those of investor-owned entities. The statement of cash flows may be prepared using the direct or indirect method of reporting cash flows.

3.26. An AICPA task force on not-for-profit organization display issues was established to assist the FASB in applying FASB Statement of Financial Accounting Concepts No. 6 to financial statements of not-for-profit organizations. The issues addressed by the task force include—

- The extent to which aggregation and disaggregation of information should be permitted or required.
- The use of multiple statements (one for each class of net assets) versus a single-page statement.
- Columnar versus layered formats.
- Display of revenues by function.
- Display of gains and losses on permanently restricted net assets.
- Display of expenses.
- Gross versus net revenues and expenses.
- Beginning and ending net asset balances.
- Sequence and composition of information.
- Required, permitted, or prohibited uses of totals and subtotals.

The task force has reported its advisory conclusions to the FASB for further consideration. Its conclusions may be the subject of a future FASB project and, accordingly, are not considered within the scope of this guide.

3.27. Both aggregated and disaggregated illustrative hospital balance sheets are presented in exhibit 1 of appendix A. Illustrations of a statement of changes in net assets—a concept of financial reporting introduced by the AICPA task force on not-for-profit organization display issues—and a statement of cash flows on an aggregated basis are not presented in exhibit 1 because (*a*) guidance for presentation of statements of changes in net assets in accordance with the concepts contained in FASB Concepts Statement No. 6 does not presently exist and (*b*) if aggregated reporting is used, the statement of cash flows would include changes in cash and cash equivalents of all funds. (The illustrative statement of cash flows in exhibit 1 is of general funds only.) These, as well as related issues, were addressed by the AICPA task force that addressed not-for-profit organization display issues (see paragraph 3.26). However, governmental health care entities should not change their reporting practices for presenting aggregated or disaggregated balance sheets as a result of this guide.

Chapter 4

Audit Considerations—General

Scope of the Engagement

4.1. For each audit engagement, the independent auditor and the health care entity should establish a clear understanding, preferably in writing, of the scope of audit services to be performed and the independent auditor's responsibilities regarding accompanying information. Some third-party payors require health care entities to submit information in the form of cost reports in order to obtain reimbursement for health care services provided. The independent auditor may be asked to report on the following: (*a*) cost-reimbursement reports; (*b*) cost reports related to research grants; (*c*) reports for contributors; (*d*) reports for local, state, or federal authorities; (*e*) reports related to bond indentures and other debt instruments; and (*f*) other special-purpose reports. The nature, timing, and extent of audit procedures to be performed and the type of reports to be issued are based on the scope of services required by the entity.

Planning the Audit

4.2. The nature, timing, and extent of planning usually vary with the size and complexity of the entity, as well as with the independent auditor's experience with the entity and the industry. Statement on Auditing Standards (SAS) No. 22, *Planning and Supervision*, contains guidance on planning an audit in accordance with generally accepted auditing standards.

4.3. The independent auditor's work in forming an opinion on financial statements consists of obtaining and evaluating evidential matter regarding management's assertions in financial statements. Assertions are representations by management that are embodied in the financial statements. They can be either explicit or implicit and can be classified according to the following broad categories:

existence and occurrence, completeness, rights and obligations, valuation and allocation, and presentation and disclosure.

4.4. The purpose of specific audit objectives and examples of control procedures in the auditing sections of the following chapters illustrate how the independent auditor might obtain an understanding of the internal control structure, assess control risk, and perform audit procedures. There is not necessarily a one-to-one relationship between audit objectives and procedures. Some procedures may relate to more than one objective. On the other hand, a combination of procedures may be needed to achieve a single objective. The illustrations are not intended to be all-inclusive or to suggest that specific audit objectives, internal control procedures, and audit procedures should be applied. Some of the objectives may not be relevant to a particular entity because of the nature of its operations or the absence of certain types of transactions. The absence of one or more of the illustrative internal control structure policies and procedures would not necessarily indicate a deficiency in the internal control structure.

4.5. The illustrations are arranged by broad audit objectives. These classifications may be useful in the evaluation process, but the classifications are of secondary importance. Some specific objectives may serve to achieve more than one broad objective.

4.6. Many of the illustrative control procedures are premised on the existence of certain essential characteristics of an internal control structure (for example, authorization of transactions, segregation of duties, documentation, supervision and review, and timeliness of procedures). To avoid repetition, these characteristics have not been emphasized in the illustrations.

Inherent Risk

4.7. In determining the scope of audit procedures to be performed, the independent auditor should be aware of certain aspects of the health care entity's operations that are usually subject to a greater level of inherent risk than others. SAS No. 47, *Audit Risk and Materiality in Conducting an Audit*, provides guidance on consideration of audit risk and materiality when planning and performing an audit of financial statements.

4.8. Because of the large monetary amounts and the complexity of determining health care service revenue and receivables, there are risks associated with health care service revenue recognition

and the valuation of the related receivables. A significant portion of services is usually paid for by third parties such as Medicare, Medicaid, and various health insurance carriers under statutory provisions or other arrangements in amounts that can be significantly different from, and frequently less than, the entity's established rates.

4.9. Risks are associated with recognizing the liability for costs that have been incurred by providers of prepaid health care services (for example, HMOs) because such costs may have been incurred but not yet reported to the providers. It is therefore necessary to estimate the liability for those costs. These estimates often require a high degree of management judgment. Management must consider historical experience as well as the effects of any changes in conditions such as seasonality trends, changes in subscriber population, and changes in the services and benefits provided.

4.10. Risks are also associated with contingencies for uninsured medical malpractice losses and obligations under continuing care contracts. A high degree of management judgment and complex analyses are usually involved in evaluating the related financial statement assertions.

4.11. There are audit risks inherent in all audit engagements, including the possibility of errors and irregularities or illegal acts by clients. SAS No. 53, *The Auditor's Responsibility to Detect and Report Errors and Irregularities*, provides guidance on the independent auditor's responsibility for the detection of errors and irregularities in an audit of financial statements. It describes factors that influence the independent auditor's ability to detect errors and irregularities and explains that the exercise of due care should give appropriate consideration to the possibility of errors and irregularities. It also provides guidance on the independent auditor's responsibility to communicate detected matters both within and without the entity whose financial statements are under audit.

4.12. The presence of some factors in isolation would not necessarily indicate increased risk. In assessing risk, the following factors may be considered:

Management Characteristics:

- Management operating and financing decisions are dominated by a single person.

- Management places undue emphasis on meeting earnings projections.
- Management's reputation in the business community is poor.
- Management compensation is influenced by earnings.
- Management lacks experience in dealing with complex matters such as third-party payment regulations or contracts and medical malpractice risks.

Operating and Industry Characteristics:

- The profitability of the entity is significantly less than the industry average or inconsistent with the industry.
- Operating results are significantly less than projected results.
- Market share is decreasing.
- Decision making is decentralized and lacks adequate monitoring.
- Internal or external matters exist that raise substantial doubt about the entity's ability to continue as a going concern.

Engagement Characteristics:

- Many contentious or difficult accounting issues are present.
- The number and complexity of third-party payor contracts has increased.
- Final settlements with third-party payors have resulted in substantial revisions to prior estimates.
- The number or amount of adjustments in prior periods has been significant.

Internal Control Structure

4.13. SAS No. 55, *Consideration of the Internal Control Structure in a Financial Statement Audit*, describes the elements of an internal control structure and explains how an independent auditor should consider the internal control structure in planning and performing an audit. An entity's internal control structure consists of three elements: control environment, accounting system, and control procedures.

4.14. To plan the audit, the independent auditor should obtain a sufficient understanding of each of the three elements by performing procedures to understand the design of policies and procedures relevant to audit planning and should evaluate whether they have been placed in operation.

4.15. After obtaining an understanding of the elements of the internal control structure, the independent auditor assesses control risk for the assertions embodied in the account balance, transaction class, and disclosure components of the financial statements. The independent auditor uses the knowledge provided by the understanding of the internal control structure and the assessed level of control risk in determining the nature, timing, and extent of substantive tests for financial statement assertions.

Analytical Procedures

4.16. SAS No. 56, *Analytical Procedures*, provides guidance on the use of analytical procedures and requires the use of analytical procedures in the planning and overall review stages of all audits. For planning purposes, these procedures should focus on (*a*) enhancing the independent auditor's understanding of the client's business and the transactions and events that have occurred since the last audit date and (*b*) identifying areas that may represent specific risks relevant to the audit. Thus the objective of the procedures is to identify such things as the existence of unusual transactions and events, as well as amounts, ratios, and trends that might indicate matters that have financial statement and audit planning ramifications.

4.17. Examples of sources of information for developing expectations include prior-period financial information, budgets, and health care financial and statistical ratios and other information that is available from the Healthcare Financial Management Association's Financial Analysis Service, which is published annually, as well as other health care industry associations.

4.18. Following are examples of analytical procedures the independent auditor may find useful in planning an audit of a health care entity:

- Comparison of account balances with budget and prior-period amounts
- Analysis of changes in revenues during the current period based on statistical data (for example, admissions, patient days, visits, and professional service procedure counts for laboratory, radiology, and surgery) and information concerning price changes
- Comparison between periods of the number of days of revenue in receivables
- Relationship between periods of the allowance for uncollectible

accounts to the balance of patient accounts receivable in the aggregate, based on known changes in the accounts receivable's aging and composition by payor

- Relationship between periods of the liability for uninsured medical malpractice claims incurred but not yet reported (IBNR) to the related expense

Accounting Estimates

4.19. In determining the scope of audit procedures to be performed, the independent auditor should recognize that certain areas of health care entity operations require accounting estimates that may be material in the preparation and presentation of financial statements. SAS No. 57, *Auditing Accounting Estimates*, provides guidance on obtaining and evaluating sufficient competent evidential matter to support significant accounting estimates in an audit of financial statements in accordance with generally accepted auditing standards.

4.20. Although management is responsible for making estimates, the independent auditor is responsible for evaluating the reasonableness of estimates and should consider appropriate procedures in planning and performing the audit. These procedures should include both subjective and objective factors.

4.21. The independent auditor should acquire an understanding of the relevance of the internal control structure to the accumulation of data and the preparation of accounting estimates. The internal control structure should also provide for adequate review and approval of accounting estimates by appropriate levels of authority.

4.22. Although significant accounting estimates may affect many elements of a health care entity's financial statements, they most often affect the following:

- The provision for third-party payor contractual adjustments and allowances and provision for estimated receivables and payables for final settlements with those payors
- The provision for uncollectible accounts
- Accruals for uninsured medical malpractice claims
- Accruals for obligations under continuing care contracts
- Accruals by providers of prepaid health care services for costs that have been incurred but not reported to the provider

Electronic Data Processing

4.23. Many health care entities use some form of electronic data processing (EDP) system, which may be operated solely by the entity, shared with others, or provided by an independent organization for a fee. Typical applications of EDP systems are revenue and receivables, payroll, accounts payable, property and equipment records, and general ledger. Some health care entities may have EDP applications for on-line billing to third-party payors, third-party-payor billing logs, and cost report preparation. In addition, some entities may have applications to determine diagnosis-related group (DRG) assignments for the Medicare PPS.

4.24. The use of EDP does not affect the objectives of the audit; however, the organizational and control procedures may differ from those used in manual or mechanical data processing, and audit procedures applied to accounting records maintained on EDP equipment may vary from those applied to records maintained manually or on mechanical equipment. This guide does not address the effects of EDP on an audit.

4.25. Guidance on auditing records for which electronic data processing is significant is contained in (*a*) SAS No. 44, *Special-Purpose Reports on Internal Accounting Control at Service Organizations*; (*b*) AICPA Audit and Accounting Guide *The Auditor's Study and Evaluation of Internal Control in EDP Systems*; (*c*) AICPA Audit and Accounting Guide *Audits of Service-Center-Produced Records*; and (*d*) AICPA Audit and Accounting Guide *Computer-Assisted Audit Techniques*.

Other Planning Considerations

4.26. In planning the audit, the independent auditor should also consider—

- Matters relating to the entity's business and the industry in which it operates.
- Financial statement items likely to require adjustment.
- Conditions that might require extension or modification of audit tests (such as the existence of related party transactions) or the existence of uninsured malpractice risks.
- The entity's experience with payment denials and other matters that are subject to review by medical review organizations.
- The nature of reports expected to be rendered (for example, a report on consolidated or consolidating financial statements,

reports on financial statements filed with the Securities and Exchange Commission (SEC), reports filed with third-party payors or other regulatory bodies, or other special reports).

4.27. Planning procedures usually include reviewing the independent auditor's files relating to the entity and holding discussions with audit personnel and the personnel of the entity. Following are examples of those procedures:

- Review correspondence files, the prior year's working papers, permanent files, financial statements, and independent auditor's reports.
- Review minutes of meetings of the governing board and board committees.
- Review the relationship of affiliated organizations to the health care entity and determine the extent to which their financial information should be included in the financial statements of the entity (see the related discussion in chapter 13).
- Review the status of unsettled cost (reimbursement) reports for prior periods filed with third-party payors.
- Discuss matters that may affect the audit with the firm's personnel responsible for any nonaudit services to the entity.
- Identify situations for which accounting estimates are required and relevant factors that may affect those estimates.
- Inquire about current business developments affecting the entity.
- Read the current year's interim financial statements and 10-Q forms.
- Review periodic reports to third-party payors or other regulatory bodies.
- Discuss the nature, scope, and timing of the engagement with the entity's management, board of directors, or audit committee.
- Consider the effects of applicable accounting and auditing pronouncements, particularly new ones.
- Coordinate the assistance of entity personnel in data preparation.
- Determine the extent of involvement, if any, of consultants, specialists, and internal auditors.
- Establish the timing of the audit work.

4.28. The independent auditor may find it helpful to maintain a permanent file that includes the following documents:

- Articles of incorporation
- Bylaws
- Chart of accounts
- Organization chart
- Documents relating to donor restrictions of gifts and bequests
- Contracts and agreements, such as leases, agreements with physicians, agreements with third-party payors, and agreements with affiliated and related organizations
- Description of the internal control structure (that is, the control environment, the accounting system, and control procedures)
- Loan agreements, bond indentures, and other debt instruments
- Minutes of board and committee meetings

4.29. The independent auditor should understand the specific cost-finding or other rate-setting methods used by third-party payors to determine final amounts reimbursable to the health care entity. These payment methods may require that a health care entity accumulate and report various statistical data, such as admissions, discharges, patient days, visits, beds, square footage, and pounds of laundry. Accordingly, in planning the audit, the independent auditor should consider whether the scope of the audit includes tests of statistical data.

4.30. The independent auditor intending to use audit-sampling procedures should refer to SAS No. 39, *Audit Sampling*, and to the audit and accounting guide *Audit Sampling* when planning the work to be done.

4.31. If the health care entity has an internal audit function, the independent auditor should also refer to SAS No. 9, *The Effect of an Internal Audit Function on the Scope of the Independent Auditor's Examination*.

Other Audit Considerations

Illegal Acts

4.32. SAS No. 54, *Illegal Acts by Clients*, prescribes the nature and extent of the consideration an independent auditor should give to the possibility of illegal acts by a client. It also provides guidance on the independent auditor's responsibilities when a possible illegal act is detected.

Going-Concern Considerations

4.33. SAS No. 59, *The Auditor's Consideration of an Entity's Ability to Continue as a Going Concern*, provides guidance to the independent auditor conducting an audit on how to evaluate whether there is substantial doubt about the entity's ability to continue as a going concern. Continuation of an entity as a going concern is assumed in financial reporting in the absence of significant information to the contrary. Ordinarily, information that significantly contradicts the going-concern assumption relates to the entity's inability to continue to meet its obligations as they become due without substantial disposition of assets outside the ordinary course of business, restructuring of debt, externally forced revision of its operations, or similar actions. SAS No. 59 states that the independent auditor has a responsibility to evaluate whether there is substantial doubt about the entity's ability to continue as a going concern for a reasonable period of time, not to exceed one year beyond the date of the financial statements being audited.

Communication of Matters Related to Internal Control Structure

4.34. SAS No. 60, *Communication of Internal Control Structure Related Matters Noted in an Audit*, provides guidance in identifying and reporting conditions that relate to an entity's internal control structure observed during an audit of financial statements. It is contemplated that the communication would generally be to the audit committee or to individuals with a level of authority and responsibility equivalent to an audit committee in organizations that do not have one (such as the board of directors, an owner in an owner-managed enterprise, or others who may have engaged the independent auditor). Conditions noted by the independent auditor that are considered reportable under SAS No. 60 should be reported, preferably in writing. If information is communicated orally, the independent auditor should document the communication by appropriate memoranda or notations in the working papers.

Communication With Audit Committees

4.35. SAS No. 61, *Communication With Audit Committees*, establishes a requirement for the independent auditor to determine

that certain matters related to the conduct of an audit are communicated to those who have responsibility for oversight of the financial reporting process. The communications required by SAS No. 61 are applicable to (*a*) entities that either have an audit committee or that have otherwise formally designated oversight of the financial reporting process to a group equivalent to an audit committee (such as a finance committee or budget committee) and (*b*) all SEC engagements as defined in SAS No. 61. In addition, communication with the audit committee or its equivalent by the independent auditor on certain specified matters when they arise in the conduct of an audit is required by other standards, including SAS No. 53, *The Auditor's Responsibility to Detect and Report Errors and Irregularities*, and SAS No. 54, *Illegal Acts by Clients*.

Client Representations

4.36. SAS No. 19, *Client Representations*, provides guidance to the independent auditor about the representations to be obtained from management as part of an audit. The specific written representations to be obtained depend on the circumstances of the engagement and the nature and basis of presentation of the financial statements. Paragraph 4 of SAS No. 19 lists matters ordinarily included in management's representation letter. Independent auditors of health care entities might also obtain representations, if applicable, of the following:

- The health care entity is in compliance with the provisions of IRC sec. 501(c)(3) and is exempt from federal income tax under IRC sec. 501(a), as evidenced by a determination letter.
- Information returns have been filed on a timely basis.
- All funds received with restrictions from outside parties have been properly segregated in the appropriate restricted fund.
- All disbursements, charges for expenditures, and interfund transfers relating to restricted funds have been made in accordance with the purpose or restriction of the fund affected and were properly authorized.
- Provision has been made, when material, for estimated retroactive adjustments by third-party payors under reimbursement agreements.
- The health care entity is in compliance with bond indentures or other debt instruments.

- Pending changes in the organizational structure, financing arrangements or other matters that have a material effect on the financial statements of the entity are properly disclosed.

Single Audit Act and Related Audit Considerations

4.37. An independent auditor may be engaged to audit the financial statements of a health care entity that receives financial assistance from a governmental agency in accordance with the Single Audit Act of 1984 and Circular A-128 *Audits of State and Local Governments*, or in accordance with Circular A-110, *Uniform Requirements for Grants to Universities, Hospitals, and Other Nonprofit Organizations*, issued by the U.S. Office of Management and Budget (OMB). Financial assistance may take the form of grants, contracts, loans, loan guarantees, property, cooperative agreements, interest subsidies, and insurance or direct appropriations.

4.38. Circular A-128 prescribes policies, procedures, and guidelines to implement the Single Audit Act and requires state and local governments that receive total federal financial assistance equal to or in excess of $100,000 in a fiscal year to have an audit performed in accordance with the Single Audit Act. The Single Audit Act states that state and local governments receiving at least $25,000, but less than $100,000, of total federal financial assistance in a year have the option of having an audit performed in accordance with either the act or with federal laws and regulations governing the programs in which they participate. The Single Audit Act does not require state or local governments receiving less than $25,000 in total federal financial assistance to have an audit.

4.39. Circular A-110 establishes standards (such as insurance requirements, record retention requirements, and banking requirements) for obtaining consistency and uniformity among federal agencies in the administration of grants to and agreements with public and private hospitals and other entities.

4.40. SAS No. 63, *Compliance Auditing Applicable to Governmental Entities and Other Recipients of Governmental Financial Assistance*, provides guidance on applying the requirements of SAS No. 53, *The Auditor's Responsibility to Detect and Report Errors and Irregularities*; SAS No. 54, *Illegal Acts by Clients*; and various other SASs to audits of certain entities that receive financial assistance from government and explains the relationship between

those requirements and the requirements of *Government Auditing Standards* (also known as the "Yellow Book") issued by the Comptroller General of the United States. The Yellow Book contains standards for audits of government organizations, programs, activities, and functions and of govenment funds received by contractors, not-for-profit organizations, and other nongovernment organizations. SAS No. 63 also provides guidance on testing compliance with laws and regulations applicable to federal financial assistance programs in audits performed in accordance with the Single Audit Act of 1984.

4.41. Additional guidance on audits in accordance with the Single Audit Act of 1984 is provided in the AICPA Audit and Accounting Guide *Audits of State and Local Governmental Units.*

Chapter 5

Cash and Cash Equivalents

Accounting and Financial Statement Presentation

5.1. Cash and cash equivalents may include money on hand, money in checking accounts, time deposits, temporary cash investments, and uninvested funds held by investment custodians.

Operating Accounts

5.2. Cash on hand consists primarily of money in the possession of cashiers who receive payments from (*a*) inpatients, outpatients, or residents; (*b*) gift shops, parking lots, and cafeterias; or (*c*) other collection points. It also includes petty cash funds used for payments of small amounts.

5.3. Checking accounts may be used to deposit daily receipts and to make disbursements or transfers to other accounts. Separate checking accounts may be maintained for payroll disbursements, payments to vendors, refunds to patients, and other special purposes.

5.4. Time deposits may be in the form of savings accounts, certificates of deposit, money market accounts, or similar accounts.

Restricted Fund Accounts

5.5. Separate accounts may be maintained for restricted cash and cash equivalents in the form of checking or savings accounts or time deposits.

Personal Fund Accounts

5.6. Health care entities may receive and hold personal funds of patients, residents, and others under an agency arrangement.

Personal funds are reported as assets, with a corresponding amount reported as a liability, in the balance sheet. The amount of personal funds reported as assets is disclosed parenthetically on the balance sheet or disclosed in the notes to the financial statements.

Auditing

5.7. The audit objectives and procedures for cash and cash equivalents of health care entities are generally similar to those of other organizations. In addition, the independent auditor may need to consider the following specific audit objectives, selected control procedures, and auditing procedures.

AUDIT CONSIDERATIONS

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
Donated Cash			
Completeness; rights and obligations; presentation and disclosure	Cash donations are properly deposited and recorded on a timely basis.	Donations received are recorded and controlled by someone other than the cashier.	Review donor correspondence and trace donation to cash receipts records and bank statement.
	Restricted donations are properly segregated and used for the restricted purpose.	Donations are reviewed for restrictions, and management monitors compliance with restrictions.	Review donor correspondence to determine the presence or absence of donor restrictions. Review minutes of board and board committee meetings for evidence of donor restrictions. Test expenditures to determine that restricted cash and cash equivalents are used for the restricted purpose.
	Restricted cash and cash equivalents are properly	Procedures are established for the proper disclosure of	Review the financial statements to determine that re-

(*continued*)

AUDIT CONSIDERATIONS (cont.)

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
Donated Cash (cont.)			
	disclosed in the financial statements.	restricted cash and cash equivalents.	strictions on cash balances are properly disclosed.
Personal Funds			
Rights and obligations; presentation and disclosure	Personal funds are properly accounted for, controlled, and disclosed in the financial statements.	Procedures ensure proper accountability, disclosure, and use of personal funds cash.	Determine that separate accounts for personal funds are maintained, if required. Review documentation supporting receipts and disbursements of personal funds. Review the financial statements to determine that personal funds are properly disclosed.
Transfers Between Funds			
Presentation and disclosure	Transfers are properly reported in the financial statements.	Procedures ensure that transfers between funds are reported in the proper period.	Review minutes and other documentation to determine that transfers between funds are authorized and reported in the proper period.

Chapter 6

Investments

Accounting and Financial Statement Presentation

6.1. Investments are initially recorded at acquisition cost or, if received as a donation, at fair market value at the date of the gift, which is thereafter treated as cost. Investments of general funds are reported as current or noncurrent assets in conformity with generally accepted accounting principles.

6.2. Investments are reported in the financial statements as follows:

a. Marketable securities include (1) equity securities, which are reported at the lower of aggregate cost or market value in accordance with the requirements of FASB Statement No. 12, *Accounting for Certain Marketable Equity Securities*, and (2) debt securities, which are reported at amortized cost if there is the intent and ability to hold to maturity, or at lower of cost or market value if not intended to be held to maturity. If the market value is less than cost and the impairment in value is deemed to be other than temporary, the investments are reported at an amount not to exceed market value. Governmental health care entities are required to disclose certain information about their investments in accordance with GASB Statement No. 3, *Deposits With Financial Institutions, Investments (Including Repurchase Agreements), and Reverse Repurchase Agreements.*

b. Unconsolidated affiliates (for example, joint ventures) are accounted for in accordance with APB Opinion No. 18, *The Equity Method of Accounting for Investments in Common Stock.*

c. Other securities (for example, real estate or oil and gas interests)

are reported at amortized cost, or at market value if an impairment in value is deemed to be other than temporary.

Investments of Not-for-Profit Health Care Entities

6.3. Some noteworthy features related to accounting for investments of not-for-profit health care entities are (*a*) accounting by fund type to comply with and account for donor or grantor restrictions on investment practices; (*b*) pooling of investments; and (*c*) valuation of marketable equity securities. In addition to imposing restrictions on the use of donations and grants, donors and grantors may impose restrictions on investment practices and may require separate accounting for principal and income transactions. Not-for-profit health care entities may also pool resources of various funds for investment purposes, or invest some resources separately and pool other resources. Income on investments and gains or losses are allocated equitably to the various funds participating in the pool, and appropriate disclosure of the participating funds is made in the financial statements.

Investment Pools

6.4. The market-value method should be used to equitably allocate investment income (including gains and losses) of investment pools. Under the market-value method, each participating fund is assigned a number of units based on its share of the total pool. When the pool is established, units are initially assigned to the participating funds based on the market value of cash and investments placed in the pool by each fund. Current market value is used to determine the number of units allocated to additional assets placed in the pool and to value withdrawals from the pool. Income from investments of the pool, including gains or losses, are allocated to participating funds based on the funds' share in the pool.

Accounting for Certain Marketable Equity Securities by Not-for-Profit Health Care Entities

6.5. Marketable equity security portfolios of not-for-profit health care entities are reported at the lower of aggregate cost or market value, determined at the balance sheet date. The amounts by

which the aggregate cost of each portfolio exceeds market value are reported as valuation allowances, unless the decline in market value is judged to be other than temporary (see paragraph 6.11).

6.6. Marketable equity securities are grouped into separate portfolios for the purpose of comparing aggregate cost and market value to determine the amount to be reported in the financial statements. Marketable equity securities included in general funds are grouped into separate portfolios according to the current or noncurrent classification of the securities. Marketable equity securities included in donor-restricted funds are grouped into separate portfolios according to the type of fund; for example, portfolios of marketable equity securities included in various specific-purpose funds are grouped together, but not with those of endowment funds.

6.7. The current portfolios of general funds of entities that are consolidated or combined in financial statements are treated as a single combined portfolio; the noncurrent general fund portfolios of those entities are also treated as a single portfolio. Portfolios of similar donor-restricted funds of entities consolidated or combined in financial statements are treated as a single portfolio. For example, portfolios of the various specific-purpose funds of a not-for-profit hospital are combined with the portfolios of marketable equity securities held in the various specific-purpose funds of an entity whose financial statements are combined with those of the not-for-profit hospital.

6.8. If there is a change between the current and noncurrent assets classification of a marketable equity security included in general funds, the security is transferred between the corresponding portfolios at the lower of its cost or market value at the date of the transfer. If market value is less than cost, the market value becomes the new cost basis and the difference is accounted for as if it were a realized loss. If the not-for-profit health care entity pools its investments (which could include investments of current and noncurrent general funds and investments of restricted funds), the cost of marketable equity securities in the fund or funds is compared with the allocation of the market value of the pooled marketable equity securities for purposes of implementing the method described in this paragraph. To apply this method properly, marketable equity securities are accounted for separately from other investments.

6.9. The following information is disclosed either in the financial statements or in the accompanying notes:

a. As of the date of each balance sheet presented, aggregate cost and market values for each portfolio into which marketable equity securities are grouped to determine the carrying amount, with identification as to which is the carrying amount

b. As of the date of the latest balance sheet presented, the following, segregated by portfolio:

- Gross unrealized gains, representing the excess of market value over cost, for all marketable equity securities in the portfolio having such an excess
- Gross unrealized losses, representing the excess of cost over market value, for all marketable equity securities in the portfolio having such an excess

c. For each period for which a statement of revenues and expenses is presented:

- Net realized gain or loss included in the statement of revenues and expenses
- The basis on which cost was determined in calculating realized gain or loss (average cost or other method used)

6.10. The financial statements are not adjusted for realized gains, losses, or changes in market prices with respect to marketable equity securities if such gains, losses, or changes occur after the date of the financial statements but before their issuance, except for the situation discussed in paragraph 6.12. However, significant net realized and net unrealized gains and losses arising after the balance sheet date but before the financial statements are issued, applicable to marketable equity securities owned at the date of the most recent balance sheet, are disclosed.

6.11. For those marketable securities for which the effect of a change in carrying amount is included in the statement of changes in fund balances as discussed in item *b* of paragraph 6.12 (rather than in the statement of revenue and expenses), a determination is made about the probable duration of an individual security's decline in market value below cost as of the balance sheet date. If the decline is judged to be other than temporary, the basis of the individual security is adjusted down to the market value at the balance sheet date and the amount of the adjustment is

reported as a realized loss. The new basis is not changed for subsequent recoveries in market value.

6.12. A loss recognized because of a change in a marketable equity security's classification between current and noncurrent assets in general funds is reported in the statement of revenue and expenses. For each period for which a statement of revenue and expenses is presented, (*a*) the change in the valuation allowance for a marketable equity securities portfolio included in current assets in general funds is disclosed and reported in the statement of revenues and expenses, and (*b*) the change in the valuation allowance for a marketable equity securities portfolio included in noncurrent assets in general funds or assets in restricted funds is disclosed and reported in the respective statement of changes in fund balances. Accumulated changes in the valuation allowance for such portfolios are disclosed in the appropriate fund balance in the balance sheet.

6.13. Realized gains or losses on the sale of investments of endowment funds are added to, or deducted from, the endowment fund principal unless such amounts are legally available for other use or are chargeable against other funds. Investment income of endowment funds is accounted for in accordance with the donors' instructions (for example, as resources available for specific operating or other purposes if restricted or in the statement of revenue and expenses if unrestricted).

6.14. Income and net realized gains or losses on investments of restricted funds other than endowment funds are added to, or deducted from, the respective fund balance unless such amounts are legally available for other use or chargeable against other funds. If such amounts are legally available for unrestricted purposes, they are reported in the statement of revenue and expenses. Because of the existence of third-party restrictions placed by donors or grantors on resources reported in restricted funds, gains or losses on investment trading between general and restricted funds and between various categories of restricted funds (for example, between endowment and plant replacement and expansion funds) are recognized as realized gains or losses and separately disclosed in the financial statements. Gains or losses are not recognized if they result from transactions between various portfolios classified as assets whose use is limited in the general funds section of the balance sheet. An example of such a transaction is one between

board-designated assets and assets set aside under agreements with third-party payors.

6.15. Unrealized gains or losses on marketable securities classified as noncurrent do not result in adjustment of the reported value of investments, except for changes in the valuation allowance related to marketable equity securities and for declines in value that result from other-than-temporary impairment.

6.16. The accounting and reporting for unrestricted investment income are discussed in chapter 12.

Auditing

6.17. Audit objectives and procedures for investments of health care entities are generally similar to those of other organizations. In addition, the independent auditor may need to consider the following specific audit objectives, selected control procedures, and auditing procedures.

AUDIT CONSIDERATIONS

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
Donated Securities			
Existence and completeness; rights and obligations	Donated securities are recorded on a timely basis.	Donated securities are acknowledged in writing. Donated securities are (1) received by persons who do not have access to other negotiable assets or (2) received by custodians who report them promptly to the entity. Documentation supporting donated securities includes all of the information necessary to record the transaction properly.	Review board, investment committee, and other committee minutes for evidence of donated securities.
	Donor-imposed restrictions, if any, on the use of principal and investment income, on investment practices, and on requirements for	Management monitors compliance with donor restrictions.	Review documents related to donor restrictions and test compliance with restrictions, if any.

(*continued*)

AUDIT CONSIDERATIONS (cont.)

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
Donated Securities (cont.)			
	separate accounting for principal and income transactions are complied with.		
Valuation	Donated securities are properly reported at fair market value at date of gift.	Fair market values are determined as of the date of gift by reference to published sources.	Compare reported values with fair market values at date of gift.
Presentation and disclosure	Donated securities are reported in the proper fund.	Restricted funds are established to account for restricted donations.	Review financial statements for propriety of reporting and disclosure of restrictions.
	Donor-imposed restrictions are disclosed in the financial statements.		
Investment Pools			
Allocation	Investments of restricted funds are pooled only in accordance with donor, grantor, or other restrictions.	Procedures ensure adherence to restrictions relating to pooling of investments.	Review donor, grantor, and other restrictions for evidence of restrictions on investment practices.
	Income and gains or losses are distributed equitably	Income and gains or losses related to pooled invest-	Test the allocation of investment income and the num-

	among the participating funds.	ments are allocated using the "market value" method. Procedures ensure that the allocation is reviewed by an individual independent of the recording function.	ber of participation units to each fund.
Presentation and disclosure	Disclosure of the participating funds is made in the financial statements.		Review the financial statements for propriety of disclosure of pooled investments.

Chapter 7

Receivables

7.1. Receivables may include amounts due for (*a*) health care services from patients, residents, third-party payors, and employers; (*b*) premiums and stop-loss insurance recoveries; (*c*) interfund and intercompany transactions; (*d*) pledges or grants; and (*e*) amounts due from employees or others.

7.2. Distinguishing bad-debt expense from charity care requires judgment. Charity care results from an entity's policy to provide health care services free of charge to individuals who meet certain financial criteria. The establishment of a policy clearly defining charity care should result in a reasonable determination. Although it is not necessary for the entity to make this determination upon admission of the individual, at some point the entity must determine that the individual meets its preestablished criteria for charity care. Charity care represents health care services that were provided but were never expected to result in cash flows. As a result, charity care does not qualify for recognition as receivables or revenue in the financial statements.

Accounts Receivable for Health Care Services

7.3. Amounts realizable from third-party payors for health care services are usually less than the provider's full established rates for those services. The realizable amounts may be determined by (*a*) contractual agreement with others (such as Blue Cross plans, Medicare, Medicaid, and HMOs), (*b*) legislation or regulation (such as worker's compensation and no-fault insurance), or (*c*) provider policy or practice (such as courtesy discounts to medical staff members and employees and other administrative adjustments).

7.4. Revenue and the related receivables for health care services are usually recorded in the accounting records on an accrual basis

at the provider's full established rates. The provision for contractual adjustments (that is, the difference between established rates and third-party payor payments) and discounts (that is, the difference between established rates and the amount collectible) are recognized on an accrual basis and deducted from gross service revenue to determine net service revenue. Contractual adjustments, discounts, and an allowance for uncollectibles are recorded to report the receivables for health care services at net realizable value. Estimates of contractual adjustments, other adjustments, and the allowance for uncollectibles are reported in the period during which the services are provided even though the actual amounts may become known at a later date (which may be (*a*) when the person is discharged, (*b*) subsequent to discharge or completion of service, (*c*) when the third party is billed, or (*d*) when payment or partial payment is received).

7.5. Payment amounts under the Medicare PPS are generally not related to the cost of the patient's services or length of hospital stay. Under the PPS, payments are based on a per-case rate (DRG payment). If the patient stays longer than the length of stay used to determine the payment rate or if costs of rendering care to the patient are greater than the payment rate, the hospital will not receive additional revenue even though additional costs may be incurred (with the exception of, for example, special consideration for extreme cases referred to as *outliers*). Therefore, the hospital should have a method to properly estimate the revenue earned for inpatients covered under the PPS that are hospitalized at the balance sheet date, and to record an estimated contractual adjustment to report the related receivables at net realizable value. The methodology used should properly match revenue with costs.

Rate Setting

7.6. The independent auditor should be familiar with the rate-setting environment in which the entity operates and the regulations and contractual agreements that determine payments to be received for health care services. Payment rates established by regulations or contractual agreements may be determined either prospectively or retrospectively.

7.7. Prospective rate setting is a method used to set payment rates in advance of the delivery of health care services. Such payment rates determine what third parties will pay for health care services during the rate period (generally one year). Prospec-

tive rate setting may result from a contractual agreement with third parties, such as a Blue Cross plan, or may be mandated through legislation. The intent of prospective rate setting is to establish payment rates before the period to which they will apply and that are not subject to change. The independent auditor should be aware, however, that some rate-setting methods described as prospective may include provision for retrospective adjustments and that some third parties pay prospective rates for certain services and retrospective rates for other services.

7.8. Under retrospective rate setting, third parties usually determine an interim payment rate and, during the rate period (generally one year), pay the health care entity for services rendered by using this rate. After the rate period has ended, a final settlement is made in accordance with federal or state regulations or contractual agreements.

Estimated Final Settlements

7.9. Under a retrospective rate-setting system, an entity may be entitled to receive additional payments or may be required to refund amounts received in excess of amounts earned under the system. Although final settlements are not made until a subsequent period, they are usually subject to reasonable estimates and are reported in the financial statements in the period in which services are rendered. Differences between the estimates originally reported in the financial statements and final settlements are included in the statement of revenue and expenses in the period the settlements are made. Those differences are not treated as prior period adjustments unless they meet the criteria for prior period adjustments as set forth in FASB Statement No. 16, *Prior Period Adjustments.*

7.10. Rate-setting methods that are described as prospective but provide for retrospective adjustments are accounted for as retrospective rate-setting systems for the services to which they apply.

Advances and Deposits

7.11. Third-party payors may make advance payments to a health care entity. The advances are reported in the financial statements as a liability unless the right of setoff against a related receivable applies.

7.12. Many health care entities require patients to make a deposit, based on estimates of the amount ultimately due, prior to or on the day that services are initially rendered. For example, nursing homes often require a deposit upon admission to the facility. Deposits received from patients are reported as a liability to the extent that a right of setoff does not exist.

Pending Appeals

7.13. Some rate-setting systems provide an appeal mechanism that allows health care entities to request that certain changes be made to payment rates because of errors in calculation, new or expanded services not recognized in existing rates, rate-setting adjustments, interpretation of regulations, or other reasons. FASB Statement No. 5, *Accounting for Contingencies*, as amended and interpreted, provides guidance with respect to accounting for gain and loss contingencies, such as those arising under rate-setting systems.

State Waiver Contingencies Under Medicare

7.14. Certain states (referred to as *waiver states*) have received permission to determine rates of payment for Medicare patients in accordance with a statewide rate-setting method different from the method used by the federal program. A condition for Medicare participation in a state waiver program typically requires that Medicare expenditures in that state not exceed prescribed limits. If Medicare expenditures exceed prescribed limits, the excess may be recoverable by the federal government depending on the conditions of the waiver. FASB Statement No. 5 provides guidance with respect to accounting for loss contingencies, such as those arising under state Medicare waivers.

Premiums and Stop-Loss Insurance Receivables

7.15. Some health care entities contract to provide comprehensive health care services for a fixed period in return for fixed periodic premiums. Many of those entities may transfer a portion of their financial risks under the contract to another organization by purchasing stop-loss insurance. Receivables of those entities may include uncollected premiums and amounts recoverable from stop-loss insurers reduced by appropriate valuation allowances.

SOP 89-5, included as appendix B of this guide, provides guidance on applying generally accepted accounting principles for stop-loss insurance costs of providers of prepaid health care services.

Financial Statement Presentation

Accounts Receivable for Health Care Services

7.16. Receivables for health care services, less an allowance for uncollectibles, discounts, and contractual adjustments, are reported as current assets in general funds. If the terms of payment have been extended beyond one year from the date of the balance sheet, that portion is classified as noncurrent. Although the aggregate amount of receivables may include balances due from patients and third-party payors (including final settlements and appeals), the amounts due from third-party payors for retroactive adjustments of items such as final settlements or appeals are generally reported separately in the financial statements.

Interfund Receivables

7.17. If general-purpose financial statements classify assets and liabilities into fund groups, interfund receivables or payables are reported separately by fund. They are also classified as current or noncurrent in general funds in conformity with generally accepted accounting principles. If general-purpose financial statements do not classify assets and liabilities into fund groups, interfund receivables or payables are eliminated by adjusting the related cash and investment accounts of the respective funds, resulting in the reporting of those accounts as if the cash or investments were actually exchanged. However, if formal interfund borrowing agreements exist, the circumstances and the terms of the borrowing agreement are disclosed.

Pledges

7.18. Pledges are reported in the period in which they are made to the entity, net of an allowance for uncollectible amounts. Pledges are classified as unrestricted (general funds) or donor-restricted (restricted funds). Unrestricted pledges are reported in the statement of revenue and expenses. If part of the pledge is to be applied during some future period, that part is reported in the general fund in the period in which it is made as deferred revenue

or, if restricted, as an addition to donor-restricted funds. If pledges are restricted in any other way, they are reported as additions to donor-restricted funds.

Other Receivables

7.19. Other receivables are reported net of the related allowance for uncollectible amounts.

Auditing

7.20. In general, receivables, particularly those arising from health care services, are material to the financial position of health care entities. Specific audit objectives, selected control procedures, and auditing procedures that should be considered by the independent auditor as they relate to the major components of receivables of health care entities are presented in the table at the end of this chapter (pages 59 to 67).

Other Audit Considerations

7.21. Direct confirmation of amounts due from discharged patients and third-party payors may be an appropriate audit procedure for obtaining evidence as to the existence and accuracy of amounts due. However, many patients whose accounts are expected to be paid by a third-party payor may not have received bills, and many third-party payors may be unable to respond to confirmation requests on specific account balances. In addition, obtaining confirmation of receivables from patients who are not discharged may be impracticable because those patients may not know the amount of their indebtedness until they are discharged.

7.22. If confirmation of amounts due from patients and third-party payors is impracticable, or determined not to be efficient or effective, the independent auditor should use alternate procedures such as the following:

- Comparing patient accounts to documentation contained in medical records.
- Reviewing and testing subsequent receipts.
- Analyzing accounts that have been written off and authorized to be written off as uncollectible and those contractual adjustments recorded in the subsequent period.
- Confirming third-party payment rates with third-party payors.

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
Receivables for Health Care Services			
Existence	Amounts reported in the financial statements represent valid receivables, which do not include charity care balances.	Admission or registration procedures ensure that complete and accurate accounts receivable and collection information is gathered, such as signed authorization for admission, patient or guarantor credit and billing information, and insurance coverage or assignment.	Review admission and registration documents to determine that information required for accurate billing and collection is obtained.
		Procedures provide reasonable assurance that services rendered to patients are medically necessary.	Review medical records to determine that services rendered were ordered by the physician and approved for medical necessity.
		A complete medical record is prepared, including the physician's discharge summary and the physician's statement attesting to the narrative description of the principal diagnosis and other clinical data.	Review medical records to determine that the physician's discharge summary and attestation are prepared and that they have been completed within the time frame established by the third-party payor.

(continued)

AUDIT CONSIDERATIONS (cont.)

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
Receivables for Health Care Services (cont.)			
			Request confirmation of amounts due from discharged patients and third-party payors (see paras. 7.21 and 7.22).
		Procedures ensure that amounts due from third-party payors for individual accounts are properly supported.	Review billings to or approvals from third-party payors and subsequent receipts, to determine that amounts are valid receivables.
			Review the results of peer review organization (PRO) and insurance company reviews for evidence that might indicate receivables may not be realized.
		Procedures ensure the proper recording of cash receipts.	Trace receipts applicable to specific accounts to detailed accounts receivable records.

		Procedures ensure charity care balances are identified and excluded from gross receivables.	Review management policy for determining charity care. Test procedures to distinguish charity care from bad debts. Review policy and reasonableness of charity care measurement.
Completeness	Amounts reported in the financial statements are complete and are properly calculated and accumulated.	Numeric or other controls over individual patient accounts are maintained.	Test numeric or other controls over patient accounts.
		Procedures ensure that detailed accounts receivable records are routinely compared with control accounts and third-party payor logs, differences are investigated and reconciled, and if necessary, adjustments of errors are made promptly.	Compare detailed accounts receivable records with control accounts and third-party payor logs, and investigate reconciling items.

(continued)

AUDIT CONSIDERATIONS (cont.)

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
Receivables for Health Care Services (cont.)			
Valuation	Receivables are reported in the financial statements at net realizable value.	Allowances for uncollectibles and contractual and other adjustments are periodically reviewed by management to ensure that receivables are reported at estimated net realizable value. Write-offs and allowances for uncollectibles are identified and approved in accordance with the entity's established policy.	Review and test the method used to determine the allowances for uncollectibles. Determine that patient accounts are appropriately classified by payor (for example, Medicare and self-pay) to evaluate collectibility. Test Medicare logs for accuracy and completeness. Test and analyze aged accounts receivable trial balances, collection trends, delinquent accounts, subsequent period write-offs, and economic or other factors used to determine the allowance for uncollectible accounts. Review collections on accounts previously written

	off to ascertain that they have been properly recorded and reported.
	Review pledges and other receivables for collectibility.
Medical records information results in proper DRG assignments for the Medicare PPS (or similar state or other third-party payment systems).	Compare billings with medical records and determine that the medical information results in proper DRG assignments and billing amounts.
Medical records personnel are properly trained and supervised to provide for proper DRG coding.	Review procedures for training medical records personnel on DRG coding.
Procedures ensure prompt coding of Medicare patient data.	Review files to determine if coding is done promptly and if follow-up is done routinely.
Medical records (primarily for Medicare patients) are subject to a second independent coding review.	Review documentation supporting a second independent coding review.
	Confirm third-party payment rates with third-party payors and test rates for propriety.

(continued)

AUDIT CONSIDERATIONS (cont.)

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
Receivables for Health Care Services (cont.)			
			Test discounts to HMOs, PPOs, and similar organizations based on related contracts.
Presentation and disclosure	Significant contractual arrangements with third parties are disclosed.		Determine that significant contractual arrangements under third-party contracts are disclosed.
Estimated Third-Party Settlements			
Existence	Amounts reported in the financial statements represent valid receivables.	Procedures ensure that estimated third-party settlements are determined in accordance with the reimbursement and rate-setting methodologies applicable to the entity.	Request confirmations, or review correspondence, from significant third-party payors related to (1) interim payment rates applicable to periods for which final settlement has not been made, (2) the amount of interim or final settlements made during the period, (3) the current status of proposed third-party payor audit adjustments, and (4) the amount of advances out-

			standing at the balance sheet date.
Completeness; valuation	Amounts included in the financial statements are accurate and complete.	Procedures ensure that estimated third-party settlements are accurately calculated and reported.	Test cost reimbursement reports and other settlement reports to determine that they are prepared on the basis of the appropriate principles of reimbursement. Review third-party payor audit reports and adjustments for prior years' cost reports or settlements to consider whether (1) the effect of such adjustments has been properly reported in the financial statements and (2) adjustments of a similar nature apply to the current period. Determine that the effects of timing differences resulting from third-party payor reimbursement matters are properly accounted for and reported.

(continued)

AUDIT CONSIDERATIONS (cont.)

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
Estimated Third-Party Settlements (cont.)			
			Test computations made to determine the amount of retroactive adjustments that are reported in the current period.
			Determine that the effect of Medicare, Medicaid, or other payment denials resulting from PRO and similar reviews are properly recorded.
			Obtain a representation from management that provisions for estimated retroactive adjustments by third-party payors under reimbursement agreements for open years are adequate.
Presentation and disclosure	Amounts reported in the financial statements are presented properly, and all required disclosures are made.		Determine that the tentative nature of third-party settlement amounts are properly disclosed.

			Determine that amounts related to pending claims or appeals are properly reported and disclosed in accordance with FASB Statement No. 5, *Accounting for Contingencies,* and that changes in estimates are reported in accordance with APB Opinion No. 20, *Accounting Changes.*
Interfund Accounts			
Valuation; presentation and disclosure	Interfund receivables are properly reported at net realizable amounts.	Interfund borrowings are approved by the governing board and are periodically evaluated for collectibility.	Review minutes and other supporting documents authorizing interfund loans, and assess collectibility by reviewing the availability of resources to repay the loan.

Chapter 8

Property and Equipment, Supplies, and Other Assets

8.1. Health care entities use various types of property and equipment. Those assets may be significant to the financial position of institutional health care entities, such as hospitals and nursing homes. Typical accounts used to record property and equipment transactions are land, land improvements, buildings and improvements, leasehold improvements, equipment (fixed and movable), leased property and equipment, accumulated depreciation and amortization, and construction in progress.

8.2. Supplies are not usually significant to the financial position of health care entities. However, because of the volume of supply transactions, they may significantly affect operations. Supplies typically include medical and surgical supplies; pharmaceuticals; linens, uniforms, and garments; food and other commodities; and housekeeping, maintenance, and office supplies.

8.3. Other assets may include prepaid expenses, deposits, and deferred expenses.

Accounting

8.4. Accounting for property and equipment, supplies, and other assets of health care entities is similar to methods used by other business organizations, except that some health care entities may account for property and equipment in general or restricted funds, as discussed in paragraphs 8.6 and 8.7.

8.5. Depreciation and amortization of property and equipment is recorded in conformity with generally accepted accounting principles. Useful lives assigned to depreciable assets should be reasonable, based on the circumstances. The American Hospital Association publishes useful guidelines for classifications and estimated useful lives for property and equipment used by hospitals. Those guidelines may also be useful to other health care entities.

Financial Statement Presentation

8.6. Except as indicated in paragraph 8.7, property and equipment of health care entities that use fund accounting for external financial reporting purposes is reported in general funds, because segregation in a separate fund implies the existence of restrictions on those assets. Property of general funds not used for operations (for example, property acquired for future expansion or investment purposes) is presented separately. Donor or legal restrictions on the proceeds from the disposition of property and equipment are disclosed.

8.7. Property and equipment of donor-restricted funds (for example, property and equipment received as a donation to endowment funds) is reported in the appropriate donor-restricted fund.

8.8. Financial statement presentation of supplies and other assets of health care entities is similar to that of other business organizations.

Auditing

8.9. Audit objectives for property and equipment, supplies, and other assets of health care entities are similar to those of other organizations. In addition, the independent auditor may need to consider the specific audit objectives, selected control procedures, and auditing procedures as presented in the table at the end of this chapter (pages 72 to 73).

Other Audit Procedures

8.10. The independent auditor may review and evaluate the entity's supplies inventory procedures, including policies and procedures used to identify, value, and dispose of obsolete supplies. Specialists from independent organizations are frequently used to count and price inventories of pharmaceuticals and medical supplies. The independent auditor may wish to observe physical counts and test pricing to the extent considered necessary in the circumstances.

8.11. Health care entities sometimes receive free merchandise, pharmaceuticals, food, and other items. The auditor may wish to consider determining whether control procedures for those items exist and test the documentation used to value and record such items.

8.12. A health care entity may have access to the use of property and equipment under a variety of arrangements. It may (*a*) own the property and equipment, (*b*) rent the property and equipment from independent or related organizations, (*c*) use property and equipment provided by a related organization (such as a religious order) or by unrelated organizations under affiliation programs, or (*d*) use property and equipment provided by a government agency or unit or a government-related hospital district. The independent auditor should inquire into, and the financial statements should disclose, the nature of any relationship between the health care entity and lessors, bailors, or other owners of property. With respect to leases, FASB Statement No. 13, *Accounting for Leases*, as amended and interpreted, provides accounting guidance.

8.13. In the absence of adequate property records, historical cost-based appraisals may be obtained for financial reporting purposes. If such appraisals are used, the independent auditor should consider reviewing the documentation, calculations, and other factors used to develop them. In addition, SAS No. 11, *Using the Work of a Specialist*, provides useful guidance in evaluating work performed by an appraiser.

8.14. In evaluating capitalization policies, the independent auditor should consider whether interest has been capitalized in accordance with the provisions of FASB Statement No. 34, *Capitalization of Interest Cost*, and related amendments and FASB Statement No. 62, *Capitalization of Interest Cost in Situations Involving Certain Tax-Exempt Borrowings and Certain Gifts and Grants*.

8.15. In evaluating the entity's depreciation policies, the independent auditor may wish to refer to the American Hospital Association's *Guidelines for Assigning Useful Lives*, which is revised periodically and sets forth plant asset classifications and the estimated useful lives of depreciable assets. The auditor should also be aware that social, economic, and scientific advances in the health care industry make obsolescence an important factor to be considered when evaluating depreciation policies and methods.

AUDIT CONSIDERATIONS

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
Donated Property and Equipment			
Valuation	Donated property and equipment is reported at fair market value at the date of donation.	Procedures ensure that the donation of property and equipment is known and recorded and that documentation supports the determination of the fair market value.	Review documentation supporting the determination of the fair market value.
Presentation and disclosure	The receipt of donated property and equipment is initially reported in a restricted fund.		Review donated property and equipment transactions for propriety of classification.
Property and Equipment Not Held for Use in Operations			
Presentation and disclosure	Property and equipment not used for health care operations is separately reported.	Property records segregate property and equipment not used for operating purposes.	Determine that property held for purposes other than health care operations is reported separately.

Property and Equipment Additions

Rights and obligations	For purposes of cost reimbursement and revenue recognition, appropriate health care planning agency or other regulatory agency approvals, if required, have been obtained for property and equipment additions.	Management regularly monitors compliance with health care planning agency regulations related to additions to property and equipment.	Determine compliance with health care planning agency or other regulatory agency requirements.

Chapter 9

Current Liabilities and Long-Term Obligations

9.1. Current liabilities may include the following: notes payable to banks; the current portion of long-term debt; accounts payable; advances from and amounts payable to third-party payors for estimated and final reimbursement settlements; refunds to, and deposits from, patients and others; deferred revenue; accrued salaries and payroll taxes; and other accruals such as pension or profit-sharing contributions, compensated absences, and income and other taxes. In addition, there may be a current portion of estimated malpractice costs that is discussed in chapter 10.

9.2. Long-term obligations may include notes, mortgages, capital leases, bonds, and obligations under continuing-care contracts. They may also include estimated malpractice costs and risk-contract-recognized losses that are discussed in chapter 10 and appendix B.

Accounting

9.3. Accounting for current liabilities of health care entities is similar to that of other business organizations. Health care entities are usually labor-intensive, and many provide employees with compensated absences, such as for holidays, vacations, and illnesses. Liabilities related to such absences are accounted for in accordance with FASB Statement No. 43, *Accounting for Compensated Absences.*

9.4. One form of financing used by not-for-profit health care entities is the issuance of tax-exempt bonds or other tax-exempt obligations issued through financing authorities. Not-for-profit health care entities report as liabilities in general funds those tax-exempt obligations that are issued for their benefit; it is understood that they are responsible for repayment when the obligations are issued.

9.5. New obligations may be incurred in an advance refunding or for the purpose of early retirement or extinguishment of debt. Those transactions are recorded in accordance with FASB Statement No. 4, *Reporting Gains and Losses from Extinguishment of Debt*, and amendments and FASB Statement No. 76, *Extinguishment of Debt*. GASB Statement No. 7, *Advance Refundings Resulting in Defeasance of Debt*, requires governmental health care entities to make certain disclosures about debt defeasance transactions.

9.6. Accounting for notes, mortgages, bonds, and leases is the same for health care entities as for other business organizations.

Obligations Under Continuing Care Contracts

9.7. CCRCs use a variety of methods to charge residents for services and the use of facilities. Three prevalent methods are—

a. *Advance fee.* Under the provisions of an individual continuing-care contract, a resident pays an advance fee in return for future services and the use of facilities. Such services generally include meals, laundry, housekeeping, social services, or health care services and are usually provided to the resident for the remainder of the resident's life or until the contract is terminated. Additional periodic fees are not paid, regardless of how long a resident lives or if the resident requires more services than anticipated. The resident generally receives no ownership interest in the facility.
b. *Advance fee with periodic fees.* Under this method, a resident pays an advance fee and periodic fees. Such periodic fees may be fixed, or they may be subject to adjustment for increases in operating costs or inflation or for other economic reasons.
c. *Periodic fees only.* On a monthly, quarterly, or semiannual basis, a resident pays a fee for the use of all services and facilities provided by the community. Such fees may be either fixed or adjustable.

9.8. Advance fees received may be refundable, either fully or partially, depending on the occurrence of some future event. Because of contractual requirements, statutory requirements, or established policy, some CCRCs refund unamortized fees to a resident on withdrawal or on termination of the contract, or to the estate on death. Others make no refunds or make refunds for a limited time, such as during a trial period.

9.9. If advance fees and periodic fees are insufficient to meet the costs of providing future services to and the use of facilities by current residents, the CCRC's obligation to provide future services and the use of facilities continues, generally without additional compensation. Accordingly, such liabilities should be accrued and reported currently.

9.10. Because of diversity in accounting and reporting for the obligation to provide future services to and use of facilities by current residents, refundable and nonrefundable fees, and the costs of acquiring contracts, the AICPA Accounting Standards Executive Committee has prepared a proposed statement of position titled *Accounting and Reporting by Continuing-Care Retirement Communities for Fees and the Obligation to Provide Future Services and the Use of Facilities, and for Initial Direct Costs of Acquiring Continuing-Care Contracts.*

Tax Considerations for Not-for-Profit Health Care Entities

9.11. Many health care entities operate as not-for-profit entities. The following sections discuss tax considerations for not-for-profit entities. The discussions are not all-inclusive, nor are they intended to replace appropriate research for an entity's tax matters. Tax considerations of investor-owned health care entities are not discussed in this guide due to the individual circumstances to which they apply and the continual changes in tax laws affecting those organizations.

Entities Owned and Operated by State and Local Governments

9.12. Those health care entities that are owned and operated by a state or local government are exempt from federal income tax pursuant to IRC sec. 115 and are also exempt from the federal income tax filing requirements. Such organizations are not only exempt from the regular federal income tax but also from the tax on unrelated business income. If a health care entity is owned and operated by a separately constituted authority or other legal entity, the entity's management should consider whether such authority or other legal entity is properly organized to preserve qualification of tax-exemption pursuant to IRC sec. 115. In some cases, state or local governmental entities will secure tax-exempt status as a section 501(c)(3) organization. If exemption as a section 501(c)(3) organization is secured, the entity may become subject to federal

income tax and the related filing requirements on the same basis as other tax-exempt entities.

Tax-Exempt Entities

9.13. Not-for-profit health care entities usually seek exemption from federal income tax under IRC sec. 501(a). Under IRC sec. 501(a), entities organized and operated exclusively for religious, charitable, or education purposes, as described in IRC sec. 501(c)(3), are exempt from federal income taxation. The following are additional requirements for such entities:

- No part of the entity's net earnings, either directly or indirectly, inure to any private shareholder or individual.
- No substantial part of the entity's activities consists of carrying on propaganda or otherwise attempting to influence legislation. (IRC sec. 501(h) provides a limited exception to the general rule that public charities may not incur expenditures to influence legislation.)
- The entity does not participate in, or intervene in, any political campaign on behalf of any candidate for public office.

9.14. The term *charitable* is used in IRC sec. 501(c)(3) in its generally accepted legal sense. Providing health care to the community is considered a charitable activity. Therefore, provided a health care entity is not organized or operated for the benefit of private interests (such as designated individuals, the creator or his family, shareholders of the entity, or persons controlled directly or indirectly by such private interests), it would generally qualify as a section 501(c)(3) organization.

9.15. The IRS has ruled in Revenue Ruling 56-185, as modified by Revenue Ruling 69-545, that in order for a hospital to establish its exemption as a public charitable organization under IRC sec. 501(c)(3), it must—

a. Be organized as a nonprofit charitable organization for the purpose of operating a hospital for the care of the sick.

b. Be operated for the care of all persons in the community able to pay the cost thereof, either directly or through a third-party reimbursement.

c. Not restrict use of its facilities to a particular group of physicians and surgeons to the exclusion of all other qualified doctors.

d. Not permit any of its earnings to benefit, directly or indirectly, any private shareholder or individual.

9.16. The IRS has ruled in Revenue Ruling 72-124 that in order for a nursing home to establish its exemption as a public charitable organization under IRC sec. 501(c)(3), it must be operated to meet the primary needs of the elderly for housing, health care, and financial security. Operating for financial security generally means that an individual will be maintained in residence even if such individual can no longer pay residence fees.

9.17. The IRS provides the following publications that cover specific aspects relating to exempt organizations:

- Publication 557, *How to Apply for and Retain Exempt Status for Your Organization*
- Publication 578, *Tax Information for Private Foundations and Foundation Managers*
- Publication 598, *Tax on Unrelated Business Income of Exempt Organizations*

In addition, the IRS publishes the *Internal Revenue Service Exempt Organizations Handbook.*

Determination of Tax-Exempt Status

9.18. To obtain tax-exempt status, an entity must request a determination of its status from the IRS. The independent auditor should obtain a copy of the ruling or latest determination letter received from the IRS to gain assurance that the organization does in fact qualify as a section 501(c)(3) organization. In addition, if the original exemption letter was dated prior to October 9, 1969, the independent auditor should also obtain a copy of the entity's determination letter that indicates that the entity is not a private foundation as described in IRC sec. 509(a). (Exempt entities qualified under IRC sec. 501(c)(3) are presumed to be private foundations unless specifically excluded by the IRS.) Private foundations are subject to an excise tax on investment income and must file Form 990-PF, "Return of Private Foundation Exempt from Income Tax."

9.19. The independent auditor should consider obtaining a copy of any revenue agent's reports issued during the current year. The independent auditor should also discuss the current status of any open IRS examinations with the entity's management and consider the effects, if any, of current and prior examinations on the financial statements related to the existence of contingent liabilities for unrelated business income tax, additional payroll tax liabilities, or penalties and interest on delinquent taxes.

9.20. During the course of the audit, the independent auditor should be alert for changes in the governing instruments of the entity that could affect its tax-exempt status. In addition, the independent auditor should review the minutes for the current year, as well as discuss with the entity's management whether the organization has engaged in any new or unusual activities that could affect its tax-exempt status.

9.21. Appropriate written representation should be obtained from management regarding the entity's tax matters. Consideration should be given to appropriateness of disclosures of the tax-exempt status and any other significant tax matters.

Private Inurement

9.22. Under Section 501(c)(3) no part of the net earnings of the charitable organization shall inure to the benefit of any private shareholder or individual. A private shareholder or individual refers to a person or persons having a private or personal interest in the activities of the organization. The IRS has stated that physicians have a personal or private interest in the activities of a hospital and could be subject to the private inurement proscription.

Unrelated Business Income Tax

9.23. Although not-for-profit entities may be exempt from federal income tax, they nevertheless may be subject to tax on unrelated business income. The objective of the tax on unrelated business is to place such activities on the same basis as that of taxable entities. Unrelated business income is the income from any regularly carried-on trade or business, the conduct of which is not substantially related to the exercise or performance of the organization's exempt purpose or function. The fact that proceeds from an activity are used exclusively for the entity's exempt purpose does not make the activity substantially related to its exempt purpose or function. As is the case with most tax definitions, there are qualifications and exceptions. Some of the more significant exclusions from this tax include—

- An annual specific deduction for certain limited activities.
- Income from activities of which substantially all the work is performed by unpaid volunteers.
- Income from activities carried on for the convenience of the entity's patients, officers, or employees.

- Dividends, interest, annuities, royalties, capital gains and losses, and rents from real property, with two major exceptions. The first is that income from investments that are debt-financed and otherwise not functionally related to the exempt purpose is taxable. The second major exception makes taxable the interest, annuities, royalties, and rents received from a controlled (80-percent-owned) taxable corporation or partnership unless this entity is engaged in an activity that would have been exempt if directly carried on by the not-for-profit organization.

9.24. Some of the more common situations that can arise in connection with unrelated business income are discussed briefly in the following paragraphs. The tax regulations are very specific in defining terms such as *regularly carried on* and *patient*.

9.25. The entity may make pharmaceutical sales to the general public and not have the income from these sales subject to the tax on unrelated business income if the sales are not frequent and continuous and if the entity does not generally make its pharmaceutical facilities available to the general public. However, if the entity operates a pharmacy in a medical office building for the convenience of physicians' private patients, the earnings derived from these operations will likely be considered taxable.

9.26. If an entity operates a gift shop that is patronized primarily by patients, visitors making purchases for patients, and employees, the operation of such a gift shop would generally not be classified as an unrelated trade or business, provided the entity does not encourage the general public to use this facility. Similarly, if an entity operates a cafeteria or coffee shop primarily for the use of visitors, patients, and employees, the operation of such a cafeteria or coffee shop would generally not be a taxable operation, provided the entity does not encourage the general public to use these facilities or externally advertise the existence of these facilities.

9.27. Income attributable to the use of a parking lot by patients, visitors, and employees would be exempt from the tax on unrelated business income. However, if the entity leases spaces in its parking lot to the general public, the additional earnings from this rental operation would probably be subject to the tax on unrelated business income. In addition, if the renting of spaces in the parking lot to the general public was so significant that the rental space made available to the entity's patients, visitors, and employees was only a small portion of the total space available, the IRS might contend that the entire net income from the parking lot is taxable.

9.28. Rental income received by a not-for-profit entity for the leasing of property owned by it may or may not be subject to tax. For instance, if a medical office building is leased to doctors who contribute significantly to the operation of the entity and greatly aid the entity in providing better and more efficient medical assistance to the community, the rentals on such a building would not be subject to tax. However, when rent is received on property that is debt-financed and the property does not contribute significantly to the operation of the entity for the benefit of the community, ascertaining whether the leasing of the medical office building is substantially related to the entity's exempt purpose or function must be based on the existing facts in each situation.

9.29. The need for detailed recordkeeping requirements is greatly increased when a tax-exempt organization engages in unrelated business activities. If taxable activities are performed by a tax-exempt organization, all direct and indirect expenses should be identified and charged or allocated on an appropriate basis to the taxable activities. Unrelated business taxable income must be reported annually on Form 990-T, "Exempt Organization Business Tax Return."

9.30. Unrelated business taxable income may be generated when a not-for-profit health care entity has business dealings with affiliated organizations. The sale of products or services, and the receipt of passive income by the entity, are potential sources of that taxable income. Sales of products or services by a not-for-profit entity to an affiliated entity may be subject to tax whether or not the purchasing entity is a not-for-profit entity. Those sales are generally exempt from tax only when the sale promotes the exempt purpose of the selling organization. When the sale is not related to the exempt purpose of the selling organization, the income may be subject to unrelated business income tax.

9.31. An exception may be applicable for sales that are not part of a regularly carried on activity. If an activity is not regularly carried on, the income from the activity may be excluded from treatment as unrelated business taxable income. Federal tax regulations define the term *regularly carried on.*

9.32. The rule that generally exempts the receipt of passive income by a not-for-profit entity is partially nullified when the passive income is received from certain affiliated organizations. This exception relates to interest, annuities, royalties, and rents. It affects affiliated organizations that are controlled by the not-for-

profit entity. If the affiliated entity is itself a not-for-profit entity, control is defined in terms of control over the appointment of directors or trustees. If the affiliated entity is a taxable entity, control is defined in terms of ownership of the combined voting power of all classes of stock entitled to vote. The specified passive income received by the not-for-profit entity is taxed based on a ratio of the unrelated business income of the affiliated entity to its total income. Federal tax regulations provide guidelines for calculating this ratio.

Arbitrage Restrictions

9.33. The Tax Reform Act of 1986 added new arbitrage restrictions whenever tax-exempt bond proceeds are invested and produce a yield higher than the interest rate on the bonds. Such bonds will not enjoy a tax-exempt status unless a special tax or rebate is paid to the U.S. Treasury Department. The act also added reporting requirements that must be adhered to for the bonds to retain their tax-exempt status.

Financial Statement Presentation

9.34. Financial reporting and disclosure requirements for current liabilities and long-term obligations of health care entities are the same as for other business organizations. In addition, with respect to continuing-care retirement communities, the method of accounting for advance fees, the method of calculating the obligation to provide future services and use of facilities, and the refund policy for refundable fees is disclosed in the financial statements.

Auditing

9.35. Audit objectives for current liabilities and long-term obligations are similar to other organizations. In addition, the independent auditor may need to consider the following specific audit objectives, selected control procedures, and auditing procedures.

AUDIT CONSIDERATIONS

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
Interfund Accounts			
Presentation and disclosure	Interfund accounts are in balance and properly reported.	Self-balancing funds are established in the accounting records.	Determine that interfund accounts are in balance and interfund transactions are properly recorded. Determine that interest expense, if any, on interfund loans is reported in the debtor fund.
Third-Party Advances			
Completeness; presentation and disclosure	Third-party advances are properly reported.	Receipts from third-party payors are adequately reviewed to determine the portion received that constitutes an advance.	Confirm Medicare, Medicaid, and other third-party advances.
Contracts With Physicians, Specialists, Related Parties, and Others			
Completeness	All liabilities related to contracts with such parties are reported in the balance sheet. Liabilities related to contracts with physicians, spe-	Contracts are reviewed and authorized in accordance with entity policy.	Read contracts with such parties for evidence of unrecorded liabilities. Test balances based on contract provisions.

	cialists, related parties, and others are properly stated.		
Presentation and disclosure			Review financial statements to determine that contracts with related parties and significant contractual agreements are disclosed.
Deferred Revenues			
Completeness; rights and obligations; presentation and disclosure	Deferred debits or credits that relate to third-party timing differences are properly reported.	The effects of timing differences are properly allocated between current and noncurrent.	Review changes in account balances since prior year-end.
		Reversals of timing differences are monitored. Procedures exist for identifying permanent and temporary timing differences.	Analyze the balances of timing differences and consider their probability of future realization or recognition.
	Deferred revenue and the obligation to provide future services to, and use of facilities by, current residents of continuing care retirement communities are recognized and properly reported.	Procedures ensure that amounts received as advance fees are recognized in the proper period and the obligation to provide future services and use of facilities is reported.	Test procedures related to the recognition of advance fees and determine that the obligation to provide future services and use of facilities is properly reported.

(*continued*)

AUDIT CONSIDERATIONS (cont.)

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
Deferred Revenues (cont.)			
	Deferred revenues that relate to educational programs and grants are properly reported.	Management regularly monitors compliance with terms of educational programs and grants.	Test the computation of deferred revenue amounts in accordance with the terms of the programs and grants.
Taxes			
Rights and obligations	The not-for-profit entity has obtained a qualifying income tax exemption from the government authority.	Management monitors compliance with applicable tax regulations.	Determine that the not-for-profit entity has obtained a determination of its tax-exempt status. Review minutes for changes in the governing instruments of the entity that could affect its exempt status. Determine the effect of any new, expanded, or unusual activities on the entity's tax-exempt status. Determine whether the entity is a private foundation as described in Section 509(a) of the Internal Revenue Code.

Liabilities and contingencies for taxes due for the current and prior years are accrued or disclosed in the financial statements in accordance with GAAP.		Review revenue agent's reports for evidence of additional tax liabilities or contingencies. Determine that tax returns have been filed on a timely basis.
Determine if unrecorded or potential tax liabilities exist or inurement issues exist.	Tax returns are prepared by knowledgeable personnel and reviewed by outside tax advisers, if necessary.	Review prior-year tax returns. Review minutes and accounting records for evidence of unrelated business activities.
	Transactions are reviewed for their effect on tax status and tax liabilities.	Determine if a private inurement situation may exist by reviewing contracts or arrangements between private shareholders or other individuals and the entity. Determine that direct and indirect expenses are properly charged or allocated to unrelated business income. Review and test the computation of the unrelated business income tax liability.

(continued)

AUDIT CONSIDERATIONS (cont.)

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
Taxes (cont.)			
Presentation and disclosure	The entity's tax-exempt status and tax contingencies are disclosed in the notes to the financial statements.		Determine that the entity's tax-exempt status is disclosed in the notes to the financial statements. Determine whether there are any contingencies resulting from revenue agent examinations or from years that have not been examined by taxing authorities.
Long-Term Obligations			
Existence; completeness; presentation and maturity	Liabilities relating to refundable fee arrangements are properly accounted for and reported.	Written documentation is prepared for refundable fee arrangements.	Review refundable fee arrangements regarding stipulations for repayments, and determine that such arrangements are properly classified and disclosed in the financial statements.

Chapter 10

Commitments and Contingencies

10.1. Commitments and contingencies may include the following: (*a*) losses arising from malpractice and other claims; (*b*) contingencies related to risk contracting; (*c*) third-party payment and rate-setting programs; (*d*) construction contract commitments; (*e*) the Hill-Burton Act obligation to provide uncompensated care; (*f*) commitments and guarantees that include contractual agreements with physicians, specialists, and others who perform services by arrangement with health care entities; and (*g*) commitments and contingent liabilities related to pension plans, operating leases, purchase commitments, and loan guarantees.

Accounting

10.2. FASB Statement No. 5, *Accounting for Contingencies*, as amended and interpreted, and FASB Interpretation No. 14, *Reasonable Estimation of the Amount of a Loss*, provide guidance on accounting for contingencies. The application of that guidance to malpractice loss contingencies and related subjects is discussed in paragraphs 10.3 through 10.22. Specifically, these paragraphs provide guidance on applying generally accepted accounting principles in accounting for uninsured asserted and unasserted medical malpractice claims, claims-made insurance policies and tail coverage, retrospectively rated premiums, captive insurance companies, and trust funds. Governmental health care entities should also consider the accounting and disclosure requirements of GASB Statement No. 10, *Accounting and Financial Reporting for Risk Financing and Related Insurance Issues.*

Accounting for Uninsured Asserted and Unasserted Medical Malpractice Claims

10.3. The ultimate costs of malpractice claims, which include costs associated with litigating or settling claims, are accrued when the incidents that give rise to the claims occur, if it can be

determined that it is probable that liabilities have been incurred and the amounts of the losses can be reasonably estimated.

10.4. If it is probable that a loss has been incurred and the information available indicates the loss is within a range of amounts, the most likely amount of loss in the range is accrued. If no amount in the range is more likely than any other, the minimum amount in the range is accrued, and the potential additional loss is disclosed if there is at least a reasonable possibility of loss in excess of the amount accrued. If the range of loss cannot be reasonably estimated, no loss is accrued.

10.5. Estimated losses are reviewed and changed, if necessary, at each reporting date; the amounts of the changes are recognized currently as additional expense or as a reduction of expense.

10.6. Estimated losses from asserted claims are accrued either individually or on a group basis, based on the best estimates of the ultimate costs of the claims. Estimated losses from unasserted claims arising from reported incidents are accrued individually or on a group basis, using the relationship of past reported incidents to eventual claim payments. All relevant information, including industry experience, is used in estimating the expected amount of asserted claims and unasserted claims arising from reported incidents.

10.7. A health care entity accrues estimated losses from unreported incidents based on its best estimate of the ultimate costs. Those estimates are based on all available evidence that is relevant to estimating unreported incidents that have occurred as well as the amount of loss related to those estimated incidents. Such evidence may include industry experience, the entity's own historical experience, and the entity's existing asserted claims and reported incidents. The accrual is limited to an estimate of the losses that will result from unreported incidents that are probable of having occurred before the end of the reporting period.

10.8. In estimating the probability that unreported incidents have occurred, some health care entities may develop a range of possible estimates of the number of unreported incidents, including zero. However, the greater the volume of a health care entity's operations, the greater the likelihood that the entity's minimum estimate of the number of probable unreported incidents will be greater than zero.

10.9. In estimating losses from malpractice claims, a health care entity uses data drawn from industry experience only to the extent

that such data is relevant to developing an estimate that is specific to the entity. The relevance of industry data depends principally on the comparability of the health care entity with the entities whose experiences are used in developing that data. Various factors (such as the nature of operations, size, and geographic location) are considered in assessing comparability. Further, industry data that is not current may not be relevant. How the health care entity plans to use the data affects which factors are more important in a given circumstance, as indicated by the following:

a. In estimating the amount of loss, the nature of the incident would typically be critical in using industry data.

b. In estimating the extent to which unreported incidents have occurred, the comparability of an entity's business activity and risk management system with that of the other entities included in the industry data would be critical in determining whether and how industry experience can be used. The inability to make such comparisons of the risk management systems would indicate that industry data should not be used in estimating the extent of an entity's probable unreported incidents.

10.10. Accrued unpaid claims and expenses that are expected to be paid during the normal operating cycle (generally within one year of the date of the financial statements) are classified as current liabilities; all other accrued unpaid claims and expenses are classified as noncurrent liabilities.

10.11. A health care entity discloses its program of medical malpractice insurance coverages and the basis for any related loss accruals. If the health care entity cannot estimate losses relating to a particular category of malpractice claims (for example, asserted claims, reported incidents, or unreported incidents) in accordance with paragraphs 10.4 through 10.9, the potential losses related to that category of claims are not accrued. However, the contingency is disclosed in the notes to the financial statements, as required by FASB Statement No. 5.

10.12. The FASB is considering the accounting implications of certain discounting applications, including discounting insurance claims. Until the discounting issue is resolved, health care entities that discount accrued malpractice claims disclose in the notes to the financial statements the carrying amount of accrued malpractice claims that are discounted in the financial statements and the interest rate or rates used to discount those claims.

Accounting for Claims-Made Insurance Policies and Tail Coverage

10.13. A claims-made insurance policy represents a transfer of risk within the policy limits to the insurance carrier for asserted claims and incidents reported to the insurance carrier. The policy, however, does not represent a transfer of risk for claims and incidents not reported to the insurance carrier. Consequently, a health care entity that is insured under a claims-made policy recognizes the estimated cost of those claims and incidents not reported to the insurance carrier, in accordance with paragraphs 10.4 through 10.9. This is done unless the health care entity has bought tail coverage and included the cost of the premium as an expense in the financial statements for that period.

Accounting for Retrospectively Rated Premiums

10.14. A health care entity with a retrospectively rated insurance policy whose ultimate premium is based primarily on the health care entity's loss experience accounts for the minimum premium as expense over the period of coverage under the policy and accrues estimated losses from asserted and unasserted claims in excess of the minimum premium, as indicated in paragraphs 10.4 through 10.9. Such estimated losses, however, are not accrued in excess of a stipulated maximum premium. If the health care entity cannot estimate losses from asserted or unasserted malpractice claims, as indicated in paragraphs 10.4 through 10.9, the health care entity discloses the existing contingency in the notes to the financial statements (see paragraph 10.11).

10.15. A health care entity insured under a retrospectively rated policy with premiums based primarily on the experience of a group of health care entities amortizes the initial premium to expense on a pro rata basis over the policy term. The entity also accrues additional premiums or refunds on the basis of the group's experience to date, which includes a provision for the ultimate cost of asserted and unasserted claims before the financial statement date, whether reported or unreported. The health care entity discloses that (*a*) it is insured under a retrospectively rated policy and (*b*) premiums are accrued based on the ultimate cost of the experience to date of a group of entities. If the health care entity cannot estimate losses from asserted or unasserted malpractice

claims, as indicated in paragraphs 10.4 through 10.9, it discloses the existing contingency in the notes to the financial statements (see paragraph 10.11).

Accounting for Medical Malpractice Claims Insured With Captive Insurance Companies

10.16. A majority-owned captive insurance company (for example, a wholly owned captive) is consolidated in accordance with FASB Statement No. 94, *Consolidation of All Majority-Owned Subsidiaries.* Multiprovider captives in which the ownership percentage is 50 percent or less are accounted for in accordance with APB Opinion No. 18, *The Equity Method of Accounting for Investment in Common Stock.*

10.17. A health care entity insured by an unconsolidated multiprovider captive insurance company for medical malpractice claims under a retrospectively rated insurance policy whose ultimate premium is primarily based on the health care entity's experience up to a maximum premium, if any, accounts for such insurance as indicated in paragraph 10.14.

10.18. A health care entity insured by an unconsolidated multiprovider captive insurance company for medical malpractice claims under a retrospectively rated policy based primarily on the experience of a group of health care entities accounts for such insurance as indicated in paragraph 10.15. However, the health care entity considers whether the economic substance of the multiprovider captive is sufficient to relieve the health care entity from further liability. The health care entity discloses that (*a*) it is insured under a retrospectively rated policy of a multiprovider captive and (*b*) premiums are accrued based on the captive's experience to date.

10.19. A health care entity that is insured by a multiprovider captive discloses in its financial statements that it is insured by a multiprovider captive, and it discloses its ownership percentage, if significant, in the captive as well as the method of accounting for its investment in and the operations of the captive. In addition, if the health care entity cannot make the necessary estimates of losses from asserted or unasserted claims, as indicated in paragraphs 10.4 through 10.9, the health care entity discloses the existing contingency in the notes to the financial statements (see paragraph 10.11).

Accounting for Trust Funds

10.20. In general, a trust fund, whether legally revocable or irrevocable, is included in the financial statements of the health care entity. A portion of the fund equal to the amount of assets expected to be liquidated to pay malpractice claims classified as current liabilities is classified as a current asset; the balance of the fund, if any, is classified as a noncurrent asset. Revenues and administrative expenses of the trust fund are included in the statement of revenue and expenses (see chapter 12). In some circumstances, the foregoing may not be possible (for example, if a common trust fund exists for a group of health care entities, if the health care entity is part of a common municipality risk-financing internal service fund, or if legal, regulatory, or indenture restrictions prevent the inclusion of a trust fund in a health care entity's financial statements). In those circumstances, the provisions of paragraphs 10.21 and 10.22 apply.

10.21. In general, estimated losses from asserted and unasserted claims are accrued and reported, as indicated in paragraphs 10.3 through 10.11. The estimated losses are not based on payments to the trust fund. However, the accounting for a health care entity that participates in a pooled fund depends on the extent to which the associated risks and rewards have been transferred to another party. An entity that transfers its risk of loss to the common trust fund and forfeits its rights to any excess funding should expense its contributions and account for its participation in the trust based on the type of coverage obtained (for example, occurrence basis, claims-made, or retrospectively rated). Governmental health care entities that are component units of a state or local government reporting entity and that participate in that entity's risk-financing internal service fund should report claims expenses equal to the charges from the internal service fund if those charges meet the requirements of paragraphs 65 through 68 of GASB Statement No. 10.

10.22. The existence of the trust fund and whether it is irrevocable is disclosed in the financial statements.

Accounting by Providers of Prepaid Health Care Services

10.23. Appendix B contains Statement of Position (SOP) No. 89-5, *Financial Accounting and Reporting by Providers of Prepaid*

Health Care Services. SOP No. 89-5 applies to all providers of prepaid health care services, such as HMOs, comprehensive medical plans (CMPs), physician groups (for example, independent practice associations), and hospitals. It provides guidance on applying generally accepted accounting principles for health care costs, contract losses, stop-loss insurance, and contract acquisition costs of providers of prepaid health care services.

Disclosures

10.24. Appendix B contains specific disclosure requirements applicable to providers of prepaid health care services.

10.25. Disclosure requirements for other commitments and contingent liabilities are similar to those of other business organizations.

Auditing

10.26. Audit objectives and procedures for commitments and contingencies are generally similar to those of other organizations. The independent auditor may need to consider the specific audit objectives, selected control procedures, and audit procedures, as described in the table at the end of this chapter (pages 104 to 106).

Auditing Medical Malpractice Loss Contingencies

10.27. The existence of an insurance policy, by itself, is no assurance that malpractice contingencies are assumed by others. The auditor should review the insurance contracts and determine the extent of the risk retained by the provider. Specific audit procedures to consider include the following:

a. Determine the type (such as occurrence basis or claims-made) and level (per occurrence/in the aggregate) of insurance protection the provider has obtained.

b. Determine if the coverage actually transfers the malpractice risks. Is the insurance with a related party (for example, captive)? Does it provide for retrospective premiums or similar adjustment?

c. Evaluate the financial viability of the carrier.

Once the extent of the risk retained is understood, the auditor will be able to determine the nature, extent, and timing of other audit procedures.

10.28. If a health care entity has transferred the risk of loss to a financially viable third party by purchasing insurance coverage of sufficient limits on an occurrence basis, no additional audit procedures are necessary. If a health care entity retains all or a portion of the risk through self-insurance or the entity purchased a claims-made policy, the independent auditor should perform additional audit procedures to obtain reasonable assurance that the health care entity's accounting for medical malpractice losses is in accordance with generally accepted accounting principles.

10.29. The independent auditor should consider the extent to which the renewal of a claims-made policy or purchase of tail coverage after the balance sheet date, but before the auditor's report is issued, limits the entity's liability exposure as of the balance sheet date. If an entity either renews a claims-made policy or purchases tail coverage, and the new policy covers claims asserted during the new policy term (regardless of when the incident occurred), the entity has transferred to the insurer the risk for that portion of the entity's claims that is expected to be reported during the new policy term (up to the new policy limits). Accordingly, the entity's liability for the incurred-but-not-reported (IBNR) claims transferred would not exceed the premium on the new policy except for anticipated claims in excess of the new policy limits.

10.30. Management's intent to renew a claims-made policy is not sufficient to constitute a limit on (IBNR) claims as of the balance sheet date unless management contractually obligates itself for renewal prior to the auditor's report date, and the cost is expensed in the period covered by the financial statements. This requirement to purchase and to expense tail coverage applies even if state regulations require that renewal of claims-made coverage be offered continually.

10.31. In such cases (that is, if the insured has the unilateral option to purchase tail coverage at a premium that may not exceed a stipulated maximum), if the provider intends to purchase that coverage, the amount of IBNR loss to be accrued may be effectively limited to the maximum tail-coverage premium stated in a policy. However, providers in these circumstances that do not intend to purchase tail coverage may not accrue the cost of obtaining that coverage as a substitute for the IBNR accrual.

Risk Management System

10.32. The auditor should obtain an understanding of the entity's risk management system, which is responsible for the identification and evaluation of incidents that may give rise to malpractice losses. The risk management system should provide reasonable assurance that the incidents that may result in losses are timely identified and effectively managed to minimize losses and safeguard the entity's assets.

10.33. Issues to consider include the following:

- Are policies and procedures adopted for identifying, evaluating, and accounting for malpractice contingencies?
- Are known claims as well as incidents that may result in a loss appropriately documented and controlled?
- Are known claims as well as incidents promptly reported to management, the risk management committee, and the insurer?
- Is the status of litigation regularly reviewed by management and the risk management committee, and are loss estimates prepared by qualified personnel?
- How reliable are prior accounting estimates in light of actual losses?

Auditing Accounting Estimates

10.34. Management is responsible for making the accounting estimates that are included in the financial statements. The auditor is responsible for evaluating the reasonableness of management's estimates. The auditor does this using one or more of the following approaches:

a. Test the process used by management to develop the estimate.

b. Develop an independent expectation of the estimate to corroborate the reasonableness of management's estimate.

c. Review subsequent events or transactions occurring prior to completion of fieldwork.

Auditing Asserted Claims and Unasserted Claims Arising From Reported Incidents

10.35. The auditor should obtain from the provider's management a description and evaluation of all uninsured malpractice contingencies that existed (*a*) at the date of the balance sheet that

is being reported on and (*b*) during the period from the balance sheet date to the date the information is furnished, including those referred to legal counsel. Written assurances should be obtained from management that they have disclosed all such matters required to be disclosed by FASB Statement No. 5.

10.36. The auditor should obtain information on litigation, claims, and assessments from legal counsel and, if appropriate, the outside risk manager and review the accrual for asserted claims and reported incidents not covered by insurers. The auditor compares estimated losses with those of prior periods and considers the adequacy of accruals in light of historical data and present conditions; accruals should include costs associated with litigating and settling claims. In evaluating the information provided by legal counsel, it may be necessary to supplement its written representations with inquiries if the representations are not clear regarding the probability of the litigation outcome or the potential range of loss.

10.37. According to SAS No. 12, *Inquiry of a Client's Lawyer Concerning Litigation, Claims, and Assessments*, a letter of audit inquiry to the lawyer handling the claims is the auditor's *primary means* of obtaining corroboration of the information furnished by management concerning claims made and known incidents for which claims have not been made that are either uninsured or in excess of the insurance coverage. Audit inquiry letters would generally not be required with respect to reported contingencies that were not considered to have a material potential loss.

Auditing Claims Incurred but Not Reported

10.38. The auditor should consider the frequency of losses due to unreported incidents and the magnitude of prior losses and underlying causes for the claims incurred but not reported. If there is a basis for an accrual, the auditor should then determine whether the entity's prior history supports the estimation of the number of claims and the probable settlement value.

10.39. Provider-specific data may include—

- A historical summary of estimated claim values of asserted, unasserted, and closed claims by occurrence period and valuation date. This type of summary is frequently referred to as a *loss development triangle* due to the visual pattern of the data. For the provider's own loss development triangle to be compiled,

the following data elements must be accumulated for each asserted claim and reported incident:

—The date of the occurrence

—The date the claim was first asserted

—The date the claim was paid or settled

—The estimated value of the claim with identification of amounts paid and unpaid at each measurement date (typically quarterly, semiannually, or annually) until the claim is ultimately settled

- Changes in claims reserving or in settlement philosophy on the part of management or an outside claims adjuster (including changes in claims adjuster) and changes in risk management personnel, policies, and procedures.
- Changes such as in the nature of operations, involvement in high-risk programs (such as obstetrics) or changes in physician credentialing procedures that could affect the relevance of historical data.
- A historical summary of numbers of exposures (such as beds, outpatient visits, and employed physicians) by fiscal period.

10.40. Provider-specific data may provide a basis for (*a*) determining the need for an accrual of an amount for reported and unreported incidents, (*b*) determining the relationship of historical reported incidents to eventual claims payments, (*c*) determining the need for a development factor to project occurrence period losses to their ultimate value, and (*d*) determining the frequency and estimated loss value of reported and unreported incidents.

Use of Industry Data

10.41. Industry data may be useful if it is current and relevant to the health care entity. The independent auditor should have a sufficient knowledge of the source and usefulness of the data included in the industry database. The auditor may wish to consult with a qualified actuary in making this determination.

10.42. Major sources of industry data relevant to medical professional liability are (*a*) insurance companies, (*b*) independent data bases such as those maintained by consulting firms and (*c*) insurance industry statistical or rating bureaus such as the Insurance Services Office (ISO). Other sources also may provide current, useful, and relevant information on medical malpractice experience. Each of

those sources accumulates loss and exposure experience and publishes results in rate filings and various experience reports supporting rates.

10.43. The following are key types of information that are provided by these sources of industry data and that can be useful in estimating medical malpractice liabilities:

a. Loss experience for a group of health care providers
b. Relevant measures of exposure for that same group of providers
c. Historical loss reporting patterns
d. Historical loss payment patterns
e. Historical trends of loss frequency and severity
f. Loss costs by type of exposure, usually for a much broader group of providers

10.44. Actuaries may use this data to derive the elements that serve as the basis for the loss estimation process, such as trend factors, increased limit factors, and the credibility of an entity's own data in projecting ultimate losses.

10.45. With an understanding of the types of industry data and their uses in actuarial analyses, the independent auditor should consider whether the industry data is sufficiently current and whether appropriate trend adjustments were made to the data to reflect current conditions. The independent auditor also should consider whether the risk characteristics of the provider were reflected to the extent possible, and how the industry data is adjusted to reflect the business activities and risk management systems of the specific provider. Data or statistics based only on industrywide averages may not be sufficient to satisfy the "probable" and "reasonably estimated" criteria of FASB Statement No. 5.

Demographic and Regulatory Factors

10.46. The health care entity should consider demographic and regulatory factors that may influence the likelihood and ultimate amount of the liability for medical malpractice claims. Factors to consider include the following:

- Occurrence of an incident of malpractice
- Adequacy of the internal claims management process
- Statute of limitations for the period in which a claim is to be reported

- Existence of sovereign or charitable immunity from malpractice liability (for example, certain governmental and not-for-profit providers)
- Statutory limitations of the claim amount
- Historical posture of the entity regarding litigation
- Malpractice history of the medical professionals associated with the treatment
- Age of the patient
- Dependency on the patient by others

Use of Actuaries and Actuarial Methods

10.47. An actuary may be engaged to provide or review the estimate of the medical malpractice loss amount or range of amounts, or to assist in developing certain factors and assumptions used in estimating the malpractice liability. The decision to use an actuary should be based on a consideration of whether (*a*) the estimated claim liability is potentially material to the fair presentation of financial statements in conformity with GAAP and (*b*) special knowledge is required to estimate the claim liability.

10.48. If an actuary is involved in a substantial way in determining the amount of a provider's malpractice self-insurance liability, the independent auditor should follow the requirements of SAS No. 11, *Using the Work of a Specialist*. If an actuary is used, the independent auditor should consider the actuary's professional qualifications, reputation, prior experience in estimating malpractice claim losses, and relationship to the client. There should be an understanding among the auditor, the client, and the actuary of the objectives and scope of the analysis and the methods and assumptions used. The independent auditor should be aware of (*a*) the limitations of assurances in actuarial calculations due to uncertainties and (*b*) restrictions as to the use of the actuarial reports. The independent auditor is responsible for determining the adequacy of the actuary's report for purposes of corroborating the representations in the financial statements. The independent auditor should perform an appropriate test of the accounting data provided by the client to the actuary. Such accounting data may include historical claim experience, policy terms (such as coverage, expiration, deductibles, presence of retrospectively determined premiums, and indemnity limitations), exposure data (such as the number of beds, high-risk medical specialties, outpatient visits,

and emergency room visits), and information about risk management systems, personnel, and procedures.

10.49. An accrual for malpractice losses should be based on estimated ultimate losses and costs associated with settling claims. Accruals should not be based on recommended funding amounts, which in addition to a provision for the actuarially determined liability, also includes a provision for (*a*) credit for investment income and (*b*) a margin for risk of adverse deviation. The malpractice loss accrual should not include risk margins or other general contingency amounts that may exceed the amount of probable loss that should be recorded under FASB Statement No. 5. The following are examples of factors to consider and adjustments that may be required to convert actuarially determined malpractice funding amounts to an appropriate loss accrual to be reported in the financial statements:

- The risk of adverse deviation is an additional cost factor applied to bring a funding requirement to a selected confidence level. This factor does not meet the criteria for recognition as a liability in accordance with FASB Statement No. 5.
- An evaluation should be made of the extent and validity of industry data when the credibility factor actuarial technique is used. The lower the credibility factor, the greater the blending of industry data. This may create an unacceptable level of industry data at lower confidence levels. Further, a low credibility factor may indicate that provider-specific data is not sufficient to support the claims liability estimation process.
- A review of the discounting approach used is necessary to develop the required disclosure. The impact on the discounting calculation of any other adjustment made to the actuarially determined amounts (such as risk of adverse deviation or the credibility of the risk management system) would have to be evaluated.
- A review of the expenses included in the loss estimation process should be made. Such expenses include the expense of settlement and litigation (that is, allocated loss adjustment expenses).

10.50. Limitations on the availability of provider-specific data, lack of a sufficient patient population for claims projection purposes, a very low credibility factor, and a variety of other factors may cause the actuary's estimate of loss to be of limited value in

developing an estimate of the liability under generally accepted accounting principles.

Uncertainties

10.51. Uncertainties arise when the evidence available is insufficient for a reasonable estimation of the effects of the outcome of a particular future event on the current financial statements. Normally, the resolution of the uncertainty is prospective. Sufficient evidence cannot therefore be expected to exist at the time of the audit. In these situations, it cannot be determined what adjustments, if any, to the financial statements may be appropriate. The existence of such an uncertainty, if material, should ordinarily result in the inclusion of an explanatory paragraph in the auditor's report. In certain circumstances, the possible effects of the uncertainty on the financial statements may be so pervasive that the balance of the financial statements has little meaning. In these cases, a disclaimer of opinion may be appropriate.

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
Malpractice Loss Contingencies			
Existence and occurrence; completeness; rights and obligations; valuation	The liability for malpractice claims is properly reported in the balance sheet. All liabilities for malpractice occurrences through the balance sheet date are included. The amount of probable loss that should be accrued is the most likely amount in a range. If no amount in the range is more likely than any other, the minimum amount in the range is accrued. If the amount of loss cannot be reasonably estimated, the nature of the contingency is disclosed.	Insurance coverage is regularly reviewed, including the financial viability of the insurer. The risk management system identifies and monitors malpractice incidents and evaluates associated losses. Risk management personnel are notified promptly of any claims or incidents that could result in a claim; claims and incidents are regularly reviewed by management. Outside legal counsel and insurance carriers review and monitor all claims. The adequacy of malpractice accruals is regularly re-	Review the amount of insurance coverage, the type of coverage (claims-made or occurrence), the deductible provisions, etc., to determine the level of risk that is retained by the entity. Consider the financial viability of the insurance carrier. Test the accuracy and completeness of the incident-reporting and -monitoring system. Send letters of inquiry to malpractice insurance carriers and legal counsel (in accordance with SAS No. 12). Review and test the method of estimating IBNR claims. Review actuarial reports used to estimate the liabil-

viewed by management, including information obtained from qualified specialists. Information supplied to specialists is reviewed for accuracy and completeness; actuarial assumptions are reviewed for compliance with GAAP.	ity for malpractice claims including the IBNR claims. Determine the extent of reliance on actuaries in accordance with SAS No. 11, *Using the Work of a Specialist.*
Provider-specific data is used to determine the amount of probable loss. Use of industry data is limited.	Determine the extent to which provider-relevant industry data is used to estimate the (*a*) accrual for reported and unreported incidents, (*b*) relationship of reported incidents to claims payments, (*c*) need for a development factor, and (*d*) frequency and loss value of reported and unreported incidents.
Changes in the risk management system are communicated on a timely basis.	Determine that additional premiums charged by insurers for retrospectively rated policies are reported as a liability.
	Review prior estimates and historical loss experience.

(*continued*)

AUDIT CONSIDERATIONS (cont.)

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
Malpractice Loss Contingencies (cont.)			
Presentation and disclosure	The program of medical malpractice insurance coverage and the basis for any loss accruals are adequately disclosed in the financial statements.		Determine whether uncertainties related to medical malpractice claims need to be disclosed in the auditor's report. Review disclosures related to medical malpractice insurance for propriety.

Chapter 11

Net Assets (Equity or Fund Balance)

Financial Statement Presentation

11.1. The equity accounts of an investor-owned health care entity are similar to those of other investor-owned businesses. Net assets of not-for-profit and governmental health care entities that report using the disaggregated method are displayed as general and donor-restricted fund balances. Net assets of not-for-profit and governmental health care entities that report using the aggregated method are displayed as unrestricted, temporarily restricted, or permanently restricted fund balances as appropriate.

11.2. The nature of restrictions on donor-restricted resources is disclosed in the financial statements.

Auditing

11.3. The audit objectives for net assets are similar to those of other entities. The independent auditor may need to consider the following specific audit objectives, selected control procedures, and auditing procedures.

AUDIT CONSIDERATIONS

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
Rights and obligations	Resources are used and accounted for in accordance with donor and grantor restrictions.	Restrictions by donors and grantors are properly documented.	Review documentation of contributions for evidence of restrictions.
		Disbursement of donor- or grantor-restricted funds are properly approved.	Test restricted fund disbursements to determine that they comply with donor and grantor restrictions.
Presentation and disclosure	Net assets are properly presented and disclosed in the financial statements.	Procedures ensure proper authorization, recording, and presentation.	Test significant fund balance transactions to determine that they are properly authorized and recorded.
		All interfund transfers are properly approved.	Review documentation supporting restricted fund transactions.
	Each fund is in balance, and financial statement disclosure is proper.	Internal reporting requires each fund to balance.	Determine that each fund is in balance and that financial statement disclosure is proper.

Chapter 12

Revenue, Expenses, Gains, and Losses

Conceptual Framework for Reporting Revenue, Expenses, Gains, and Losses

12.1. FASB Concepts Statement No. 6, *Elements of Financial Statements*, provides a useful conceptual framework for preparers of financial statements to distinguish among elements of financial statements for purposes of display. This chapter draws on the concepts contained in FASB Concepts Statement No. 6 in discussing revenue, expenses, gains, and losses with respect to providers of health care services. Revenues and expenses are generally displayed as gross amounts, whereas gains and losses may be displayed as net amounts. The application of these concepts to the classification of revenue, expenses, gains, and losses in the statement of revenue and expenses of health care entities is discussed in the following paragraphs.

Classification of Revenue, Expenses, Gains, and Losses

12.2. Activities associated with the provision of health care services constitute the ongoing, major, or central operations of providers of health care services. Revenues and expenses arise from those activities. Gains and losses, on the other hand, result from a provider's peripheral or incidental transactions and from other events stemming from the environment that may be largely beyond the control of the provider and its management. As opposed to revenues and expenses, gains and losses occur casually or incidentally in relation to the provider's ongoing activities. The classification of items as revenue or gain and expense or loss therefore depends on the individual health care provider. The

same transaction may result in revenue to one health care provider and gain to another.

12.3. Gains and losses can be further classified as either *operating* or *nonoperating* depending on their relation to a provider's major ongoing or central operations. Many gains and losses are classified as nonoperating because of their peripheral or incidental nature. However, a gain or loss closely related to a provider's ongoing operations may be classified as operating.

Revenue

12.4. Revenue from health care services is usually recorded when the respective service is provided to a patient or resident and is classified based on the type of service rendered or contracted to be rendered. Two examples of revenue for health care services are—

- Patient service revenue, which may be further classified as routine services (for example, room, board, general nursing, and home health), other nursing services (for example, operating room, recovery room, and delivery room), and professional services (for example, physicians' care, laboratories, radiology, pharmacy, and renal dialysis).
- Resident service revenue, which may be further classified as maintenance or rental fees and amortization of advance fees.

12.5. Contributions, tax support, and other subsidies are classified as gains when they are peripheral or incidental to the activities of the health care provider. However, they are classified as revenues in those circumstances in which these sources are deemed to be ongoing major or central activities by which the provider attempts to fulfill its basic function of providing health care services. For example, donors' contributions are revenues to those health care providers for which fund-raising is an ongoing major activity by which the provider attempts to fulfill its basic function of providing health care services. The same donations, however, would be a gain to a health care provider that does not actively seek contributions and receives them only occasionally. Similarly, contributions such as those for endowments are usually gains because they occur only occasionally for most health care providers. (See chapter 3 for further reporting guidance.)

12.6. Other revenue normally includes revenue from services other than health care provided to patients and residents, as well as sales and services to nonpatients. Such revenue arises from the normal day-to-day operations of most health care entities and is accounted for separately from health care service revenue.

12.7. Depending on the relation of the transaction to the health care entity's operations, other revenue may include—

- Revenue such as gifts, grants, or endowment income restricted by donors to finance charity care.
- Revenue from educational programs, which include tuition for schools (such as nursing) and laboratory and X-ray technology.
- Revenue from research and other gifts and grants, either unrestricted or for a specific purpose.
- Revenue from miscellaneous sources, such as the following:
  - — Rental of health care facility space
  - — Sales of medical and pharmacy supplies to employees, physicians, and others
  - — Fees charged for transcripts for attorneys, insurance companies, and others
  - — Proceeds from sale of cafeteria meals and guest trays to employees, medical staff, and visitors
  - — Proceeds from sale of scrap, used X-ray film, etc.
  - — Proceeds from sales at gift shops, snack bars, newsstands, parking lots, vending machines, and other service facilities operated by the health care entity

Gains and Losses

12.8. Gains and losses result from a provider's peripheral or incidental transactions. Depending on the relation of the transactions to the health care entity's operations, gains (losses) may include—

- Contributions, either unrestricted or for a specific purpose. Gifts for general operating purposes from foundations and similar groups and the estimated value of donated services that meet the conditions specified in paragraph 2.7 are also placed in this classification.

- Amounts from endowment funds, which include interest and dividends on investments of those endowment funds.
- Tax support and other subsidies. This includes tax levies and other subsidies from governmental or community agencies received for general support of the entity.
- Returns on investments of general funds. This ordinarily includes interest, dividends, and rents, as well as net gains or losses resulting from increases and decreases in the value of investments. The following are circumstances under which these items may be classified differently:
  - — Investment income and realized gains and losses on borrowed funds held by a trustee (to the extent not capitalized according to FASB Statement No. 62, *Capitalization of Interest Cost in Situations Involving Tax-Exempt Borrowings and Certain Gifts and Grants*) are reported as other revenue.
  - — Investment income on malpractice trust funds is reported as other revenue.
  - — Investment income that is essential to the ongoing major or central operations is reported as revenue (for example, a provider with a large endowment that provides funds that are necessary for the provider to operate).
- Miscellaneous gains (losses), such as the following:
  - —Gain or loss on sale of health care entity properties
  - —Net rentals of facilities not used in the operation of the entity
  - —Upon termination of restrictions, term endowment funds that are available for general operating purposes

  (See chapter 3 for a further discussion of the reporting of the foregoing items.)

Expenses

12.9. The basis and timing of the recognition of expenses for health care entities are generally the same as for other business organizations.

Financial Statement Presentation

12.10. Concepts for reporting revenue, expenses, gains, and losses are discussed in paragraphs 12.1–12.9.

12.11. For financial reporting purposes, service revenue is reported net of provisions for contractual and other adjustments in the statement of revenue and expenses.

12.12. Revenue earned by health care providers under capitation arrangements with prepaid health care plans and others may be separately reported.

12.13. The notes to the financial statements disclose the methods of revenue recognition and recording of unrestricted and restricted donations and investment income of both general and restricted funds. In addition, with regard to contractual adjustments and third-party settlements, identification and explanation of the estimated amounts that are payable or receivable by the entity are disclosed.

12.14. The extent of classifications and subclassifications of expenses depends on many factors, such as the size of the health care entity and external requirements for comparability with other health care entities. For example, bad-debt expense may be reported separately or included in administrative services or other adjustments.

12.15. The following are suggested major classifications of expenses as functional or natural, according to the type of the expense:

Functional	*Natural*
• Nursing services	• Salaries and wages
• Other professional services	• Employee benefits
• General services	• Fees to individuals and organizations
• Fiscal services	• Supplies and other expenses
• Administrative services	• Purchased services
• Bad debts	• Bad debts
• Depreciation	• Depreciation
• Interest	• Interest

12.16. Expenses incurred in soliciting contributions are disclosed separately in the financial statements.

Auditing

12.17. The independent auditor may need to consider the following specific audit objectives, selected control procedures, and auditing procedures to audit revenue, expenses, gains, and losses.

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
Revenue and Gains for Health Care Services			
Existence and occurrence; completeness; presentation and disclosure	Revenue and gains are reported in the proper period on the accrual basis of accounting and properly classified by the type of service rendered.	Procedures ensure that revenue is accrued as services are performed. Charges to patients are evidenced by the proper authorizations for services. Procedures such as the following ensure that charges for services and supplies provided to patients, residents, and others are properly recorded: • Days of care used to record daily service charges are reconciled to daily census reports prepared by nursing and medical records personnel. • Postings for other nursing and ancillary services are evidenced by service requisitions.	Test propriety of charges to patients, residents, and others by comparing them with the documentation contained in medical records and departmental service logs. Determine that revenue is accrued as services are performed. Perform overall tests of revenue based on the number of days of care and other units of service records.

• Completed service requisitions received by the accounting department are subject to batch or other controls and compared with departmental service logs or medical records.	Test controls over recording charges for services and supplies.
• Charges for services are checked to the approved list of rates.	Test charges to schedule of rates approved by management or rate-setting authorities.
Units of service and statistics that affect revenue determination are properly accumulated.	Review statistical reports (patient days, lab tests, visits, etc.) to consider reliability of statistical records. Compare current period revenue with prior period revenue and budgets and investigate and obtain explanations for unusual variances.
Rates are approved by management and, if applicable, comply with regulatory requirements.	Review minutes for approval of rates and, if applicable, compare rates with those established by regulatory agencies.

(continued)

AUDIT CONSIDERATIONS (cont.)

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
Revenue and Gains for Health Care Services (cont.)			
		Controls are in effect to assure the accuracy and completeness of medical records information for DRG assignment.	Test the accuracy of revenue recorded based upon DRG assignments by— • Reviewing the results of the PRO's DRG validation audits, PRO reviews of the appropriateness of admissions and related denials, and PRO reviews of the medical necessity of outlier services, including days and costs. • Testing DRG assignments by reviewing medical and other information contained in medical records.
	Revenue from health care services is reported net of contractual adjustments and other adjustments in the statement of revenue and expenses.		Review financial statements to determine that revenue is reported net of contractual adjustments and other adjustments.

Deductions from revenue, if disclosed, are reported in the proper period and are properly classified.		
Procedures ensure that charges for health care services are reported in the period in which services are rendered.	Controls ensure that there is a proper cutoff of revenue at the balance sheet date.	Test revenue cutoff for health care services by reviewing charges posted several days before and after the balance sheet date. Determine that revenue from per-case payments for patients hospitalized at the balance sheet date is properly prorated to the applicable reporting period.
	Procedures provide assurance that charges are properly controlled and recorded.	
	Procedures ensure that services and supplies are charged to patients at the correct price and that the related revenue is properly recorded and classified.	Compare charges posted to patient accounts with approved rates and medical records information.
	Controls ensure that deductions from revenue are recorded in the proper period and are properly classified.	Test contractual adjustments, other adjustments, and bad debts to determine that they are accounted for in accordance with the respective contracts and the entity's policy.
	The authority to approve deductions from revenue is separate from the cashiering and billing functions.	

(continued)

AUDIT CONSIDERATIONS (cont.)

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
Revenue and Gains for Health Care Services (cont.)			
		Contractual and other adjustments are properly authorized, controlled, and recorded. Charity care, bad-debt write-offs, and courtesy and policy discounts are properly authorized, controlled, and recorded.	Review third-party payor contracts and methods of payment and test the entity's computation of estimated adjustments to revenue to requirements under such contracts by— • Comparing prior-year settlements with prior-year estimates and determining that all differences have been accounted for properly. • Comparing interim per-unit (for example, patient day, discharge) payment rates established by third-party payors with estimated average allowable payments per unit and multiplying the difference between the rates by the

			number of units served under the contract. Test the entity's procedures for determining retrospective revenue adjustments as a result of third-party settlements or negotiations.
Other Revenue, Gains and Losses, and Nonoperating Gains and Losses			
Existence and occurrence; completeness; presentation and disclosure	Other revenue and gains and losses are reported in the proper period and are properly classified.	Procedures ensure that other revenue and gains and losses are controlled and adequate information is available to properly record and classify them. The revenue system adequately accounts for revenue and for other operating and nonoperating gain and loss transactions and is independent of the cash receipts function. Miscellaneous revenue or gains that result from the sale of used X-ray films, medical transcripts, accommodation sales to employ-	Scan miscellaneous cash receipts and investigate large or unusual amounts.

(*continued*)

AUDIT CONSIDERATIONS (cont.)

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
Other Revenue, Gains and Losses, Nonoperating Gains and Losses (cont.)			
		ees, and revenue from gift shops, cafeterias, etc., are controlled.	
		Revenue or gains from educational programs is controlled through enrollment statistics, registration records, or class-admission reports, and such records are reconciled with revenue periodically.	Compare recorded revenue from educational activities with independently calculated estimates.
		Research projects are properly authorized, and a determination is made about the specific-purpose funds available to cover related costs.	Test research grants and receipts for other donor-restricted purposes by referring to appropriate contracts and documents, including budgets of related projects, field audit reports prepared by representatives of grantors, and other supporting documentation.

		Internal controls over unrestricted gifts and donations are exercised through written receipt and acknowledgment procedures.	Review supporting documentation underlying gifts and bequests, including correspondence, acknowledgement notifications, receipts, and minutes of the governing board and committee meetings.
		Safekeeping procedures and investment registers are used to control and record returns on investments and gains or losses from investment transactions.	
		Inventories of equipment are compared to asset records to help provide control over the proper recording of gains and losses on sales or disposals of equipment.	
Presentation and disclosure	Unrestricted gifts, donations, and bequests are properly reported.		Determine that unrestricted gifts, donations, and bequests are properly reported.
	Other revenue or gains are properly reported in the fi-		Determine that gifts, grants, or endowment in-

(*continued*)

AUDIT CONSIDERATIONS (cont.)

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
Other Revenue, Gains and Losses, Nonoperating Gains and Losses (cont.)			
	nancial statements, and all required disclosures have been made.		come restricted by donors to finance charity care are included in other revenue or gains. Review the financial statements to determine that the methods of revenue recognition and recording unrestricted and restricted donations and investment income are disclosed.
Expenses			
Existence and occurrence; completeness; valuation and allocation; presentation and disclosure	Expenses are reported in the proper period and are properly classified.	Controls ensure that expenses are properly reported in the current period and are properly classified.	Compare current period expenses with prior-period expenses and budgets and investigate unusual variances. Examine agreements between the entity and independent contractors (including physicians) and—

- Test contract amounts accrued to written agreements.
- Obtain written representation from management outlining terms of any oral agreements and, if appropriate, request confirmation of the details of agreements.

Test the entity's method of recording services and supplies furnished to employees (such as the value of meals, housing, and laundry), and test the distribution of those items through various departments and the treatment thereof for FICA, withholding, and insurance purposes.

For entities that record values for contributed services, the following procedures should be considered:

- Determine that all of the conditions required to re-

(*continued*)

AUDIT CONSIDERATIONS (cont.)

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
Expenses (cont.)			cord the value of donated services exist. • Test the value assigned to contributed services based on hours worked, job descriptions, and comparison with compensation paid to workers in similar positions. • Test time records and computations supporting salary-equivalent amounts for contributed services. Test fund-raising costs for propriety of classification and disclosure. Review comparative operational statistics and the rela-

tionship of such statistics to expenses.

Review and analyze, if necessary, the following expenses:

- Maintenance and repairs
- Professional fees
- Administration and general
- Laboratory supplies and *expense*
- X-ray supplies and expense
- Dietary supplies and expense
- Operating room supplies and expense
- Medical and surgical expense
- Miscellaneous expense
- New or unusual expenses

Chapter 13

Reporting Entity and Related Organizations

13.1. The FASB is presently studying the concept of a reporting entity and issues related to consolidations, the application of the equity method of accounting, and accounting for various types of joint ventures. The GASB is also studying issues related to the financial reporting entity. Accordingly, pending resolution by the FASB and GASB, those matters are not within the scope of this guide.

13.2. Foundations, auxiliaries, guilds, and similar organizations frequently assist and, in many instances, are related to health care entities. ARB No. 51, *Consolidated Financial Statements*, provides guidance on whether the financial statements of related organizations should be consolidated or combined. FASB Statement No. 94, *Consolidation of all Majority-Owned Subsidiaries*, which amended ARB No. 51, requires the consolidation of majority-owned subsidiaries unless control is temporary or does not rest with the majority owner. The FASB project discussed in paragraph 13.1 will also consider what disaggregated information should be disclosed with consolidated financial statements; accordingly, to prevent loss in the meantime of information about unconsolidated subsidiaries now required by APB Opinion No. 18, *The Equity Method of Accounting for Investments in Common Stock*, continued disclosure of that information for subsidiaries that are consolidated as a result of FASB Statement No. 94 is required. APB Opinion No. 18 provides guidance on accounting for investments in the common stock of unconsolidated subsidiaries.

13.3. Not-for-profit health care entities may be related to one or more separate not-for-profit organizations. A separate organization is considered to be related to a health care entity if one of the following conditions is met:

a. The health care entity controls the separate organization through contracts or other legal documents that provide the health care

entity with the authority to direct the separate organization's activities, management, and policies.

b. The health care entity is, for all practical purposes, the sole beneficiary of the organization. The health care entity is considered the organization's sole beneficiary if any one of the three following circumstances exists:

1. The organization has solicited funds in the name of the health care entity and with the expressed or implied approval of the health care entity, and substantially all the funds solicited by the organization were intended by the contributor, or were otherwise required, to be transferred to the health care entity or used at its discretion or direction.
2. The health care entity has transferred some of its resources to the organization, and substantially all of the organization's resources are held for the benefit of the health care entity.
3. The health care entity has assigned certain of its functions (such as the operation of a dormitory) to the organization, which is operating primarily for the benefit of the health care entity.

Financial Reporting

13.4. If the condition described in paragraph 13.3*a* and at least one of the conditions described in paragraph 13.3*b* are satisfied, and if the financial statements of the health care entity and the related organizations are not consolidated or combined in accordance with ARB No. 51, as amended, then the entity's financial statements should disclose information concerning the related organizations. The health care entity should present summarized information about the assets, liabilities, results of operations, and changes in fund balances of related organizations in the notes to the health care entity's financial statements. The health care entity should also describe the nature of the relationships between it and the related organizations. (Exhibit 13a illustrates the foregoing disclosure by a not-for-profit hospital for a related foundation.) When a related organization makes its assets available to the health care entity, the health care entity accounts for them in accordance with the terms and conditions prescribed by the related organization.

13.5. There may be instances in which the items presented in

the financial statements of the related organization are not consolidated, combined, or disclosed in accordance with the foregoing requirements. If a related organization holds material amounts of funds that have been designated for the benefit of the health care entity or if there have been material transactions between the health care entity and the related organization, the health care entity's financial statements should disclose the existence and nature of the relationship between the health care entity and the related organization. Further, if there have been material transactions between the health care entity and the related organization during the periods covered by the health care entity's financial statements, the following information is also disclosed:

a. A summary description of the transactions for the period reported on, including amounts, if any, and any other information deemed necessary to gain an understanding of the effects on the health care entity's financial statements

b. The dollar volume of transactions and the effects of any change in the terms from the preceding period

c. Amounts due from or to the related organization and, if not otherwise apparent, the terms and manner of settlement

13.6. Exhibit 13b illustrates the disclosures set forth in paragraph 13.5 for a not-for-profit hospital that, during the year, received substantial amounts of contributions from a not-for-profit community health fund-raising organization that is controlled by the hospital but that also raises funds for other health-related organizations in the community. Similar information is also disclosed in situations when (*a*) the health care entity does not control the separate organization but is its sole beneficiary and (*b*) there have been material transactions during the year between the health care entity and the separate organization.

13.7. The reporting and disclosure requirements of the health care entity under the circumstances noted in paragraphs 13.2 through 13.6 are summarized as follows:

Circumstances	*Requirements*
The health care entity is related to a separate organization and meets the criteria stated in ARB No. 51.	Consolidate or combine in accordance with ARB No. 51.

(continued)

Circumstances	*Requirements*
The health care entity does not meet the criteria stated in ARB No. 51, but controls and is the sole beneficiary of the related organization's activities.	In a note to the financial statements, disclose summarized financial data of the related organization (such as total assets, total liabilities, changes in fund balance, total revenue, total expenses, and amount of distributions to the health care entity) and disclose the nature of the relationship between the health care entity and the related organization.
Neither of the aforementioned is present, but the related organization holds significant amounts of funds designated for the health care entity.	Disclose the existence and nature of the relationship.
There have been material transactions between the health care entity and the related organization. (This could be present in any of the foregoing circumstances.)	In the notes to the financial statement (*a*) disclose the existence and nature of the relationship and (*b*) describe and quantify the transactions.

Related Party Transactions

13.8. Significant relationships and transactions not in the ordinary course of business with directors, management, medical staff, or other related parties should be disclosed in accordance with FASB Statement No. 57, *Related Party Disclosures*. SAS No. 45, *Omnibus Statement on Auditing Standards—1983*, sets forth procedures for the auditor to consider in determining the existence of transactions with related parties and identifying them.

Auditing

13.9. The independent auditor may need to consider the following specific audit objectives, control procedures, and auditing procedures for related party organizations, balances, and transactions.

AUDIT CONSIDERATIONS

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
Existence and occurrence; completeness; presentation and disclosure	The reporting entity is appropriate.	Procedures ensure that investees, affiliates, and other related entities are appropriately accounted for.	Review articles of incorporation, bylaws and minutes of directors' meetings, shareholder lists, and filings with regulatory authorities to determine the existence of related parties. Obtain representations from management as to whether all investees, affiliates, and related entities have been properly accounted for or disclosed. Review transactions with investees, affiliates, and other related entities to determine that they are properly reported.
	Identification and disclosure of relationships and transactions with related organiza-	Procedures ensure that conflict-of-interest policies, procedures, and disclosure	Test significant related party transactions as follows:

(*continued*)

AUDIT CONSIDERATIONS (cont.)

Financial Statement Assertions	*Specific Audit Objectives*	*Examples of Selected Control Procedures*	*Examples of Auditing Procedures*
	tions because of economic dependence of the entity.	requirements are met.	
		The governing board approves all transactions of related parties.	• Determine substance. • Examine documents (invoices, contracts, and agreements). • Determine basis of pricing. • Determine collectibility of receivables and advances.
		Records are maintained for related party transactions (party, date, description, quantity, and price).	Compare related party transactions and balances with those of prior periods. Review related party transactions for completeness by— • Considering previously identified transactions or relationships. • Reviewing minutes of directors' and other meetings. • Discussing related party

		transactions with entity personnel. • Reviewing unusual transactions. • Reviewing responses to related party (conflict-of-interest) questionnaires.
Presentation and disclosure	Related party transactions and organizations are properly reported.	Review presentation and disclosure of related party information for completeness.

EXHIBIT 13a

Illustrative Note: Sample Hospital Foundation

Note X. Sample Hospital Foundation (the foundation) was established to raise funds to support the operation of Sample Hospital. The foundation's bylaws provide that all funds raised, except for funds required for the operation of the foundation, be distributed to or be held for the benefit of the hospital. The foundation's bylaws also provide the hospital with the authority to direct its activities, management, and policies. The foundation's general funds, which represent the foundation's unrestricted resources, are distributed to the hospital in amounts and in periods determined by the foundation's board of trustees, who may also restrict the use of general funds for hospital plant replacement or expansion or other specific purposes. Plant replacement and expansion funds, specific-purpose funds, and assets obtained from income from endowment funds of the foundation are distributed to the hospital as required to comply with the purposes specified by donors. A summary of the foundation's assets, liabilities, and fund balances, results of operations, and changes in fund balances follows.

	December 31	
	19X1	*19X0*
	(in thousands)	
Assets, principally cash and cash-equivalent investments	$11,118	$10,265
Liabilities*	1,046	1,025
Fund balances:		
General	3,525	3,230
Restricted	6,547	6,010
Total fund balances	10,072	9,240
Total liabilities and fund balances	$11,118	$10,265

(continued)

* Includes $1 million payable at the end of each year to Sample Hospital. These amounts were paid after the end of each year.

	December 31	
	19X1	*19X0*
	(in thousands)	
Support and revenue	$ 4,867	$ 4,240
Expenses		
Distributions to Sample Hospital†	4,154	3,112
Other	228	320
Total expenses	4,382	3,432
Excess of support and revenue over expenses	485	808
Other changes in fund balances	347	112
Fund balance, beginning of year	9,240	8,320
Fund balance, end of year	$10,072	$ 9,240

† The distributions by the foundation to Sample Hospital are included in the hospital's financial statements, as follows:

	19X1	*19X0*
	(in thousands)	
Unrestricted grants and contributions	$1,404	$ 912
Restricted grants for specific purposes	250	200
Plant replacement and expansion	2,500	2,000
	$4,154	$3,112

EXHIBIT 13b

Illustrative Note: Related Party Transactions

The following illustrates the disclosure by a not-for-profit hospital that is considered to be related to a separate not-for-profit organization because it controls the separate organization but is not its sole beneficiary. Material transactions also occurred between the hospital and the related organization.

Note Y. Because of the existence of common trustees and other factors, ABC Hospital is deemed to control Community Health Foundation (the foundation). The foundation is authorized by ABC Hospital to solicit contributions on its behalf. In its general appeal for contributions to support the community's providers of health care services, the foundation also solicits contributions for certain other health care institutions. In the absence of donor restrictions, the foundation has discretionary control over the amounts to be distributed to the providers of health care services, the timing of such distributions, and the purposes for which such funds are to be used.

The contributions made by the foundation to the hospital during the years ended December 31, 19X1 and 19X0, are included in the hospital's financial statements as follows:

	19X1	*19X0*
General (unrestricted) contributions	$150,000	$150,000
Restricted contributions for—		
Specific purposes	35,000	25,000
Plant replacement and expansion purposes	25,000	50,000
Endowment	50,000	150,000
Total	$260,000	$375,000

Chapter 14

Independent Auditor's Reports

14.1. The guidance in SAS No. 58, *Reports on Audited Financial Statements*, applies to audit reports on the financial statements of health care entities. Such reports may contain an unqualified opinion, an unqualified opinion with an explanatory paragraph, a qualified opinion, a disclaimer of opinion, or an adverse opinion. The facts and circumstances of each particular audit will govern the appropriate form of report. Report examples appearing in this chapter illustrate the form of certain auditor's reports issued by the independent auditor in auditing the financial statements of a health care entity.

Unqualified Opinion

14.2. The independent auditor's standard report states that the financial statements present fairly, in all material respects, an entity's financial position, results of operations, and cash flows in conformity with generally accepted accounting principles. This conclusion may be expressed only when the independent auditor has formed such an opinion on the basis of an audit performed in accordance with generally accepted auditing standards. An example of the independent auditor's standard report is shown in exhibit 14a.

Unqualified Opinion With Explanatory Paragraph

14.3. SAS No. 58 indicates instances when an explanatory paragraph should be added following the standard opinion paragraph for (*a*) material uncertainties (exhibit 14b) and (*b*) a change in accounting principles or in their method of application that has a material effect on the comparability of financial statements (exhibit 14c).

Qualified Opinion

14.4. SAS No. 58 states that certain circumstances may require a qualified opinion. A qualified opinion states that except for the effects of the matter to which the qualification relates, the financial statements present fairly, in all material respects, the financial position, results of operations, and cash flows in conformity with generally accepted accounting principles. Such an opinion is expressed when—

a. There is a lack of sufficient competent evidential matter or there are restrictions on the scope of the audit that have led the independent auditor to conclude that an unqualified opinion cannot be expressed and the independent auditor has concluded not to disclaim an opinion (exhibit 14d).

b. The independent auditor believes, on the basis of the audit, that the financial statements contain a departure from generally accepted accounting principles, the effect of which is material, and has concluded not to express an adverse opinion (exhibit 14e).

Additional Information

14.5. SAS No. 29, *Reporting on Information Accompanying the Basic Financial Statements in Auditor-Submitted Documents*, contains useful guidance on reporting on additional information. The information covered by SAS No. 29 is presented to accompany the basic financial statements in an independent auditor-submitted document and is not considered necessary for presentation of financial position, results of operations, and cash flows in conformity with generally accepted accounting principles. Such information includes additional details or explanations of items in or related to the basic financial statements, consolidating information, historical summaries of items extracted from the basic financial statements, statistical data, and other material, some of which may be from sources outside the accounting system or outside the health care entity.

14.6. With respect to supplementary and other information, guidance is contained in SAS No. 8, *Other Information in Documents Containing Audited Financial Statements*, and SAS No. 52, *Omnibus Statement on Auditing Standards—1987*. Among other changes,

SAS No. 52 amends SAS No. 29 regarding required supplementary information. In addition, SAS No. 42, *Reporting on Condensed Financial Statements and Selected Financial Data,* contains guidance on reporting in a client-prepared document when condensed financial statements or selected financial data are presented by a public entity.

Special Reports

14.7. If a health care entity is required to follow reporting requirements of a regulatory agency, to report under a cash receipts and disbursements basis of accounting, or to report on another comprehensive basis of accounting other than generally accepted accounting principles, the auditor should follow the guidance in SAS No. 62, *Special Reports.* SAS No. 62 also provides reporting guidance when reporting on specified elements, accounts, or items of a financial statement; compliance with aspects of contractual agreements or regulatory requirements related to audited financial statements; financial presentations to comply with contractual agreements or regulatory provisions; and financial information presented in prescribed forms. Guidance may also be found in SAS No. 35, *Special Reports—Applying Agreed-upon Procedures to Specified Elements, Accounts, or Items of a Financial Statement.*

EXHIBIT 14a

Unqualified Opinion—Comparative Financial Statements

Independent Auditor's Report

[*Date*]

To the Board of Trustees
XYZ Health Care Entity

We have audited the accompanying balance sheets of XYZ Health Care Entity as of September 30, 19X2 and 19X1, and the related statements of revenue and expenses of general funds, changes in fund balances, and cash flows of general funds for the years then ended. These financial statements are the responsibility of XYZ Health Care Entity's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of XYZ Health Care Entity as of September 30, 19X2 and 19X1, and the results of its operations and its cash flows of general funds for the years then ended in conformity with generally accepted accounting principles.

[*Signature*]

EXHIBIT 14b

Unqualified Opinion With Explanatory Paragraph for Material Uncertainty Related to Medical Malpractice Liability

Independent Auditor's Report

[*Date*]

To the Board of Trustees
XYZ Health Care Entity

[*Standard wording for first three paragraphs*]

As more fully described in Note X, claims in excess of professional liability insurance coverage have been asserted against XYZ Health Care Entity. Legal counsel and management are unable to estimate the ultimate cost, if any, that may result from the resolution of those claims; accordingly, no provision for claims in excess of professional liability insurance has been made in the accompanying financial statements.

[*Signature*]

EXHIBIT 14c

Unqualified Opinion With Explanatory Paragraph for Change in Accounting Principle That Has a Material Effect on the Comparability of Financial Statements

Independent Auditor's Report

[*Date*]

To the Board of Trustees
XYZ Health Care Entity

[*Standard wording for first three paragraphs*]

As discussed in Note X to the financial statements, during 19X2 XYZ Health Care Entity changed its method of accounting for pensions.

[*Signature*]

EXHIBIT 14d

Qualified Opinion—Scope Limitation

Independent Auditor's Report

[Date]

To the Board of Trustees
XYZ Health Care Entity

[Same first paragraph as the standard report]

Except as discussed in the following paragraph, we conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

We were unable to obtain audited financial statements supporting XYZ's investment in an affiliate stated at $_____ and $_____ at September 30, 19X2 and 19X1, respectively, or its equity in earnings of that affiliate of $_____ and $_____, which is included in the excess of revenues and gains over expenses for the years then ended as described in Note X to the financial statements; nor were we able to satisfy ourselves as to the carrying value of the investment in the affiliate or the equity in its earnings by other auditing procedures.

In our opinion, except for the effects of such adjustments, if any, as might have been determined to be necessary had we been able to examine evidence regarding the affiliate investment and earnings, the financial statements referred to in the first paragraph present fairly, in all material respects, the financial position of XYZ Health Care Entity as of September 30, 19X2 and 19X1, and the results of its operations and its cash flows of general funds for the years then ended in conformity with generally accepted accounting principles.

[Signature]

EXHIBIT 14e

Qualified Opinion—Departure From Generally Accepted Accounting Principles That Has a Material Effect on the Financial Statements

Independent Auditor's Report

[*Date*]

To the Board of Trustees
XYZ Health Care Entity

[*Same first and second paragraphs as the standard report*]

XYZ Health Care Entity has excluded, from property and debt in the accompanying balance sheets, certain lease obligations that, in our opinion, should be capitalized to conform with generally accepted accounting principles. If these lease obligations were capitalized, property would be increased by $_____ and $_____, long-term debt would be increased by $_____ and $_____, and the general fund balance would be increased by $_____ and $_____ as of September 31, 19X2 and 19X1, respectively. In addition, the excess of revenue over expenses would be increased by $_____ and $_____, respectively, for the years then ended.

In our opinion, except for the effects of not capitalizing certain lease obligations as discussed in the preceding paragraph, the financial statements referred to in the first paragraph present fairly, in all material respects, the financial position of XYZ Health Care Entity as of September 30, 19X2 and 19X1, and the results of its operations and its cash flows of general funds for the years then ended in conformity with generally accepted accounting principles.

[*Signature*]

Appendix A

Illustrative Financial Statements

The following illustrative financial statements (exhibits 1 through 6) illustrate the applications of the reporting practices discussed in this guide. Specific types of health care entities have been selected to illustrate a wide diversity of reporting practices; it is not intended that these illustrations represent either the only types of disclosure or the only statement formats that would be appropriate. For example, the reporting of revenue, gains, expenses, and losses will vary depending on the relationship of the underlying transaction to the entity's operations. More or less detail should appear either in the financial statements or in the notes, depending on the circumstances.

As discussed in paragraph 3.27 of this guide, the illustrative hospital financial statements include two illustrative balance sheets:

1. A disaggregated "layered" reporting approach, illustrated in exhibit 1a
2. An aggregated reporting approach, illustrated in exhibit 1b

The direct or indirect method of reporting cash flows may be used to present the statement of cash flows.

Governmental health care entities are required to follow the accounting and reporting requirements of the Governmental Accounting Standards Board (GASB) Statements. GASB pronouncements may require governmental health care entities to present information beyond what is presented in these illustrative financial statements. For example, GASB Statement No. 3, *Deposits with Financial Institutions, Investments (including Repurchase Agreements), and Reverse Repurchase Agreements*, requires governmental entities to make certain disclosures about the credit and market risks of their investments. GASB Statement No. 5, *Disclosure of Pension Information by Public Employee Retirement Systems and State and Local Governmental Employers*, requires certain disclosures about pension benefits provided to employees of governmental health care entities. GASB Statement No. 9, *Reporting Cash Flows of Proprietary and Nonexpendable Trust Funds and Governmental Entities That Use Proprietary Fund Accounting*, requires governmental health care entities to present a statement of cash flows using a format that differs in some respects from that required by FASB Statement No. 95, *Statement of Cash Flows*, and that requires the reporting of cash flows information on both restricted and unrestricted funds.

Index to Illustrative Financial Statements

Sample Hospital

Balance Sheets
December 31, 19X7 and 19X6

Assets	*19X7*	*19X6*	*Liabilities and Fund Balances*	*19X7*	*19X6*
General Funds					
Current assets:			Current liabilities:		
Cash and cash equivalents	$ 3,103,000	$ 4,525,000	Current installments of long-term debt (note 7)	$ 970,000	$ 1,200,000
Assets whose use is limited—required for current liabilities (notes 5, 7, and 8)	970,000	1,300,000	Current portion of capital lease obligations (note 7)	500,000	550,000
Patient accounts receivable, net of estimated uncollectibles of $2,500,000 in 19X7 and $2,400,000 in 19X6	15,100,000	14,194,000	Accounts payable	2,217,000	2,085,000
Estimated third-party payor settlements—Medicare (note 3)	441,000	600,000	Accrued expenses	3,396,000	3,225,000
Supplies, at lower of cost (first-in, first-out) or market	1,163,000	938,000	Estimated third-party payor settlements—Medicaid (note 2)	2,143,000	1,942,000
Other current assets	321,000	403,000	Deferred third-party reimbursement	200,000	210,000
Due from donor-restricted funds, net	—	500,000	Advances from third-party payors	122,000	632,000
Total current assets	21,098,000	22,460,000	Current portion of estimated malpractice costs (note 8)	600,000	500,000
			Retainage and construction accounts payable	955,000	772,000
			Due to donor-restricted funds	300,000	—
			Total current liabilities	11,403,000	11,116,000

(continued)

EXHIBIT 1a (cont.)

Sample Hospital

Balance Sheets
December 31, 19X7 and 19X6

Assets	*19X7*	*19X6*	*Liabilities and Fund Balances*	*19X7*	*19X6*
Assets whose use is limited (notes 5, 7, and 8):					
By board for capital improvements	11,000,000	10,000,000	Deferred third-party reimbursement	746,000	984,000
By agreements with third-party payors for funded depreciation	9,234,000	6,151,000			
Under malpractice funding arrangement—held by trustee	3,007,000	2,682,000	Estimated malpractice costs, net of current portion (note 8)	3,207,000	2,182,000
Under indenture agreement—held by trustee	11,708,000	11,008,000	Long-term debt, excluding current installments (note 7)	22,644,000	23,614,000
Total assets whose use is limited	34,949,000	29,841,000			
Less assets whose use is limited and that are required for current liabilities	970,000	1,300,000	Capital lease obligations, excluding current portion (note 7)	500,000	400,000
			Fund balance	69,310,000	64,567,000
Noncurrent assets whose use is limited	33,979,000	28,541,000			
Property and equipment, net (notes 6 and 7)	51,038,000	50,492,000			
Other assets:					
Prepaid pension cost (note 12)	85,000	35,000			
Deferred financing costs	693,000	759,000			

Investment in affiliated company (note 4)	917,000	576,000			
Total other assets	1,695,000	1,370,000	Commitments and contingent liabilities (notes 3, 6, 8, 12, and 13)	—	—
	$107,810,000	$102,863,000		$107,810,000	$102,863,000
Donor-Restricted Funds					
Specific-purpose funds					
Cash	$ 378,000	$ 378,000	Accounts payable	$ 205,000	$ 72,000
Investments, at cost that approximates market	728,000	455,000	Deferred grant revenue	92,000	—
Grants receivable	613,000	535,000	Due to general funds	—	255,000
			Fund balance	1,422,000	1,041,000
	$ 1,719,000	$ 1,368,000		$ 1,719,000	$ 1,368,000
Plant replacement and expansion funds					
Cash	$ 24,000	$ 321,000			
Investments, at cost that approximates market	252,000	165,000	Due to general funds	$ —	$ 345,000
Pledges receivable, net of estimated uncollectibles of $60,000 in 19X7 and $120,000 in 19X6	132,000	380,000	Fund balance	558,000	521,000
Due from general funds	150,000	—			
	$ 558,000	$ 866,000		$ 558,000	$ 866,000
Endowment funds					
Cash	$ 1,253,000	$ 653,000	Fund balance	$ 5,259,000	$ 6,073,000
Investments, net of $175,000 valuation allowance in 19X7, market value $3,798,000 in 19X7 and $5,013,000 in 19X6 (note 9)	3,856,000	5,320,000			
Due from general funds	150,000	100,000			
	$ 5,259,000	$ 6,073,000		$ 5,259,000	$ 6,073,000

See accompanying notes to financial statements.

Sample Hospital

Statements of Revenue and Expenses of General Funds
Years Ended December 31, 19X7 and 19X6

	19X7	*19X6*
Net patient service revenue (notes 3 and 7)	$92,656,000	$88,942,000
Other revenue	6,010,000	5,380,000
Total revenue	98,666,000	94,322,000
Expenses (notes 7, 8, 12, and 13):		
Professional care of patients	53,016,000	48,342,000
Dietary services	4,407,000	4,087,000
General services	10,888,000	9,973,000
Administrative services	11,075,000	10,145,000
Employee health and welfare	10,000,000	9,335,000
Medical malpractice costs	1,125,000	200,000
Depreciation and amortization	4,782,000	4,280,000
Interest	1,752,000	1,825,000
Provision for bad debts	1,010,000	1,103,000
Total expenses	98,055,000	89,290,000
Income from operations	611,000	5,032,000
Nonoperating gains (losses):		
Unrestricted gifts and bequests (note 11)	822,000	926,000
Loss on investment in affiliated company (note 4)	(37,000)	(16,000)
Income on investments of endowment funds	750,000	650,000
Income on investments whose use is limited:		
By board for capital improvements	1,120,000	1,050,000
By agreements with third-party payors for funded depreciation	850,000	675,000
Under indenture agreement	100,000	90,000
Other investment income	284,000	226,000
Nonoperating gains, net	3,889,000	3,601,000
Revenue and gains in excess of expenses and losses	$ 4,500,000	$ 8,633,000

See accompanying notes to financial statements.

Sample Hospital

Statements of Changes in Fund Balances
Years Ended December 31, 19X7 and 19X6

	19X7				*19X6*			
		Donor-Restricted Funds				*Donor-Restricted Funds*		
	General Funds	*Specific-Purpose Funds*	*Plant Replacement and Expansion Funds*	*Endowment Funds*	*General Funds*	*Specific-Purpose Funds*	*Plant Replacement and Expansion Funds*	*Endowment Funds*
Balances at beginning of year	$64,567,000	$ 1,041,000	$ 521,000	$ 6,073,000	$56,679,000	$ 933,000	$ 501,000	$ 5,973,000
Additions:								
Revenue and gains in excess of expenses and losses	4,500,000	—	—	—	8,633,000	—	—	—
Gifts, grants, and bequests (notes 10 and 11)	—	869,000	220,000	—	—	558,000	290,000	—
Investment income	—	62,000	20,000	—	—	50,000	15,000	—
Net realized gain on sale of investments	—	—	100,000	—	—	—	20,000	100,000
Transfer to finance property and equipment additions	243,000	—	(243,000)	—	255,000	—	(255,000)	—
	4,743,000	931,000	97,000	—	8,888,000	608,000	70,000	100,000

(*continued*)

Sample Hospital

Statements of Changes in Fund Balances
Years Ended December 31, 19X7 and 19X6

	19X7				*19X6*			
		Donor-Restricted Funds				*Donor-Restricted Funds*		
	General Funds	*Specific-Purpose Funds*	*Plant Replacement and Expansion Funds*	*Endowment Funds*	*General Funds*	*Specific-Purpose Funds*	*Plant Replacement and Expansion Funds*	*Endowment Funds*
Deductions:								
Provision for uncollectible pledges	—	—	(60,000)	—	—	—	(50,000)	—
Capital contribution to Sample Health System (note 11)	—	—	—	—	(1,000,000)	—	—	—
Net realized loss on sale of investments	—	—	—	(639,000)	—	—	—	—
Unrealized loss on marketable equity securities (note 9)	—	—	—	(175,000)	—	—	—	—
Transfer to other revenue	—	(550,000)	—	—	—	(500,000)	—	—
	—	(550,000)	(60,000)	(814,000)	(1,000,000)	(500,000)	(50,000)	—
Balances at end of year	$69,310,000	$ 1,422,000	$ 558,000	$ 5,259,000	$64,567,000	$ 1,041,000	$ 521,000	$ 6,073,000

See accompanying notes to financial statements.

EXHIBIT 1a (cont.)

Sample Hospital

Statements of Cash Flows of General Funds (Direct Method) Years Ended December 31, 19X7 and 19X6*

	19X7	*19X6*
Cash flows from operating activities and gains and losses:		
Cash received from patients and third-party payors	$ 90,342,000	$ 85,619,000
Cash paid to employees and suppliers	(89,214,000)	(81,510,000)
Other receipts from operations	6,042,000	5,563,000
Receipts from unrestricted gifts and bequests	1,122,000	905,000
Interest and dividends received	2,510,000	2,330,000
Interest paid (net of amount capitalized)	(1,780,000)	(1,856,000)
Net cash provided by operating activities and gains and losses	9,022,000	11,051,000
Cash flows from investing activities:		
Purchase of property and equipment	(4,728,000)	(5,012,000)
Transfer from donor-restricted fund for purchase of property and equipment	243,000	255,000
Investment in affiliated company	(394,000)	(425,000)
Capital contribution to Sample Health System	—	(1,000,000)
Cash invested in assets whose use is limited	(4,798,000)	(855,000)
Net cash used by investing activities	(9,677,000)	(7,037,000)
Cash flows from financing activities:		
Increase in retainage and construction accounts payable	183,000	175,000
Repayment of long-term debt	(1,200,000)	(1,630,000)
Payments from donor-restricted funds related to temporary loans	500,000	—
Payments on capital lease obligations	(550,000)	(600,000)
Temporary loans from (to) donor-restricted funds	300,000	(193,000)
Net cash used by financing activities	(767,000)	(2,248,000)
Net increase (decrease) in cash and cash equivalents	(1,422,000)	1,766,000
Cash and cash equivalents at beginning of year	4,525,000	2,759,000
Cash and cash equivalents at end of year	$ 3,103,000	$ 4,525,000

See accompanying notes to financial statements.

* The direct and indirect methods of reporting cash flows by hospitals are presented for illustrative purposes.

Reconciliation of Revenue and Gains in Excess of Expenses and Losses to Net Cash Provided by Operating Activities and Gains and Losses:

	19X7	*19X6*
Revenue and gains in excess of expenses and losses	$ 4,500,000	$ 8,633,000
Adjustments to reconcile revenue and gains in excess of expenses and losses to net cash provided by operating activities and gains and losses:		
Depreciation and amortization	4,782,000	4,280,000
Provision for bad debts	1,010,000	1,103,000
Amortization of deferred financing costs	66,000	45,000
Loss on investment in affiliated company	53,000	—
Noncash gifts and bequests	—	(175,000)
Decrease in amounts due to third-party payors	(398,000)	(77,000)
Increase in liability for estimated malpractice costs	1,125,000	200,000
Increase in patient accounts receivable	(1,916,000)	(3,141,000)
Increase in supplies and other current assets	(193,000)	(118,000)
Increase in accounts payable and accrued expenses	303,000	301,000
Increase in interest earned but not received on assets whose use is limited	(310,000)	—
Net cash provided by operating activities and gains and losses	$ 9,022,000	$11,051,000

Supplemental Disclosures of Cash Flow Information

Sample Hospital entered into capital lease obligations of $600,000 for new equipment in 19X7.

See accompanying notes to financial statements.

Sample Hospital

Statements of Cash Flows of General Funds (Indirect Method) Years Ended December 31, 19X7 and 19X6*

	19X7	*19X6*
Cash flows from operating activities and gains and losses:		
Revenue and gains in excess of expenses and losses:	$ 4,500,000	$ 8,633,000
Adjustments to reconcile revenue and gains in excess of expenses and losses to net cash provided by operating activities and gains and losses:		
Depreciation and amortization	4,782,000	4,280,000
Provision for bad debts	1,010,000	1,103,000
Amortization of deferred financing costs	66,000	45,000
Loss on investment in affiliated company	53,000	—
Noncash gifts and bequests	—	(175,000)
Decrease in net amounts due to third-party payors	(398,000)	(77,000)
Increase in liability for estimated malpractice costs	1,125,000	200,000
Increase in patient accounts receivable	(1,916,000)	(3,141,000)
Increase in supplies and other current assets	(193,000)	(118,000)
Increase in accounts payable and accrued expenses	303,000	301,000
Increase in interest earned but not received on assets whose use is limited	(310,000)	—
Net cash provided by operating activities and gains and losses	9,022,000	11,051,000
Cash flows from investing activities:		
Purchase of property and equipment	(4,728,000)	(5,012,000)

(*continued*)

* The direct and indirect methods of reporting cash flows by hospitals are presented for illustrative purposes.

EXHIBIT 1a (cont.)

	19X7	*19X6*
Transfer from donor-restricted fund for purchase of property and equipment	243,000	255,000
Investment in affiliated company	(394,000)	(425,000)
Transfer to Sample Health System	—	(1,000,000)
Cash invested in assets whose use is limited	(4,798,000)	(855,000)
Net cash used by investing activities	(9,677,000)	(7,037,000)
Cash flows from financing activities:		
Increase in retainage and construction accounts payable	183,000	175,000
Repayment of long-term debt	(1,200,000)	(1,630,000)
Payments from donor-restricted funds related to temporary loans to donor-restricted funds	500,000	—
Payments on capital lease obligation	(550,000)	(600,000)
Temporary loans from (to) donor-restricted funds	300,000	(193,000)
Net cash used by financing activities	(767,000)	(2,248,000)
Net increase (decrease) in cash and cash equivalents	(1,422,000)	1,766,000
Cash and cash equivalents at beginning of year	4,525,000	2,759,000
Cash and cash equivalents at end of year	$ 3,103,000	$ 4,525,000

Supplemental Disclosures of Cash Flow Information

Sample Hospital entered into capital lease obligations of $600,000 for new equipment in 19X7.

Cash paid for interest (net of amount capitalized) in 19X7 and 19X6 was $1,780,000 and $1,856,000, respectively.

See accompanying notes to financial statements.

Sample Hospital

Notes to Financial Statements December 31, 19X7 and 19X6

1. Summary of Significant Accounting Policies

Organization. Sample Hospital (Hospital) is a not-for-profit acute care hospital. Effective June 30, 19X6, under a plan of reorganization, Sample Health System was formed as the parent holding company of the Hospital. In its capacity as sole member of the Hospital, Sample Health System has the right to appoint Hospital trustees, approve major Hospital expenditures, and approve long-term Hospital borrowings.

Charity care. The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

Income taxes. The Hospital is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code.

Net patient service revenue. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Investments and investment income. Donated investments are reported at fair value at the date of receipt, which is then treated as cost. Marketable equity securities included in investment portfolios are carried at the lower of aggregate cost (determined on an average-cost basis) or market at the balance sheet date. Other marketable securities are stated at cost, adjusted for impairments in value that are deemed to be other than temporary. Sample Hospital's investment in Affiliated Company is reported on the equity method of accounting that approximates Sample Hospital's equity in the underlying net book value of Affiliated Company.

Investment income on proceeds of borrowings that are held by a trustee, to the extent not capitalized, and investment income on assets deposited in the malpractice trust are reported as other revenue. Investment income from all other general fund investments and investment income of endowment funds are reported as nonoperating gains. Investment income and gains (losses) on investments of donor-restricted funds are added to (deducted from) the appropriate restricted fund balance.

Pledges. Pledges, less an allowance for uncollectible amounts, are recorded as receivables in the year made. Unrestricted pledges are reported in the statement of revenue and expenses of general funds; restricted pledges are reported as additions to the appropriate retricted fund balance.

Statement of revenue and expenses of general funds. For purposes of display, transactions deemed by management to be ongoing, major, or central to the provision of health care services are reported as revenues and expenses. Peripheral or incidental transactions are reported as gains and losses.

Costs of borrowing. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Deferred financing costs are amortized over the period the obligation is outstanding using the interest method.

Amortization of deferred financing costs is capitalized during the period of construction of capital assets.

Donor-restricted funds. Donor-restricted funds are used to differentiate resources, the use of which is restricted by donors or grantors, from resources of general funds on which donors or grantors place no restriction or that arise as a result of the operations of the Hospital for its stated purposes. Restricted gifts and other restricted resources are recorded as additions to the appropriate restricted fund.

Resources restricted by donors for plant replacement and expansion are added to the general fund balance to the extent expended within the period.

Resources restricted by donors or grantors for specific operating puposes are reported in other revenue to the extent used within the period.

Assets whose use is limited. Assets whose use is limited include assets set aside by the Board of Trustees for future capital improvements, over which the Board retains control and may at its discretion subsequently use for other purposes; assets set aside in accordance with agreements with third-party payors; and assets held by trustees under indenture agreements and self-insurance trust arrangements.

Property and equipment. Property and equipment acquisitions are recorded at cost. Property and equipment donated for hospital operations are recorded as additions to the donor-restricted plant replacement and expansion funds at fair value at the date of receipt and as a transfer to the general fund balance when the assets are placed in service.

Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed on the straight-line method. Equipment under capital leases is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the financial statements.

An accelerated method for depreciating certain operating equipment acquired before 1970 has been elected for third-party reimbursement purposes. Third-party reimbursement is deferred to the extent of the effect of the difference between accelerated depreciation used for reimbursement reporting and straight-line depreciation used for financial reporting.

Cash and cash equivalents. Cash and cash equivalents include investments in highly liquid debt instruments with a maturity of three months or less, excluding amounts whose use is limited by board designation or other arrangements under trust agreements or with third-party payors.

Estimated malpractice costs. The provision for estimated self-insured medical malpractice claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported.

2. *Charity Care*

The Hospital maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges forgone for services and supplies furnished under its charity care policy, the estimated cost of those services and supplies, and equivalent service statistics. The following information measures the level of charity care provided during the years ended December 31, 19X7 and 19X6.

	19X7	*19X6*
Charges forgone, based on established rates	$6,000,000	$5,700,000
Estimated costs and expenses incurred to provide charity care	$5,600,000	$5,000,000
Equivalent percentage of charity care patients to all patients served	5.7%	5.6%

3. *Net Patient Service Revenue*

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows.

- *Medicare.* Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Inpatient nonacute services, certain outpatient services, and defined capital and medical education costs related to Medicare beneficiaries are paid based on a cost reimbursement methodology. The Hospital is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicare fiscal intermediary. The Hospital's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization under contract with the Hospital. The Hospital's Medicare cost reports have been audited by the Medicare fiscal intermediary through December 31, 19X6.
- *Medicaid.* Inpatient and outpatient services rendered to Medicaid program beneficiaries are reimbursed under a cost reimbursement methodology. The Hospital is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the

Hospital and audits thereof by the Medicaid fiscal intermediary. The Hospital's Medicaid cost reports have been audited by the Medicaid fiscal intermediary through December 31, 19X6.

- *Blue Cross.* Inpatient services rendered to Blue Cross subscribers are reimbursed at prospectively determined rates per day of hospitalization. The prospectively determined per-diem rates are not subject to retroactive adjustment.

The Hospital has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the Hospital under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

4. Investment in Affiliated Company

In 19X2 the Hospital entered into an agreement with two unrelated hospitals to establish and operate an ambulatory care center. In accordance with this agreement, each hospital invested $970,000 for a 33⅓-percent equity interest in the common stock of the center. The investment was made in installments during the years 19X5 through 19X7, and in May 19X7 the ambulatory care center began operations. The investment is recorded on the equity method.

Summarized financial information from the unaudited financial statements of Affiliated Company follows:

	December 31, 19X7	*December 31, 19X6*
Current assets	$1,779,000	$1,835,000
Noncurrent assets	4,052,000	4,007,000
Current liabilities	1,566,000	1,325,000
Noncurrent liabilities	1,514,000	2,789,000
Shareholders' equity	2,751,000	1,728,000

	Year Ended	
	December 31, 19X7	*December 31, 19X6*
Revenue	$3,220,000	$2,899,000
Net loss	(111,000)	(48,000)

5. Assets Whose Use Is Limited

Assets whose use is limited that are required for obligations classified as current liabilities are reported in current assets. The composition of assets whose use is limited at December 31, 19X7 and 19X6, is set forth in the following table. Investments are stated at cost that approximates market.

	19X7	19X6
By board for capital improvements:		
Cash and short-term investments	$11,000,000	$10,000,000
By agreements with third-party payors for funded depreciation:		
Cash and short-term investments	$ 8,503,000	$ 5,712,000
U.S. Treasury obligations	316,000	316,000
Interest receivable	415,000	123,000
	$ 9,234,000	$ 6,151,000
Under malpractice funding arrangement—held by trustee:		
Cash and short-term investments	$ 1,058,000	$ 857,000
U.S. Treasury obligations	1,949,000	1,825,000
	$ 3,007,000	$ 2,682,000
Under indenture agreement—held by trustee:		
Cash and short-term investments	$ 592,000	$ 1,260,000
U.S. Treasury obligations	11,024,000	9,674,000
Interest receivable	92,000	74,000
	$11,708,000	$11,008,000

6. *Property and Equipment*

A summary of property and equipment at December 31, 19X7 and 19X6, follows.

	19X7	19X6
Land	$ 3,000,000	$ 3,000,000
Land improvements	472,000	472,000
Buildings and improvements	46,852,000	46,636,000
Equipment	29,190,000	26,260,000
Equipment under capital leases	2,851,000	2,752,000
	82,365,000	79,120,000
Less accumulated depreciation and amortization	34,928,000	30,661,000
	47,437,000	48,459,000
Construction in progress	3,601,000	2,033,000
Property and equipment, net	$51,038,000	$50,492,000

Construction contracts of approximately $7,885,000 exist for the remodeling of Hospital facilities. At December 31, 19X7, the remaining commitment on these contracts approximated $4,625,000.

7. *Long-Term Debt and Capital Leases*

A summary of long-term debt and capital leases at December 31, 19X7 and 19X6, follows.

	19X7	*19X6*
9.25% Revenue Notes, due November 1, 19XX, collateralized by a pledge of the Hospital's gross receipts	$21,479,000	$22,016,000
9.25% mortgage loan, due January 19XX, collateralized by a mortgage on property and equipment with a depreciated cost of $1,800,000 at December 31, 19X7	2,010,000	2,127,000
9.75% note payable, due March 19XX, unsecured	125,000	671,000
Total long-term debt	23,614,000	24,814,000
Less current installments of long-term debt	970,000	1,200,000
Long-term debt excluding current installments	$22,644,000	$23,614,000
Capital lease obligations, at varying rates of imputed interest from 9.8% to 12.3% collateralized by leased equipment with an amortized cost of $1,500,000 at December 31, 19X7	$ 1,000,000	$ 950,000
Less current portion of capital lease obligations	500,000	550,000
Capital lease obligations, excluding current portion	500,000	400,000

Under the terms of the Revenue Note Indenture, the Hospital is required to maintain certain deposits with a trustee. Such deposits are included with assets whose use is limited in the financial statements. The Revenue Note Indenture also places limits on the incurrence of additional borrowings and requires that the Hospital satisfy certain measures of financial performance as long as the notes are outstanding.

Scheduled principal repayments on long-term debt and payments on capital lease obligations for the next five years are as follows:

	Long-Term Debt	*Obligations Under Capital Leases*
19X8	$ 970,000	$ 500,000
19X9	912,000	260,000
19Y0	983,000	260,000

19Y1	1,060,000	95,000
19Y2	1,143,000	—
	$5,068,000	1,115,000
Less amount representing interest on obligations under capital leases		115,000
Total		$1,000,000

A summary of interest cost and investment income on borrowed funds held by the trustee under the Revenue Note Indenture during the years ended 19X7 and 19X6 follows:

	19X7	*19X6*
Interest cost:		
Capitalized	$ 740,000	740,000
Charged to operations	$1,752,000	1,825,000
Total	$2,492,000	2,565,000
Investment income:		
Capitalized	$ 505,000	$ 663,000
Credited to other revenue	330,000	386,000
Total	$ 835,000	1,049,000

8. *Medical Malpractice Claims*

The Hospital is uninsured with respect to medical malpractice risks. Losses from asserted claims and from unasserted claims identified under the Hospital's incident reporting system are accrued based on estimates that incorporate the Hospital's past experience, as well as other considerations including the nature of each claim or incident and relevant trend factors. Accrued malpractice losses have been discounted at rates ranging from 7 percent to 9 percent. No accrual for possible losses attributable to incidents that may have occurred but that have not been identified under the incident reporting system has been made because the amount is not reasonably estimable.

The Hospital has established an irrevocable trust fund for the payment of medical malpractice claim settlements. Professional insurance consultants have been retained to assist the Hospital with determing amounts to be deposited in the trust fund.

9. *Endowment Funds—Investments*

Donor-restricted endowment fund investment portfolios include marketable equity securities that are carried at the lower of cost or market. Marketable equity securities of endowment funds at December 31, 19X7 and 19X6, are summarized as follows:

	Cost	*Quoted Market Value*	*Gross Unrealized Gains*	*Gross Unrealized Losses*
19X7	$1,476,000	$1,301,000	$ 8,000	$ 183,000
19X6	1,620,000	1,832,000	228,000	16,000

Realized gains on marketable equity securities of endowment funds amounted to $10,000 in 19X7 and $50,000 in 19X6.

10. Assets Held in Trust

The Hospital is an income beneficiary of the Thomas A. Smith trust. Because the assets of the trust are not controlled by the Hospital, they are not included in the Hospital's financial statements. On December 31, 19X7, the market value of the assets totaled approximately $2,652,000. Distributions of income are made at the discretion of the trustees. Income distributed to the Hospital by the trust is restricted for construction or equipment additions and amounted to $150,000 in 19X7 and $140,000 in 19X6.

11. Related Party Transactions

Because of the existence of common trustees and other factors, Sample Hospital and Sample Health Foundation (Foundation) are related parties. The Foundation is authorized by the Hospital to solicit contributions on its behalf. In its general appeal for contributions to support the community's providers of health care services, the Foundation also solicits contributions for certain other health care institutions. In the absence of donor restrictions, the Foundation has discretionary control over the amounts, timing, and use of its distributions.

Contributions made by the Foundation to the Hospital during the years ended December 31, 19X7 and 19X6, are reported in the Hospital's financial statements as follows:

	19X7	*19X6*
Unrestricted gifts and bequests	$375,000	$525,000
Restricted contributions for—		
Specific purposes	300,000	200,000
Plant replacement and expansion	70,000	85,000

In addition, the Hospital made a capital contribution of $1,000,000 to Sample Health System during 19X6.

12. Pension Plan

The Hospital has a defined benefit pension plan covering substantially all of its employees. The plan benefits are based on years of service and the employees' compensation during the last five years of covered employment. The Hospital makes annual contributions to the plan equal to the amounts of net periodic pension cost. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future.

The actuarially computed net periodic pension cost for 19X7 and 19X6 included the following components:

	19X7	*19X6*
Service cost-benefits earned during the period	$905,000	$770,000

	19X7	19X6
Interest cost on projected benefit obligation	700,000	650,000
Actual return on plan assets	(950,000)	(800,000)
Net amortization and deferral	70,000	80,000
Net periodic pension cost	$725,000	$700,000

Assumptions used in the accounting for net periodic pension cost were as follows:

	As of December 31	
	19X7	19X6
Discount rates	7.0%	7.0%
Rates of increase in compensation levels	6.0	6.0
Expected long-term rate of return on assets	8.0	8.0

The following table sets forth the plan's funded status and amounts recognized in the Hospital's financial statements at December 31, 19X7 and 19X6:

	19X7	19X6
Actuarial present value of benefit obligations:		
Vested benefit obligation	$ 8,020,000	$ 6,800,000
Nonvested benefit obligation	1,900,000	1,930,000
Accumulated benefit obligation	9,920,000	8,730,000
Effect of projected future compensation levels	1,000,000	980,000
Projected benefit obligation	10,920,000	9,710,000
Plan assets at fair value (primarily listed stocks and U.S. bonds)	11,050,000	9,800,000
Plan assets in excess of projected benefit obligation	130,000	90,000
Unrecognized net gain from past experience different from that assumed	(30,000)	(40,000)
Prior service cost not yet recognized in net periodic pension cost	50,000	55,000
Unrecognized net asset at January 1, 19X6, being recognized over 15 years	(65,000)	(70,000)
Prepaid pension cost, included in other assets in the balance sheets	$ 85,000	$ 35,000

13. Commitments

Leases that do not meet the criteria for capitalization are classified as operating leases with related rentals charged to operations as incurred.

The following is a schedule by year of future minimum lease payments under operating leases as of December 31, 19X7, that have initial or remaining lease terms in excess of one year.

Year Ending December 31	*Minimum Lease Payments*
19X8	$ 517,000
19X9	506,000
19Y0	459,000
19Y1	375,000
19Y2	343,000
Total minimum lease payments	$2,200,000

Total rental expense in 19X7 and 19X6 for all operating leases was approximately $859,000 and $770,000, respectively.

14. Subsequent Event

On February 9, 19X8, the Hospital signed a contract in the amount of $1,050,000 for the purchase of certain real estate.

EXHIBIT 1b

Aggregated Balance Sheets

Approach Used to Prepare Aggregated Balance Sheets

A. Assets

Assets of the restricted funds (excluding due-to/due-from accounts—see note C) are included with assets whose use is limited, with amounts required for restricted fund current liabilities classified as current assets.

B. Liabilities

Liabilities of the restricted funds (excluding due-to/due-from accounts) are deemed to be current and therefore are reported with current liabilities.

C. Due-to/Due-from Accounts

There are two reasons why due-to/due-from accounts may exist:

- Cash of one fund is deposited with the cash account of another fund at the reporting date.
- A loan between funds has occurred.

If an aggregated balance sheet is prepared, due-to/due-from accounts generally are not reported on the balance sheet. In either situation above, cash may be reported at different amounts depending on the situation.

The due-to/due-from accounts in this illustrative statement were deemed to exist because of the first situation described above. Therefore, the due-to/due-from accounts were eliminated and the corresponding amounts of cash balances were adjusted as if the cash was actually exchanged.

Additional Disclosures

1. The amount of the assets, including details of their composition and the nature of the restrictions imposed by donors for specific purposes and permanent endowment funds
2. The details of interfund borrowing arrangements

EXHIBIT 1b (cont.)

Sample Hospital*

Balance Sheets
December 31, 19X7 and 19X6

Assets	*19X7*	*19X6*	*Liabilities and Fund Balances*	*19X7*	*19X6*
Current assets:			Current liabilities:		
Cash and cash equivalents	$ 2,803,000	$ 5,025,000	Current installments of long-term debt	$ 970,000	$ 1,200,000
Assets whose use is limited—required for current liabilities	1,267,000	1,372,000	Current portion of capital lease obligations	500,000	550,000
Patient accounts receivable, net of estimated uncollectibles of $2,500,000 in 19X7 and $2,400,000 in 19X6	15,100,000	14,194,000	Accounts payable	2,422,000	2,157,000
Estimated third-party payor settlements—Medicare	441,000	600,000	Accrued expenses	3,396,000	3,225,000
Supplies, at lower of cost (first-in, first-out) or market	1,163,000	938,000	Estimated third-party payor settlements—Medicaid	2,143,000	1,942,000
Other current assets	321,000	403,000	Deferred third-party reimbursement	200,000	210,000
Total current assets	21,095,000	22,532,000	Advances from third-party payors	122,000	632,000
			Current portion of estimated malpractice costs	600,000	500,000
			Retainage and construction accounts payable	955,000	772,000
			Advances and deferred revenue	92,000	—
			Total current liabilities	11,400,000	11,188,000
Assets whose use is limited or restricted					
By board for capital improvements	11,000,000	10,000,000			

By agreements with third-party payors for funded depreciation	9,234,000	6,151,000	Deferred third-party reimbursement	746,000	984,000
Under malpractice funding arrangement—held by trustee	3,007,000	2,682,000	Estimated malpractice costs, net of current portion	3,207,000	2,182,000
Under indenture agreement—held by trustee	11,708,000	11,008,000			
By donors or grantors for specific purposes	2,277,000	1,634,000			
By donors for permanent endowment funds	5,259,000	6,073,000			
			Long-term debt, excluding current installments	22,644,000	23,614,000
Total assets whose use is limited or restricted	42,485,000	37,548,000	Capital lease obligations, excluding current installments	500,000	400,000
			Total liabilities	38,497,000	38,368,000
Less assets whose use is limited and that are required for current liabilities	1,267,000	1,372,000	Net assets:		
			Unrestricted	69,310,000	64,567,000
			Temporarily restricted by donors/grantors	1,980,000	1,562,000
Noncurrent assets whose use is limited or restricted	41,218,000	36,176,000	Permanently restricted by donors	5,259,000	6,073,000
			Total net assets	76,549,000	72,202,000
Property and equipment, net	51,038,000	50,492,000			
Other assets:					
Prepaid pension cost	85,000	35,000			
Deferred financing costs	693,000	759,000			
Investment in affiliated company	917,000	576,000			
Total other assets	1,695,000	1,370,000			
	$115,046,000	$110,570,000		$115,046,000	$110,570,000

* Notes to these financial statements have been omitted from this exhibit. See exhibit 1a for examples of notes.

EXHIBIT 2

Sample Nursing Home, Inc.

Balance Sheets
December 31, 19X2 and 19X1

Assets	*19X2*	*19X1*	*Liabilities and Shareholders' Equity*	*19X2*	*19X1*
Current assets:			Current liabilities:		
Cash and cash equivalents	$ 95,000	$ 129,000	Current maturities of long-term debt	$ 50,000	$ 50,000
Investments, at cost that approximates market	150,000		Accounts payable	78,000	52,000
Assets whose use is limited—required for current liabilities	50,000	50,000	Accrued expenses	175,000	188,000
			Deposits from patients	50,000	45,000
			Income taxes payable	74,000	15,000
Patient accounts receivable less allowance for doubtful accounts: 19X2—$6,700; 19X1—$5,300	162,000	152,000	Total current liabilities	427,000	350,000
Estimated third-party payor settlements	71,000	62,000	Deferred income tax liability	6,000	14,000
Interest receivable	7,000	—			
Supplies	59,000	57,000	Long-term debt, less current maturities	1,700,000	1,750,000
Prepaid expenses	3,000	2,000			
Total current assets	597,000	452,000			
Assets whose use is limited:					
Under indenture agreement—held by trustee	176,000	153,000	Shareholders' equity:		
By board for capital improvements	47,000	47,000	Common stock, $20 par value; authorized 5,000 shares; issued and outstanding 3,500 shares	70,000	70,000

Total assets whose use is limited	223,000	200,000	Retained earnings	376,000	229,000
Less assets whose use is limited and that are required for current liabilities	50,000	50,000	Total shareholders' equity	446,000	299,000
Noncurrent assets whose use is limited	$ 173,000	$ 150,000			
Property and equipment:					
Land	205,000	205,000			
Land improvements	37,000	32,000			
Buildings	1,399,000	1,399,000			
Furniture, fixtures, and equipment	228,000	189,000			
	1,869,000	1,825,000			
Less accumulated depreciation	210,000	141,000			
Property and equipment, net	1,659,000	1,684,000			
Other assets:					
Note receivable	81,000	72,000			
Bond issuance cost, net of accumulated amortization of $38,000 in 19X2 and $32,000 in 19X1	42,000	48,000			
Land held for investment	27,000	7,000			
Total other assets	150,000	127,000			
Total assets	$ 2,579,000	$ 2,413,000	Total liabilities and shareholders' equity	$ 2,579,000	$ 2,413,000

See accompanying notes to financial statements.

EXHIBIT 2 (cont.)

Sample Nursing Home, Inc.

Statements of Income and Retained Earnings
Years Ended December 31, 19X2 and 19X1

	19X2	*19X1*
Net patient service revenue	$ 2,163,000	$ 1,949,000
Other revenue	67,000	22,000
Total revenue	2,230,000	1,971,000
Expenses:		
Nursing services	1,083,000	1,010,000
Dietary services	228,000	225,000
General services	212,000	212,000
Administrative services	173,000	147,000
Interest	164,000	172,000
Provision for bad debts	92,000	83,000
Depreciation	69,000	57,000
Total expenses	2,021,000	1,906,000
Income from operations	209,000	65,000
Nonoperating gains—interest and dividends	18,000	7,000
Income before provision for income taxes	227,000	72,000
Provision for income taxes	80,000	29,000
Net income	147,000	43,000
Retained earnings at beginning of year	229,000	186,000
Retained earnings at end of year	$ 376,000	$ 229,000

See accompanying notes to financial statements.

Sample Nursing Home, Inc.

Statements of Cash Flows
Years Ended December 31, 19X2 and 19X1

	19X2	*19X1*
Cash flows from operating activities and gains:		
Cash received from residents and third-party payors	$ 2,048,000	$ 1,796,000
Cash received from others	67,000	22,000
Cash paid to employees and suppliers	(1,679,000)	(1,495,000)
Interest and dividends received	10,000	10,000
Interest paid	(160,000)	(170,000)
Taxes paid	(29,000)	(30,000)
Deposits received from patients	35,000	15,000
Deposits refunded to patients	(30,000)	(20,000)
Net cash provided by operating activities and gains	262,000	128,000
Cash flows from investing activities:		
Purchase of land held for investment	(20,000)	—
Purchase of investments	(150,000)	—
Proceeds from sale of property	—	2,000
Additions to property and equipment	(44,000)	(79,000)
Cash invested in assets whose use is limited	(23,000)	—
Increase in notes receivable	(9,000)	—
Net cash used in investing activities	(246,000)	(77,000)
Cash flows from financing activities:		
Repayment of long-term debt	(50,000)	(50,000)
Net cash used by financing activities	$ (50,000)	$ (50,000)
Net increase (decrease) in cash	(34,000)	1,000
Cash at beginning of year	129,000	128,000
Cash at end of year	$ 95,000	$ 129,000

EXHIBIT 2 (cont.)

Reconciliation of Net Income to Net Cash Provided by Operating Activities and Gains:

	19X2	*19X1*
Net income	$ 147,000	$ 43,000
Adjustments to reconcile net income to net cash provided by operating activities and gains:		
Depreciation	69,000	57,000
Provision for bad debts	92,000	83,000
Amortization	6,000	6,000
Loss on disposal of property	—	11,000
Increase (decrease) in deferred income tax liability	(8,000)	7,000
Net effect of changes in receivables, supplies, prepaid expenses, accounts payable, accrued expenses, and deposits	(44,000)	(79,000)
Net cash provided by operating activities and gains	$ 262,000	$ 128,000

See accompanying notes to financial statements.

Sample Nursing Home, Inc.

Notes to Financial Statements December 31, 19X2 and 19X1

1. Summary of Significant Accounting Policies

Sample Nursing Home, Inc. operates a 128-bed nursing home in Abacus, New State. A summary of the Company's significant accounting policies follows.

Income taxes. The provisions for income taxes are based on net income reported for financial reporting purposes. Deferred income taxes arise from timing differences between financial and income tax reporting of various items (principally depreciation). Tax credits are treated as a reduction of the provision for income taxes in the year in which the credits arise.

Patient service revenue. Patient service revenue is reported at the estimated net realizable amounts from residents, third-party payors, and others for service rendered.

Revenue under third-party payor agreements is subject to audit and retroactive adjustment. Provisions for estimated third-party payor settlements are provided in the period the related services are rendered. Differences between the estimated amounts accrued and interim and final settlements are reported in operations in the year of settlement.

Assets whose use is limited. Assets set aside by the board of directors for capital improvements and assets limited as to use under terms of the note indenture are classified as assets whose use is limited.

Property and equipment. Property and equipment are recorded at cost. Depreciation is calculated on the straight-line method over the estimated useful lives of depreciable assets.

Bond issuance costs. Costs incurred in issuing the Series 19X1 bonds are being amortized over the term of the bonds using the straight-line method.

Cash and cash equivalents. Cash and cash equivalents include investments in highly liquid debt instruments with a maturity of three months or less, excluding amounts whose use is limited by board designation or note indenture.

2. Assets Whose Use Is Limited

Assets whose use is limited under the Series 19X1 note indenture agreement at December 31, 19X2 and 19X1, are summarized as follows:

	19X2	*19X1*
U.S. Treasury obligations, at cost that approximates market	$ 150,000	$ 130,000

(*continued*)

	19X2	19X1
Cash	23,000	21,000
Accrued interest income	3,000	2,000
	$ 176,000	$ 153,000

Assets set aside by the board of directors for capital improvements consist of certificates of deposit, at a cost that approximates market.

3. *Long-Term Debt*

Long-term debt at December 31, 19X2 and 19X1, was as follows:

	19X2	19X1
9.5 percent notes payable to the City of Abacus, maturing $50,000 annually through November 1, 19XX, with a final maturity of $1,000,000 on November 1, 20XX	$ 1,750,000	$ 1,800,000
Less current maturities	50,000	50,000
	$ 1,700,000	$ 1,750,000

The notes are collateralized by a first-mortgage lien on all property and equipment of the Company and a security interest in all of its receipts. The note indenture requires the maintenance of certain deposits with a trustee, which are included in assets whose use is limited.

Future maturities of long-term debt as of December 31, 19X2, follow.

19X3	$ 50,000
19X4	50,000
19X5	50,000
19X6	50,000
19X7	50,000
Thereafter	$1,500,000
Total	$1,750,000

4. *Income Taxes*

The provisions for income taxes on earnings were as follows:

	19X2	19X1
Current:		
Federal	$ 72,000	$ 15,000
State	2,000	—
Total current	74,000	15,000

	19X2	*19X1*
Deferred:		
Federal	6,000	13,000
State	—	1,000
Total deferred	6,000	14,000
Total provision for income taxes	$ 80,000	$ 29,000

Deferred income taxes are provided for the temporary differences between the financial reporting basis and the tax basis of the Company's assets and liabilities.

A reconciliation between the "statutory" federal income tax rate and the effective tax rate in the statements of income is as follows:

	19X2	*19X1*
Statutory tax rates	34%	40%
State taxes, net of federal benefit	1	1
Effective tax rates	35%	41%

5. Pension Plan

The disclosures contained in this note would be similar to the disclosures contained in note 12 of exhibit 1a and therefore are not repeated here.

EXHIBIT 3

Sample Continuing Care Retirement Community

Balance Sheets
December 31, 19X5 and 19X4

Assets	*19X5*	*19X4*
Current assets:		
Cash	$ 375,000	$ 330,000
Accounts receivable (net of allowance for doubtful accounts of $4,000 and $5,000)	187,000	197,000
Supplies	40,000	21,000
Prepaid expenses	15,000	8,000
Total current assets	617,000	556,000
Assets whose use is limited:		
Under note agreement—investments	2,130,000	1,753,000
By board for capital improvements—investments	100,000	65,000
	2,230,000	1,818,000
Property and equipment:		
Land	557,000	557,000

Liabilities and Fund Balance (Deficit)	*19X5*	*19X4*
Current liabilities:		
Current maturities of long-term debt	$ 90,000	$ 77,000
Accounts payable	180,000	174,000
Accrued expenses	161,000	178,000
Deposits on unoccupied units	22,000	40,000
Total current liabilities	453,000	469,000
Long-term debt, less current maturities	8,871,000	8,935,000
Refundable fees	59,000	144,000
Estimated obligation to provide future services, in excess of amounts received or to be received	88,000	100,000
Deferred revenue from advance fees	9,304,000	9,585,000

Land improvements	205,000	203,000	Fund balance (deficit)	(952,000)	(1,489,000)
Buildings and improvements	14,573,000	14,564,000			
Furniture and equipment	752,000	698,000			
	16,087,000	16,022,000			
Accumulated depreciation	(1,194,000)	(742,000)			
Net property and equipment	14,893,000	$15,280,000			
Deferred financing costs (net of accumulated amortization of $28,000 and $21,000)	83,000	90,000			
Total assets	$17,823,000	$17,744,000	Total liabilities and fund balance (deficit)	$17,823,000	$17,744,000

See accompanying notes to financial statements.

EXHIBIT 3 (cont.)

Sample Continuing Care Retirement Community

Statements of Revenue and Expenses and Changes in Fund Balance (Deficit)
Years Ended December 31, 19X5 and 19X4

	19X5	*19X4*
Revenue:		
Resident services, including amortization of advance fees of $935,000 and $915,000	$ 3,946,000	$ 3,152,000
Patient revenue from nonresidents	249,000	275,000
Investment income	107,000	78,000
Other	75,000	68,000
Total revenue	4,377,000	3,573,000
Expenses:		
Resident care	649,000	566,000
Dietary	781,000	701,000
Housekeeping	185,000	170,000
Plant	491,000	421,000
General and administrative	436,000	445,000
Depreciation	452,000	447,000
Interest	967,000	955,000
Total expenses	3,961,000	3,705,000
	416,000	(132,000)
Change in obligation to provide future services and use of facilities to current residents	12,000	(82,000)
Income (loss) from operations	428,000	(214,000)
Nonoperating gains—Contributions	109,000	73,000
Revenue and gains in excess of (less than) expenses	537,000	(141,000)
Fund balance (deficit) beginning of year	(1,489,000)	(1,348,000)
Fund balance (deficit) end of year	$ (952,000)	$ (1,489,000)

See accompanying notes to financial statements.

Sample Continuing Care Retirement Community

Statements of Cash Flows
Years Ended December 31, 19X5 and 19X4

	19X5	*19X4*
Cash flows from operating activities and nonoperating gains:		
Cash received from residents and third-party payors	$ 3,252,000	$ 2,341,000
Other receipts from operations	75,000	68,000
Investment income received	109,000	73,000
Contributions received	107,000	78,000
Cash paid to employees and suppliers	(2,589,000)	(2,042,000)
Interest paid	(950,000)	(945,000)
Net cash provided (used) by operating activities and nonoperating gains	4,000	(427,000)
Cash flows from investing activities:		
Acquisition of property and equipment	(65,000)	(250,000)
Cash invested in assets whose use is limited	(412,000)	(238,000)
Assets whose use is limited, used for acquisition of property and equipment	—	467,000
Net cash used by investing activities	(477,000)	(21,000)
Cash flows from financing activities:		
Proceeds from advance fees and deposits	615,000	857,000
Refunds of advance fees and deposits	(46,000)	(52,000)
Proceeds from issuance of long-term debt	26,000	—
Payments of long-term debt	(77,000)	(307,000)
Net cash provided by financing activities	518,000	498,000
Net increase in cash	45,000	50,000
Cash at beginning of year	330,000	280,000
Cash at end of year	$ 375,000	$ 330,000

EXHIBIT 3 (cont.)

Reconciliation of Income (Loss) From Operations to Net Cash Provided by Operating Activities and Nonoperating Gains:	*19X5*	*19X4*
Revenue and gains in excess of (less than) expenses	$ 537,000	$ (141,000)
Adjustments to reconcile revenue and gains in excess of (less than) expenses to net cash provided (used) by operating activities and nonoperating gains:		
Amortization of advance fees	(935,000)	(915,000)
Loss (gain) on obligation to provide future services	(12,000)	82,000
Depreciation and amortization	459,000	481,000
Provision for bad debts	3,000	3,000
Net (increase) decrease in receivables, supplies, and payables	(48,000)	69,000
Net cash provided by (used by) operating activities and nonoperating gains	$ 4,000	$ (427,000)

See accompanying notes to financial statements.

Sample Continuing Care Retirement Community

Notes to Financial Statements December 31, 19X5 and 19X4

1. Summary of Significant Accounting Policies

Sample Continuing Care Retirement Community (CCRC) provides housing, health care, and other related services to residents through the operation of a retirement facility containing 249 apartments and a seventy-eight-bed health care facility. A summary of significant accounting policies follows.

Advance fees. Fees paid by a resident upon entering into a continuing care contract, net of the portion thereof that is refundable to the resident, are recorded as deferred revenue and are amortized to income using the straight-line method over the estimated remaining life expectancy of the resident.

Obligation to provide future services. CCRC annually calculates the present value of the net cost of future services and use of facilities to be provided to current residents and compares that amount with the balance of deferred revenue from advance fees. If the present value of the net cost of future services and use of facilities exceeds the deferred revenue from advance fees, a liability is recorded (obligation to provide future services and use of facilities) with the corresponding charge to income. The obligation is discounted at 9 percent, based on the expected long-term rate of return on government obligations.

Investments. Investments, which consist of U.S. Treasury obligations, are stated at cost, which approximates fair market value. Interest and investment income are recognized when earned.

2. Property and Equipment

Property and equipment are stated at cost. Donated property is recorded at its estimated fair value at the date of receipt, which is then treated as cost. Depreciation is computed on the straight-line method based on the following estimated useful lives:

Land improvements	20 years
Buildings and improvements	40 years
Furniture and equipment	5–15 years

When assets are retired or otherwise disposed of, the cost and related accumulated depreciation are removed from the accounts, and any resulting gain or loss is recognized in income for the period. The cost of maintenance and repairs is expensed as incurred; significant renewals and betterments are capitalized.

3. Deferred Financing Costs

Deferred financing costs are being amortized using the interest method over the term of the related financing agreement.

4. Tax Status

CCRC is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code and is exempt from federal income taxes pursuant to Section 501(a) of the Internal Revenue Code.

5. Long-Term Debt

Long-term debt at December 31, 19X5 and 19X4, is as follows:

	19X5	*19X4*
10.75% mortgage note payable	$ 8,901,000	$ 8,965,000
Notes payable to bank—unsecured	34,000	14,000
Other	26,000	33,000
	8,961,000	9,012,000
Less current maturities	90,000	77,000
	$ 8,871,000	$ 8,935,000

The mortgage note is payable in consecutive monthly installments of principal and interest of $85,425 to May 20XX. The note is collateralized by a first mortgage on property and equipment with a depreciated value at December 31, 19X5, of $14,893,000 and by a pledge of all operating revenue.

As required by the mortgage note agreement, CCRC established an initial debt service reserve fund of $1,000,000 at April 15, 19X3. All resident fees received thereafter, net of resident fee refunds and debt service payments not to exceed $300,000 annually in the first four years and $200,000 annually thereafter, are to be added to the debt service reserve fund until the total sum of $2,050,000 is accumulated. Since June 1, 19X4, CCRC has been required to deliver to the trustee $5,500 per month to establish maintenance reserves until the aggregate of such payments equals a residential unit reserve and a health care center reserve of $240,000 and $90,000, respectively. At December 31, 19X5, the trustee held investments aggregating $2,130,000. Such amount has been classified as assets whose use is limited.

Scheduled annual principal maturities of long-term debt for the next five years are as follows:

19X6	$ 90,000
19X7	90,000
19X8	95,000
19X9	105,000
19X0	105,000

6. Assets Whose Use is Limited

The disclosures contained in this note would be similar to the disclosures contained in note 5 of exhibit 1a and therefore are not repeated here.

7. Pension Plan

The disclosures contained in this note would be similar to the disclosures contained in note 12 of exhibit 1a and therefore are not repeated here.

EXHIBIT 4

Sample Home Health Agency

Balance Sheets
December 31, 19X5 and 19X4

Assets	*19X5*	*19X4*
Current assets:		
Cash and cash equivalents	$ 74,000	$ 41,000
Investments	112,000	102,000
Accounts receivable, net of estimated uncollectibles of $61,000 in 19X5 and $30,000 in 19X4	752,000	476,000
Other receivables	27,000	22,000
Total current assets	965,000	641,000
Assets whose use is limited (note 3):		
Cash	35,000	35,000
Bank certificates of deposit	100,000	100,000
	135,000	135,000

Liabilities and Fund Balances	*19X5*	*19X4*
Current liabilities:		
Current maturities of long-term debt (note 4)	$ 13,000	$ 13,000
Accounts payable	40,000	21,000
Accrued payroll and vacation costs	496,000	352,000
Estimated third-party payor settlements (note 2)	28,000	31,000
Advances from third-party payors	70,000	66,000
Total current liabilities	647,000	483,000

(*continued*)

EXHIBIT 4 (cont.)

Sample Home Health Agency

Balance Sheets
December 31, 19X5 and 19X4

Assets	*19X5*	*19X4*	*Liabilities and Fund Balances*	*19X5*	*19X4*
Equipment:			Long-term debt less current maturities (note 4)	105,000	118,000
Medical and office equipment	56,000	39,000			
Vehicles	50,000	37,000			
	106,000	76,000			
Less accumulated depreciation	(45,000)	(24,000)			
Net equipment	61,000	52,000	Fund balance	429,000	252,000
Deferred finance charges, net of accumulated amortization of $15,000 in 19X5 and $10,000 in 19X4.	20,000	25,000		$ 1,181,000	$ 853,000
	$ 1,181,000	$ 853,000			

See accompanying notes to financial statements.

Sample Home Health Agency

Statements of Revenue and Expenses and Changes in Fund Balance Years Ended December 31, 19X5 and 19X4

	19X5	*19X4*
Net patient service revenue (note 2)	$ 4,042,000	$ 2,687,000
Other revenue	27,000	32,000
Total revenue	4,069,000	2,719,000
Expenses: (note 5)		
Professional care of patients	2,714,000	1,835,000
General and administrative	1,042,000	675,000
Occupancy	90,000	83,000
Provision for bad debts	46,000	21,000
Depreciation	21,000	15,000
Interest	16,000	19,000
Total expenses	3,929,000	2,648,000
Income from operations	140,000	71,000
Nonoperating gains:		
Contributions	19,000	15,000
Investment income	18,000	12,000
Total nonoperating gains	37,000	27,000
Revenue and gains in excess of expenses	177,000	98,000
Fund balance at beginning of year	252,000	154,000
Fund balance at end of year	$ 429,000	$ 252,000

See accompanying notes to financial statements.

EXHIBIT 4 (cont.)

Sample Home Health Agency

Statements of Cash Flows
Years Ended December 31, 19X5 and 19X4

	19X5	*19X4*
Cash flow from operating activities and nonoperating gains:		
Cash received from patients and third-party payors	$ 3,721,000	$ 2,542,000
Other receipts from operations	22,000	32,000
Cash paid to employees and suppliers	(3,683,000)	(2,540,000)
Interest paid	(11,000)	(14,000)
Nonoperating gains	37,000	27,000
Net cash provided by operating activities and nonoperating gains	86,000	47,000
Cash flows from investing activities:		
Purchase of equipment	(30,000)	(19,000)
Purchase of investments	(10,000)	(15,000)
Net cash used by investing activities	(40,000)	(34,000)
Cash flows from financing activities		
Payment of long-term debt	(13,000)	—
Net cash used by financing activities	(13,000)	—
Net increase in cash	33,000	13,000
Cash at beginning of year	41,000	28,000
Cash at end of year	$ 74,000	$ 41,000

Reconciliation of Revenue and Gains in Excess of Expenses to Net Cash Provided by Operating Activities and Nonoperating Gains:

	19X5	*19X4*
Revenue and gains in excess of expenses	$ 177,000	$ 98,000
Adjustments to reconcile revenue and gains in excess of expenses to net cash provided by operating activities and nonoperating gains:		
Provision for bad debts	46,000	21,000
Depreciation and amortization	26,000	20,000
Increase in accounts receivable	(322,000)	(150,000)
Increase in other receivables	(5,000)	(2,000)
Increase in accounts payable and accrued expenses	163,000	50,000
(Decrease) increase in estimated third-party receivables	(3,000)	3,000
Increase in advances from third-party payors	4,000	7,000
Net cash provided by operating activities and nonoperating gains	$ 86,000	$ 47,000

See accompanying notes to financial statements.

Sample Home Health Agency

Notes to Financial Statements
Years Ended December 31, 19X5 and 19X4

1. Summary of Significant Accounting Policies

Sample Home Health Agency (the Agency) was incorporated in 19X0 as a not-for-profit corporation. The Agency provides health and supportive services to individuals at their homes.

Charity care. The Agency has a policy of providing charity care to patients who are unable to pay. Such patients are identified based on financial information obtained from the patient and subsequent analysis. Since the Agency does not expect payment, estimated charges for charity care are not included in revenue.

Net patient service revenue. Net patient service revenue represents the estimated net realizable amounts from patients, third-party payors, and others for services rendered.

Income taxes. The Agency is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code.

Assets whose use is limited. Assets set aside for board-designated purposes are classified as assets whose use is limited.

Investments. Investments consist of U.S. Treasury obligations at cost, which approximates market value.

Equipment. Equipment is recorded at cost. Depreciation is computed using the straight-line method over the estimated useful lives of the assets.

Cash and cash equivalents. Cash and cash equivalents include investments in highly liquid debt instruments with a maturity of three months or less, excluding amounts whose use is limited by board designation.

2. Third-Party Rate Adjustments and Revenue

Approximately 38 percent in 19X5 and 37 percent in 19X4 of net patient service revenue was derived under federal and state third-party reimbursement programs. These revenues are based, in part, on cost reimbursement principles and are subject to audit and retroactive adjustment by the respective third-party fiscal intermediaries. In the opinion of management, retroactive adjustments, if any, would not be material to the financial position or results of operations of the Agency.

3. *Board-Designated Assets*

The board of directors has designated cash and investments aggregating $135,000 to be used for future major capital improvements. Those assets are classified in the balance sheets as assets whose use is limited.

4. *Long-Term Debt*

Long-term debt at December 31, 19X5 and 19X4, is as follows:

	19X5	*19X4*
Note payable to Bank, interest at 15%, collateralized by equipment with a depreciated cost of $42,000	$ 118,000	$ 131,000
Less current maturities	13,000	13,000
Long-term debt, less current maturities	$ 105,000	$ 118,000

Scheduled maturities of long-term debt at December 31, 19X5 are as follows:

19X6	$ 13,000
19X7	13,000
19X8	13,000
19X9	13,000
19X0	13,000
Thereafter	53,000
Total	$ 118,000

5. *Pension Plan*

The disclosures contained in this note would be similar to the disclosures contained in note 12 of exhibit 1a.

6. *Charity Care*

Charity care represented approximately 3 percent and 4 percent of visits in 19X5 and 19X4, respectively.

EXHIBIT 5

Sample Health Maintenance Organization

Balance Sheets
December 31, 19X5 and 19X4

Assets	*19X5*	*19X4*
Current assets:		
Cash	$ 2,000	$ 193,000
Temporary cash investments	2,935,000	828,000
Premiums receivable	358,000	407,000
Other receivables	263,000	261,000
Supplies	190,000	184,000
Prepaid expenses	197,000	99,000
Total current assets	3,945,000	1,972,000
Property and equipment (notes 3 and 4)	7,559,000	7,062,000
Less accumulated depreciation and amortization	(1,803,000)	(1,436,000)
	5,756,000	5,626,000
State guaranty fund deposit (note 5)	150,000	150,000
Debt issuance costs, net of accumulated amortization of $42,000 in 19X5 and $39,000 in 19X4	18,000	21,000
Total assets	$ 9,869,000	$ 7,769,000

Liabilities and Fund Balances	*19X5*	*19X4*
Current liabilities:		
Unsecured 12% note payable to a bank	$ —	$ 44,000
Portion of long-term debt payable within one year (note 4)	241,000	109,000
Accounts payable—medical services	2,245,000	1,471,000
Other accounts payable and accrued expenses	829,000	661,000
Unearned premium revenue	141,000	202,000
Total current liabilities	3,456,000	2,487,000
Long-term debt, less portion payable within one year (note 4)	4,295,000	4,382,000
Commitments and contingencies (notes 2 and 8)		
Fund balance	2,118,000	900,000
Total liabilities and fund balance	$ 9,869,000	$ 7,769,000

See accompanying notes to financial statements.

Sample Health Maintenance Organization

Statements of Revenue and Expenses and Changes in Fund Balance Years Ended June 30, 19X5 and 19X4

	19X5	*19X4*
Revenue:		
Premiums earned	$27,682,000	$22,500,000
Coinsurance	689,000	500,000
Interest and other income	242,000	100,000
	28,613,000	23,100,000
Expenses:		
Contracted hospital, physician, and other services	12,749,000	9,734,000
Health centers—medical services	10,116,000	8,786,000
Health centers—administration	1,556,000	1,530,000
General administration	1,695,000	1,309,000
Membership services	527,000	440,000
Interest	385,000	375,000
Depreciation and amortization	367,000	336,000
	27,395,000	22,510,000
Income from operations	1,218,000	590,000
Fund balance at beginning of year	900,000	310,000
Fund balance at end of year	$ 2,118,000	$ 900,000

See accompanying notes to financial statements.

EXHIBIT 5 (cont.)

Sample Health Maintenance Organization

Statements of Cash Flows
Years Ended June 30, 19X5 and 19X4

	19X5	*19X4*
Cash flows from operating activities:		
Cash received from premiums, stop-loss insurance recoveries, and coinsurance	$28,969,000	$24,410,000
Cash paid to employees and to providers of health care services	(26,405,000)	(22,818,000)
Interest income received	230,000	90,000
Interest paid	(382,000)	(372,000)
Net cash provided by operating activities	2,412,000	1,310,000
Cash flows from investing activities:		
Additions to property and equipment	(497,000)	(121,000)
Net cash used by investing activities	(497,000)	(121,000)
Cash flows from financing activities:		
Proceeds from long-term debt	300,000	—
Repayment of long-term debt	(299,000)	(1,000,000)
Net cash provided from (used by) financing activities	1,000	(1,000,000)
Net increase in cash and temporary cash investments	1,916,000	189,000
Beginning cash and temporary cash investments	1,021,000	832,000
Ending cash and temporary cash investments	$ 2,937,000	$ 1,021,000

Reconciliation of Income From Operations to Net Cash Provided by Operating Activities:

	19X5	*19X4*
Income from operations	$ 1,218,000	$ 590,000
Adjustments to reconcile income from operations to net cash provided by operating activities:		
Depreciation and amortization	370,000	339,000
Increase in accounts payable—medical services	774,000	335,000
Increase (decrease) in unearned premium revenue	(61,000)	115,000
Decrease in premiums receivable	49,000	84,000
Net effect of changes in other receivables, supplies, prepaid expenses, and other payables	62,000	(153,000)
Net cash provided by operating activities	$ 2,412,000	$ 1,310,000

See accompanying notes to financial statements.

Sample Health Maintenance Organization

Notes to Financial Statements June 30, 19X5 and 19X4

1. Formation and Purpose of Sample HMO

Sample Health Maintenance Organization (Sample HMO) was incorporated in 19X0 as a not-for-profit corporation for the purpose of providing comprehensive health care services on a prepaid basis and for the purpose of establishing and operating organized health maintenance and health care delivery systems.

Sample HMO has been determined to be a qualified health maintenance organization (HMO) under Title XIII of the Public Health Service Act.

2. Summary of Significant Accounting Policies

Temporary cash investments. Temporary cash investments at June 30, 19X5 and 19X4, include a repurchase agreement with a bank and certificates of deposit with original maturities of less than ninety days carried at a cost that is equivalent to market.

Premiums revenue. Membership contracts are on a yearly basis subject to cancellation by the employer group or Sample HMO upon thirty days written notice. Premiums are due monthly and are recognized as revenue during the period in which Sample HMO is obligated to provide services to members.

Health care service cost recognition. Sample HMO contracts with various health care providers for the provision of certain medical care services to its members. Sample HMO compensates those providers on a capitation basis. As part of a cost control incentive program, Sample HMO retains up to XX percent of the capitation as a risk-sharing fund. In the event of hospital utilization in excess of budget, those providers bear the risk to the extent of XX percent of the capitation fee. Operating expenses include all amounts incurred by Sample HMO under the aforementioned contracts.

The cost of other health care services provided or contracted for is accrued in the period in which it is provided to a member based in part on estimates, including an accrual for medical services provided but not reported to Sample HMO.

Inventories of supplies. Inventories of drugs and other supplies are stated at the lower of cost (first-in, first-out) or market.

Property and equipment. Property and equipment are recorded at cost, less accumulated depreciation. Maintenance and repairs are charged to expense, and betterments are capitalized. Property and equipment costing approximately $700,000 was financed by health maintenance organization initial development grants received in 19X1–19X2 from the U.S. Department of Health and Human Services. This property will be

owned by Sample HMO as long as the equipment and facilities are used for projects related to the objectives of the Public Health Service Act.

Depreciation is computed using the straight-line method over the estimated useful lives of the related assets as follows:

Building	40 years
Improvements	20–25 years
Data processing and laboratory equipment and automobiles	3–7 years
Medical equipment	10 years
Office equipment	5–10 years

Amortization of debt issuance costs. Debt issuance costs are deferred and amortized using the interest method over the term of the related debt.

Retirement plan expense. Sample HMO has a retirement plan as more fully described in note 6. Charges to expense are recognized when the corporation makes contributions to the plan.

Federal income tax. Sample HMO is exempt from federal income taxes under Section 501(c) (4) of the Internal Revenue Code; accordingly, no provision for federal income taxes has been made in the accompanying financial statements.

Reinsurance (stop-loss insurance). Reinsurance premiums are reported as health care costs, and reinsurance recoveries are reported as revenue.

3. *Property and Equipment*

Property and equipment at June 30, 19X5 and 19X4, consists of the following:

	19X5	*19X4*
Land	$ 300,000	$ 300,000
Buildings and improvements	5,473,000	5,459,000
Furniture and equipment	1,786,000	1,303,000
	7,559,000	7,062,000
Less accumulated depreciation	(1,803,000)	(1,436,000)
	$ 5,756,000	$ 5,626,000

4. Long-Term Debt

Long-term debt is collateralized by assets with a depreciated cost of $4,943,000. A summary of long-term debt at June 30, 19X5 and 19X4, follows.

	19X5	*19X4*
HHS loan, interest at 7.5%	$ 2,020,000	$ 2,111,000
HHS loan, interest at 9.25%	1,658,000	1,694,000
Secured equipment loans	858,000	686,000
	4,536,000	4,491,000
Less portion payable within one year	241,000	109,000
	$ 4,295,000	$ 4,382,000

Scheduled principal payments on long-term debt are as follows:

Fiscal Year	*Scheduled Principal Payments*
19X6	$ 241,000
19X7	259,000
19X8	280,000
19X9	800,000
19Y0	2,956,000
	$4,536,000

5. State Guarantee Fund Deposit

In August 19X5 the state in which sample HMO is domiciled enacted legislation specifically governing HMOs. Under this legislation, the corporation is required to maintain a deposit of $150,000 with the director of the division of insurance of the state (the Division).

6. Employee Retirement Plan

The corporation has a contributory defined contribution retirement plan covering substantially all employees. Expense determined in accordance with the plan formula (4 percent to 10 percent of eligible covered compensation) was $354,000 for the year ended June 30, 19X5 ($275,000 in 19X4).

7. Stop-Loss Insurance

Sample HMO entered into a stop-loss insurance agreement with an insurance company to limit its losses on individual claims. Under the terms of this agreement, the insurance company will reimburse Sample HMO approximately XX percent of the cost of each member's annual

hospital services, in excess of a $XXX deductible, up to a lifetime limitation of $XXX per member. In the event Sample HMO ceases operations, (*a*) plan benefits will continue for members who are confined in an acute care hospital on the date of insolvency until their discharge and (*b*) plan benefits will continue for any other member until the end of the contract period for which premiums have been paid.

Stop-loss insurance premiums of approximately $700,000 and $500,000 are included in health care costs in 19X5 and 19X4, respectively. Approximately $600,000 and $400,000 in stop-loss insurance recoveries are deducted from health care costs in 19X5 and 19X4, respectively.

Included in other receivables is approximately $50,000 recoverable from insurers.

8. Malpractice Claims

Malpractice claims have been asserted against Sample HMO by various claimants. The claims are in various stages of processing, and some may ultimately be brought to trial. In the opinion of counsel, the outcome of these actions will not have a significant effect on the financial position or the results of operations of Sample HMO. Incidents occurring through June 30, 19X5, may result in the assertion of additional claims. Other claims may be asserted arising from past services provided. Management believes that these claims, if asserted, would be settled within the limits of insurance coverage.

EXHIBIT 6

Sample Ambulatory Care, Inc.

Balance Sheets
December 31, 19X5 and 19X4

Assets	*19X5*	*19X4*
Current assets:		
Cash	$ 65,000	$ 76,000
Patient accounts receivable less allowance for uncollectible accounts: 19X5—$15,000; 19X4—$5,000	290,000	278,000
Estimated retroactive adjustments—third-party payors (note 4)	19,000	32,000
Accounts receivable—other	13,000	8,000
Supplies	21,000	18,000
Prepaid expenses and deposits	5,000	9,000
Total current assets	413,000	421,000
Property and equipment, at cost:		
Land	100,000	100,000
Land improvements	322,000	322,000
Buildings	682,000	682,000
Equipment	1,390,000	1,389,000
	2,494,000	2,493,000

Liabilities and Fund Balances	*19X5*	*19X4*
Current liabilities:		
Notes payable (note 3)	$ 138,000	$ 144,000
Accounts payable	52,000	87,000
Accrued payroll, benefits, and taxes	33,000	22,000
Estimated retroactive adjustments—third-party payors (note 4)	30,000	24,000
Financing advance from third-party payor	—	1,000
Total current liabilities	253,000	278,000

Less accumulated depreciation	217,000	100,000
Net property and equipment	2,277,000	2,393,000
Other assets:		
Advances receivable (note 5)	14,000	5,000
Total assets	$ 2,704,000	$ 2,819,000

Commitment (note 5)	—	—
Fund balance	2,451,000	2,541,000
Total liabilities and fund balance	$ 2,704,000	$ 2,819,000

See accompanying notes to financial statements.

EXHIBIT 6 (cont.)

Sample Ambulatory Care, Inc.

Statements of Revenue and Expenses and Changes in Fund Balance Years Ended December 31, 19X5 and 19X4

	19X5	*19X4*
Net patient service revenue (note 7)	$ 860,000	$ 357,000
Operating gains	26,000	14,000
Total revenue and gains	886,000	371,000
Expenses:		
Salaries and wages	425,000	184,000
Employee benefits	77,000	54,000
Supplies	107,000	52,000
Purchased services	177,000	109,000
Insurance	34,000	22,000
Professional fees	27,000	1,000
Interest	15,000	17,000
Depreciation	117,000	100,000
Total expenses	979,000	539,000
Loss from operations	(93,000)	(168,000)
Nonoperating gain—interest income	3,000	11,000
Expenses in excess of revenue and gains	(90,000)	(157,000)
Balance at beginning of period	2,541,000	2,698,000
Balance at end of period	$ 2,451,000	$ 2,541,000

See accompanying notes to financial statements.

Sample Ambulatory Care, Inc.

Statements of Cash Flows
Years Ended December 31, 19X5 and 19X4

	19X7	*19X6*
Cash flows from operating activities and gains:		
Cash received from patients and third-party payors	$ 866,000	$ 368,000
Cash received from others	21,000	6,000
Interest received	3,000	11,000
Interest paid	(15,000)	(16,000)
Cash paid to employees and suppliers	(870,000)	(432,000)
Net cash provided from (used for) operating activities and gains	5,000	(63,000)
Cash flows from investing activities—		
Purchase of equipment	(1,000)	(4,000)
Advances made	(9,000)	(5,000)
Net cash used for investing activities	(10,000)	(9,000)
Cash flows from financing activities:		
Proceeds from notes payable	—	144,000
Payments on notes payable	(6,000)	—
Net cash provided by (used for) financing activities	(6,000)	144,000
Net increase (decrease) in cash	(11,000)	72,000
Cash at beginning of year	76,000	4,000
Cash at end of year	$ 65,000	$ 76,000

EXHIBIT 6 (cont.)

Reconciliation of Net Loss to Net Cash Used for (Provided From) Operating Activities and Gains:

	19X7	*19X6*
Net loss	$ (90,000)	$ (157,000)
Adjustments to reconcile net loss to net cash used for operating activities and gains:		
Depreciation	117,000	100,000
Provision for bad debts	14,000	4,000
Net (increase) decrease in receivables and net third-party payor adjustments	(12,000)	(19,000)
Net (increase) decrease in inventories of supplies, prepaid expenses and deposits	1,000	(2,000)
Net (increase) decrease in accounts payable, accrued expenses and advances from Blue Cross	(25,000)	11,000
Net cash used for (provided from) operating activities and gains	$ 5,000	(63,000)

See accompanying notes to financial statements.

Sample Ambulatory Care, Inc.

Notes to Financial Statements December 31, 19X5 and 19X4

1. Summary of Significant Accounting Policies

Net patient service revenue. Patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered.

Third-party contractual adjustments. Retroactively calculated third-party contractual adjustments are accrued on an estimated basis in the period the related services are rendered. Net patient service revenue is adjusted as required in subsequent periods based on final settlements.

Charity care. Sample Ambulatory Care, Inc. has a policy of providing charity care to patients who are unable to pay. Such patients are identified and related charges are estimated, based on financial information obtained from the patient and subsequent analysis. Since management does not expect payment for charity care, the estimated charges are excluded from revenue.

Supplies. Supplies are stated at the lower of cost (first-in, first-out) or net realizable value.

Depreciation. Depreciation of property and equipment is computed on the straight-line method over the estimated lives of depreciable assets.

Investment income. Investment income and gains on investment transactions are recorded as nonoperating gains.

2. Formation and Scope of Operations

Sample Ambulatory Care, Inc. was incorporated on September 7, 19X3, to operate an ambulatory care health facility to treat or prevent injury and disease, to provide funds or to expend funds to further the treatment or prevention of injury or disease, and to develop and participate in activities designed to promote the general health of the community.

Three area hospitals—ABC Hospital and Health Center, DEF Hospital, and GHI Hospital—entered into a members' agreement to develop this ambulatory care center. In accordance with this agreement, each hospital contributed capital of $947,000 to Sample Ambulatory Care, Inc.

Sample Ambulatory Care, Inc. began operations in October 19X3.

3. Related Party Transactions

During 19X3 Sample Ambulatory Care, Inc. entered into a contract with one of the member hospitals (managing hospital) for the management of the business and affairs of Sample Ambulatory Care, Inc. Under this agreement, Sample Ambulatory Care, Inc. pays $4,000 per month to the managing hospital. The agreement with the managing hospital was to

remain in effect through December 31, 19X5, but has been extended on a month-to-month basis.

In addition, during 19X4 each hospital loaned $48,000 to Sample Ambulatory Care, Inc. in the form of promissory notes at an interest rate of prime plus one percent (effective rates of 10 percent and 9 percent in 19X5 and 19X4, respectively). Of the total $144,000 liability, $48,000 is payable on demand after November 28, 19X5, to one member hospital, with the remaining portion ($96,000) payable on demand after December 8, 19X5, to the other two member hospitals. During 19X5 Sample Ambulatory Care, Inc. paid $2,000 to each member hospital, thereby reducing the obligation to $138,000.

4. Revenue From Contracting Agencies

Sample Ambulatory Care, Inc. participates as a provider of health care services to Blue Cross, Medicare, and County Indigent Plan patients. Reimbursement for covered services is based on tentative payment rates. Final reimbursement is determined after submission of annual cost reports and audits thereof by the fiscal intermediaries. Provisions for estimated reimbursement adjustments are reported in the financial statements in the period that the services are rendered.

5. Advances Receivable

In May 19X4 Sample Ambulatory Care, Inc. entered into a five-year agreement with XYZ Affiliates (XYZ). Under this agreement, XYZ is to provide emergency medical services as well as charge and bill each patient treated at Sample Ambulatory Care, Inc. Sample Ambulatory Care, Inc. has guaranteed that XYZ will collect at least $18,000 per month during the term of this agreement. In any month in which XYZ does not collect the minimum guarantee, Sample Ambulatory Care, Inc. advances funds to XYZ to cover the deficiency. Such advances are to be repaid to the extent XYZ's net cash collections exceed the minimum guarantee amount. Management estimates that the advances will be fully recovered in 19X8.

6. Income Taxes

Sample Ambulatory Care, Inc. is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code.

7. Charity Care

Sample Ambulatory Care, Inc. has a policy of providing charity care to indigent patients in emergency situations. These services, which are excluded from revenues, amounted to $27,000 and $13,000 in 19X3 and 19X4, respectively, when measured at Sample Ambulatory Care, Inc.'s established rates.

Appendix B

Statement of Position 89-5

Financial Accounting and Reporting by Providers of Prepaid Health Care Services

May 8, 1989

Issued by
Accounting Standards Division

American Institute of
Certified Public Accountants

AICPA

NOTE

Statements of position of the accounting standards division present the conclusions of at least a majority of the Accounting Standards Executive Committee, which is the senior technical body of the Institute authorized to speak for the Institute in the areas of financial accounting and reporting. Statements of position do not establish standards enforceable under rule 203 of the AICPA Code of Professional Conduct. However, paragraph 7 of Statement on Auditing Standards (SAS) No. 5, *The Meaning of "Present Fairly in Conformity With Generally Accepted Accounting Principles" in the Independent Auditor's Report*, as amended by SAS No. 43, *Omnibus Statement on Auditing Standards*, and SAS No. 52, *Omnibus Statement on Auditing Standards—1987*, includes AICPA statements of position among the sources of established accounting principles that an AICPA member should consider if the accounting treatment of a transaction or event is not specified by a pronouncement covered by rule 203. If an established accounting principle from one or more of these sources is relevant to the circumstances, the AICPA member should be prepared to justify a conclusion that another treatment is generally accepted.

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SUMMARY

This statement of position (SOP) provides guidance on applying generally accepted accounting principles in accounting and reporting by providers of prepaid health care services on health care costs, contract losses (premium deficiencies), stop-loss insurance (reinsurance), and contract acquisition costs. Briefly, the statement recommends the following:

1. Health care costs should be accrued as the services are rendered, including estimates of the costs incurred but not yet reported to the plan. Furthermore, if a provider is obligated to render services to specific members beyond the premium period due to provisions in the contract or regulatory requirements, the costs to be incurred of such services should also be accrued currently. Costs that will be incurred after a contract is terminated, such as guaranteed salaries, rent, and depreciation; net of any related anticipated revenues, should be accrued when it is determined that a contract with a sponsoring employer or other group will be terminated. Amounts payable to hospitals, physicians, or other health care providers under risk-retention, bonus, or similar programs should be accrued during the contract period based on relevant factors, such as experience to date.

2. A loss should be recognized when it is probable that expected future health care costs and maintenance costs under a group of existing contracts will exceed anticipated future premiums and stop-loss insurance recoveries on those contracts.

3. Stop-loss insurance premiums should be included in reported health care costs. Stop-loss insurance recoveries should be reported as a reduction of the related health care costs. Receivables representing amounts recoverable from insurers should be reported as assets, reduced by appropriate valuation allowances.

4. Contract acquisition costs should be expensed as incurred.

The provisions of this statement are effective for fiscal years beginning on or after June 15, 1989, with earlier application encouraged. Accounting changes adopted to conform to the provisions of this statement should be applied retroactively, if practicable.

Financial Accounting and Reporting by Providers of Prepaid Health Care Services

Introduction

1. The rapidly rising cost of health care services in recent years has led to an increased interest and acceptance of prepaid health care plans. These plans serve as an alternative system for the delivery and financing of health care services. Many employers now offer employees a choice between traditional insurance coverage and prepaid health care plans.

2. As a result of the rapid growth of prepaid health care plans, diverse practices have developed in accounting for and reporting health care costs, contract losses (premium deficiencies), stop-loss insurance (reinsurance), and contract acquisition costs of providers of prepaid health care services. This statement has been prepared as a basis for reducing the existing diversity of accounting and reporting practices in these areas. The appendix describes the operations of health maintenance organizations (HMOs), which are the most common form of organization providing prepaid health care services.

Scope

3. This statement applies to providers of prepaid health care services as defined in paragraph 4.

Definitions

4. The following terms are used in this statement:

Acquisition costs. Marketing costs that are (a) directly related to the acquisition of specific subscriber contracts and member enrollment and (b) incremental to general marketing activities.

Associated entity. An individual practice association, a medical group, or a similar entity that contracts with a prepaid health care provider to provide health care services.

Capitation fee. A fixed amount per member that is paid periodically (usually monthly) to a provider as compensation for providing defined health care services according to the contract provisions. The fee is set by contract between the provider of services and the prepaid health care provider. These contracts are generally with medical groups or individual practice associations, but may also be with hospitals and other providers. The capitation fee may be actuarially determined on the basis of expected costs to be incurred.

Contract period. The period for which premium rates are fixed by contract (typically one year).

Copayment. A payment required to be made by a member to a provider when health care services are rendered. Examples of typical copayments include fixed charges for each physician office visit, prescriptions, or certain elective surgical procedures.

Date of initial service. The date that a prepaid health care provider identifies that a member has an illness or shows symptoms requiring the member to obtain future health care services.

Health care costs. All costs of prepaid health care providers other than general and administrative, selling, maintenance, marketing and interest.

Health maintenance organizations (HMOs). A generic group of medical care entities organized to provide defined health care services to members in return for fixed, periodic premiums (usually paid monthly) paid in advance.

Incurred but not reported (IBNR) costs. Costs associated with health care services incurred during a financial reporting period but not reported to the prepaid health care provider until after the financial reporting date.

Individual practice association (IPA). A partnership, association, corporation, or other legal entity organized to provide or arrange for the delivery of health care services to members of a prepaid health care plan and nonmember patients. In return, the IPA receives either a capitation fee or a specified fee based on the type of service rendered.

Maintenance costs. Costs of maintaining enrollment records and processing collections and payments.

Medical group. An association of physicians and other licensed health care professionals organized on a group basis to practice medicine.

Member. An individual who is enrolled as a subscriber or as an eligible dependent of a subscriber in a prepaid health care plan.

Preferred provider organization (PPO). An organization that contracts with providers to deliver health care services for a negotiated fee based on the level of utilization. There are financial incentives to subscribers to use the contracting providers. PPOs generally operate as brokers and normally do not accept the transfer of financial risk.

Premium (subscriber fee). The consideration paid to a prepaid health care provider for providing contract coverage. Premiums are typically established on an individual, two-party, or family basis and paid monthly.

Premium period. The period to which a premium payment applies (generally one month) that entitles a member to health care services according to the contract provisions.

Prepaid health care plan. An arrangement between a health care provider and a sponsoring organization, such as an employer, specifying the payment of a fixed sum or fixed amount per member in advance for services to be delivered by the provider in accordance with the terms of the arrangement. The arrangement (plan) may cover a wide range of health care services (for example, comprehensive medical plans) or a specialized aspect of health care service (for example, dental and eye care plans).

Prepaid health care services. Any form of health care service provided to a member in exchange for a scheduled payment (or payments) established before care is provided—regardless of the level of service subsequently provided.

Providers of prepaid health care services (prepaid health care providers). Entities that provide or arrange for the delivery of health care services in accordance with the terms and provisions of a prepaid health care plan. Providers assume the financial risk of the cost of delivering health care services in excess of preestablished fixed premiums. However, some or all of this financial risk may be contractually transferred to other providers or by purchasing stop-loss insurance. The most common form of organization providing prepaid health care services is the health maintenance organization, which is described in paragraphs 6 to 18 and the appendix of this statement. Other providers of prepaid health care services may include comprehensive medical plans, physicians groups (for example, independent practice associations), and hospitals.

Stop-loss insurance. A contract in which an insurance company agrees to indemnify providers against certain health care costs incurred by members. (The term "reinsurance" is used extensively in the prepaid health care industry but generally refers to stop-loss insurance.)

Subscriber. The person who is responsible for payment of premiums or whose employment is the basis for eligibility for membership in a prepaid health care plan.

Background

5. Paragraphs 6 to 18 provide a general description of HMOs. A more detailed description is provided in the appendix of this statement.

6. An HMO is a formally organized health care system that combines delivery and financing functions. An HMO provides its members with defined health care services in return for fixed periodic premiums (usually monthly) paid in advance.

7. Many HMOs are not-for-profit entities, but there is a growing trend to establish for-profit HMOs. The Public Health Services Act and the regulations of the United States Department of Health and Human Services specify the features of, and the reporting requirements for, federally qualified HMOs. However, HMOs are not required to be federally qualified. Most HMOs are also regulated by state agencies—typically the department of insurance, the health department, or the department of corporations.

8. There are four basic kinds of HMOs. They differ in the type of relationship they have with physicians and members, as follows:

a. *Staff HMO.* The HMO employs and compensates the physicians. All premiums and other revenues accrue to the HMO.

b. *Group HMO.* Physicians practice in a centralized center or clinic usually provided by the HMO. The physicians are organized as a partnership, professional corporation, or other association, which contracts to provide health care services to members of the HMO. The HMO compensates the medical group.

c. *Individual practice association (IPA) HMO.* Patients are treated in the physicians' offices. The HMO may contract with a physician group that, in turn, contracts with individual physicians. Alternatively, the HMO may contract directly with individual physicians. Medical expenses of IPAs tend to be variable, whereas staff and group HMOs tend to have high percentages of fixed costs.

d. *Network HMO.* An HMO contracts with various physician groups that are organized in single-specialty or multi-specialty group practices to provide defined health care services to members over the contract term. Unlike the other kinds of HMOs, network HMOs are not recognized for federal qualification.

9. An HMO usually provides financial incentives to physicians to control health care costs. Physicians or other health care providers compensated on a capitation basis have incentives to keep total costs below the fees received. Physicians may receive bonuses if utilization of hospital and outpatient services by HMO members is lower than expected. In an IPA HMO, a physician usually receives a percentage of the standard fee charged by the IPA; the remaining amount is retained by the IPA in a risk pool for later distribution based on cost experience.

10. An HMO's contractual arrangements with individual physicians, physician groups, IPAs, or hospitals specify which entity bears the financial risk for adverse cost experience. An HMO may fix its costs—and thus limit its financial risk—by compensating health care providers on a capitation basis, rather than a fee-for-service basis. Likewise, an IPA may limit its financial risk by contracting with physicians or hospitals on a capitation basis. In staff and group HMOs, costs of physician and outpatient services are relatively fixed, because the physicians and support personnel are salaried employees. Consequently, a substantial portion of a staff or group HMO's total costs does not vary with the amount of services provided. Incremental costs primarily consist of costs of specialized services bought from other providers on a fee-for-service basis.

11. Premium rates typically are set by HMOs for contract periods of one year and are designed to cover the anticipated total costs of services to be rendered to members during those periods, as well as provide for margins for profit and adverse experience. Premiums are often community-rated, that is, one premium rate schedule is established for all members in a particular geographic area.

12. Under a community-rating method, each member is charged the same premium for the same health care benefits. This method distributes health care costs equally over the community of subscribers rather than charging the unhealthy more than the healthy. The premium revenue is expected to cover the health care costs of the entire membership.

13. Alternatively, premiums under an experience-rating method are based on the actual or anticipated health care costs of each contract. Member groups that incur higher health care costs in relation to other member groups pay higher premiums.

14. A fundamental difference between community rating and experience rating relates to the particular base used for setting premium rates. In a community-rated HMO, the community is generally understood to mean the HMO's entire membership. Alternatively, in an experience-rated HMO, members covered by each contract constitute a separate population base.

15. Premiums are generally required to be paid monthly in advance. Subscribers can cancel HMO contracts at the end of any month. An HMO generally cannot cancel contracts or increase premium rates during the contract periods.

16. Premiums are reported as revenue in the month that members are entitled to health care services. Premiums collected in advance generally are reported as deferred income.

17. An HMO undertakes to provide health care services to members during the contract period and normally does not provide health care services if the premiums are not paid. HMOs generally do not exclude preexisting conditions.

18. In certain circumstances, an HMO may continue providing service to a member hospitalized at the end of the contract period and until the member is discharged from the hospital (or until medical care ceases) due to contractual obligations, state regulatory requirements, or management policy. The HMO also may provide for an extension of coverage for specific items such as pregnancy.

Accounting for Health Care Costs

Discussion

19. The primary accounting issue is when to recognize the cost of prepaid health care services as expenses, either (a) as those services are rendered or (b) on the date of initial service, thereby requiring the current accrual of future costs of health care services expected to be provided to members for illnesses or conditions requiring continuing medical treatment.

Present Practices

20. There is considerable diversity in accounting for the costs of prepaid health care services. Providers may presently account for such costs (a) on the cash basis (paragraph 21), (b) when the costs are reported to the provider (paragraph 21), (c) when the services are rendered, including an estimate of incurred but not reported (IBNR) costs (paragraph 22), or (d) based on the estimated future cost of services to be provided to hospitalized members (paragraphs 23-29). In addition, some have proposed that providers also accrue at the date of initial service the estimated cost of future services to be provided to non-hospitalized members (related to a particular illness or accident) over the remainder of the contract term or in all future periods (paragraphs 24-29).

Views on the Issues

21. *Cash Basis and As-Reported Basis.* Accrual accounting is the prescribed basis of accounting for financial statements prepared in conformity with generally accepted accounting principles (GAAP). Therefore, the recognition of the costs of prepaid health care services as expenses solely in the period paid or reported to the provider does not conform with GAAP.

22. *Accrual of Health Care Costs as Services are Rendered.* Some believe that health care costs should be accrued as the services are rendered and, therefore, should include an estimate of IBNR costs. This method is consistent with the generally accepted practice of accruing expenses as incurred and matching related revenues and expenses (monthly premiums would be matched against monthly expenses). Supporters of this approach believe that monthly premiums designed to cover monthly expenses should not be matched against a combination of current and future expenses, which would be the case if costs were accrued at the date of initial service. They believe that regardless of whether a provider has an obligation to provide services beyond the period that premiums are paid, it should not have to accrue currently a liability for future services. Finally, they believe that a prepaid health care plan is predicated on a group basis; therefore, future costs associated with particular individuals should not be designated for special accounting treatment as described in the following paragraphs.

23. *Accrual of Health Care Costs According to Contractual Liability.* Some believe that in addition to accruing costs as described in paragraph 22, a provider should accrue any estimated future health care costs that it is obligated to provide beyond the period for which the premium has been paid (premium period). For example, some providers accrue estimated future health care costs as of the date a member is admitted to a hospital. They argue that, under some contracts, a provider must continue to provide services to a hospitalized member until the member is discharged regardless of whether the contract expires or premiums are continually paid. They believe, therefore, that the expense is incurred when the member is hospitalized because the provider cannot later avoid the costs associated with that hospitalization.

24. *Accrual of Health Care Costs at the Date of Initial Service.* Some believe that health care costs should be accrued at the date of initial service. This would require the accrual of estimated future costs associated with individual members requiring long-term treatment. Supporters of this approach believe it is consistent with Financial Accounting Standards Board (FASB) Statement of Financial Accounting Standards (SFAS) No. 5, *Accounting for Contingencies*, requiring the accrual of liabilities when the amounts are reasonably estimable. They also believe that the obligation to provide future services meets the definition of liabilities in FASB Statement of Financial Accounting Concepts (SFAC) No. 6, *Elements of Financial Statements*. Finally, they believe this method is consistent with GAAP for accident and health insurance policies and that the service provided by prepaid health care providers is substantially the same as the service provided by insurance companies.

25. Some supporters of this approach believe that the costs to be accrued as of the date of initial service only relate to services to be provided during the remainder of the contract period. They believe that providers are obligated only to provide services to the end of the contract period. Therefore, costs that may be incurred beyond that date should not be accrued currently because the contract may not be renewed or premium rates may be significantly changed.

26. Others believe that the costs to be accrued at the date of initial service should relate to all future services expected to be provided to the member. They believe it is reasonable to assume that members with significant health problems will continue to renew their contracts with the providers. Therefore, it is probable that the costs will be incurred, even in subsequent contract periods.

27. Opponents of the methods discussed in paragraphs 23 to 26 believe that prepaid health care providers currently have no liability for future services. They believe that the event resulting in a liability to the provider is the rendering of health care services, not the occurrence of an accident or illness during the contract or premium period. A prepaid health care provider undertakes to provide health care services for a particular period without regard to the timing of the accident or illness that leads to the service. They believe that a liability should not be accrued until the services are rendered.

28. Opponents of the methods discussed in paragraphs 23 to 26 also believe the methods could result in a mismatching of reported revenues and expenses, because they would recognize a relatively greater amount of expense in the earlier part of the contract period, whereas the methods discussed in paragraph 22 would result in a more level recognition of expense over the period. In addition, the methods described in paragraphs 23 to 26 would require a significantly greater degree of estimation, which could adversely affect the cost of preparing financial statements and the usefulness of the information. Furthermore, the method described in paragraph 26 might require consideration of factors such as estimated future premiums and the time value of money, which would make the financial statements more subjective.

29. Some of those who believe that the estimated costs of future services should be accrued currently believe that such costs should include only the incremental costs to be incurred as a result of the health care services to be provided. Costs such as physicians' salaries and capitation fees or other costs related to provider-owned hospitals or other inpatient facilities that will not increase as a result of the amount of services to be provided should not be accrued currently. They believe that the accrual should relate to identifiable incremental costs of providing health care services and not to fixed period costs. Others believe that all costs incurred in providing the services should be accrued, because these costs are directly related to the provider's obligation. They would also accrue an allocable portion of the nonincremental ("fixed") costs.

Conclusion

30. Health care costs should be accrued as the services are rendered, including estimates of the costs of services rendered but not yet reported. Furthermore, if a provider of prepaid health care services

is obligated to render services to specific members beyond the premium period due to provisions in the contract or regulatory requirements, the costs to be incurred of such services should also be accrued currently. (See the exhibit on the following page.) Costs that will be incurred after a contract is terminated, such as guaranteed salaries, rent, and depreciation, net of any related anticipated revenues, should be accrued when it is determined that a contract with a sponsoring employer or other group will be terminated.

31. Amounts payable to hospitals, physicians, or other health care providers under risk-retention, bonus, or similar programs should be accrued during the contract period based on relevant factors, such as experience to date.

32. The basis for accruing health care costs and significant business and contractual arrangements with hospitals, physicians, and other associated entities should be disclosed in the notes to the financial statements.

Implementation Aid—Accounting for Health Care Costs

The following illustrates the conclusions in the first and second sentences of paragraph 30. The illustrations demonstrate accounting for providers of prepaid health care services for two variations of contractual terms; however, other variations may exist.

Assumptions:

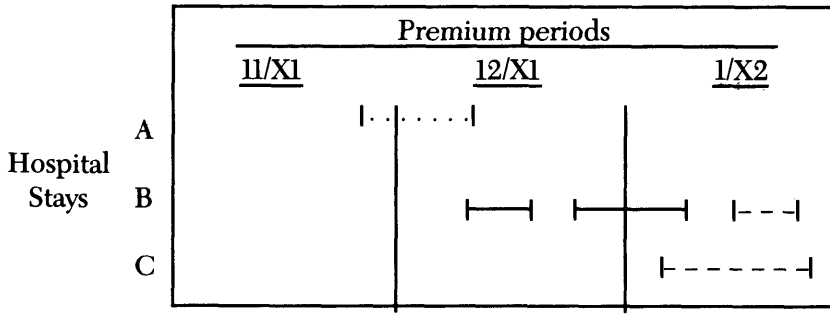
a. Patients A, B, and C are referred to Community Hospital by the prepaid health care provider:

Patient	*Reason for Hospital Stay*	*Period(s) of Hospital Stay*
A	Short-term illness	November 26, 19X1–December 6, 19X1
B	Long-term illness	December 5, 19X1–December 14, 19X1
		December 19, 19X1–January 10, 19X2
		January 15, 19X2–January 21, 19X2
C	Long-term illness	January 7, 19X2–January 28, 19X2

b. Reporting date is 12/31/X1

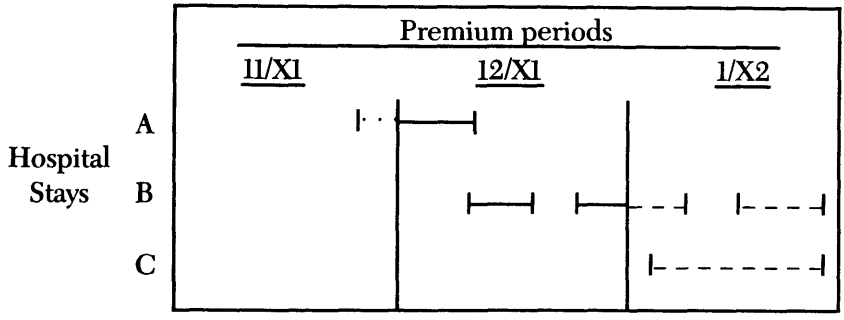
c. Contract period is July 1, 19X1, through June 30, 19X2.

Illustration 1
Contract Provides Coverage for Hospital Stays That Begin During the Premium Period



Note: . . . . cost of services to be recorded in premium period 11/X1.
____ cost of services to be recorded in premium period 12/X1.
_ _ _ cost of services to be recorded in premium period 1/X2.

Illustration 2
Contract Provides Coverage for Days of a Hospital Stay Within a Premium Period



Note: . . . . cost of services to be recorded in premium period 11/X1.
____ cost of services to be recorded in premium period 12/X1.
_ _ _ cost of services to be recorded in premium period 1/X2.

Accounting for Loss Contracts

Discussion

33. A prepaid health care provider enters into contracts to provide members with specified health care services for specified periods, in return for fixed periodic premiums for fixed periods. Associated entities such as medical groups and IPAs may enter into similar contracts with prepaid health care providers in which they agree to deliver identified health care services to the providers' members for specified periods in return for fixed capitation fees. Prepaid health care contracts can be terminated only by the action or inaction of the subscriber, for example, not paying premiums. The premium revenue is expected to cover health care costs and other costs over the terms of the contracts. Only in unusual circumstances would a provider be able to increase premiums on contracts in force to cover expected losses. A provider may be able to control or reduce future health care delivery costs to avoid anticipated losses, but the ability to avoid losses under existing contracts may be difficult to measure or demonstrate.

34. Expected losses on existing contracts are currently recognized in other industries, such as construction and insurance, whose premium deficiencies are recorded when anticipated claims and other costs are

expected to exceed unearned premiums. Paragraph 96 of SFAS No. 5 states the following:

> . . . this Statement does not prohibit (and, in fact, requires) accrual of a *net* loss (that is, a loss in excess of deferred premiums) that probably will be incurred on insurance policies that are in force, provided that the loss can be reasonably estimated, just as accrual of net losses on long-term construction-type contracts is required.

Current accounting and financial reporting literature does not specifically address the question of whether prepaid health care providers should accrue anticipated losses on health care contracts in force currently.

Present Practices

35. Losses are generally not recognized when anticipated costs are expected to exceed anticipated revenues during the unexpired terms of the existing contracts.

Views on the Issues

36. Some believe that anticipated losses on contracts should not be accrued currently. They maintain that health care costs incurred in subsequent periods are not costs of the current period because the events resulting in anticipated health care costs—the rendering of service—have not occurred. They believe that providers are usually obligated to provide services only as long as premiums are paid. They believe that reporting anticipated losses currently involves the assumption that the contract will continue and that future premiums will be paid, but these events relate to a future period. They also believe that providers do not have significant liabilities for unearned premiums as insurance companies do, because premiums are generally collected monthly to cover the cost of treatment during that month. The premium deficiency concept of insurance accounting therefore does not apply to prepaid health care providers.

37. Others believe that losses should be recognized when the anticipated future contract premiums are less than estimated future health care costs and maintenance expenses. They note that the basic agreement between a provider and the member fixes the premium rate for the entire contract period, and the contract can be terminated only by the member. Consequently, the provider's ability to avoid incurring anticipated future losses is limited. They believe that the

criteria for accruing a liability in conformity with SFAS No. 5 have been met when it is probable that projected health care costs and maintenance expenses will exceed anticipated premium revenue to be received over the remaining terms of existing contracts.

38. Some believe that losses should be recognized only when incremental health care costs and maintenance expenses exceed anticipated future premiums during the unexpired terms of groups of existing contracts. Fixed period costs, such as staff physicians' salaries and costs related to provider-owned facilities or other indirect costs that will not change as a result of the contract, should not be considered in computing the loss. Supporters of this approach believe that fixed period costs should never be considered in reporting losses. They believe that a loss should be recorded only when the provider is financially worse off as a result of the contract. Others believe that all health care costs and maintenance expenses should be considered in determining whether a loss has been incurred, including fixed costs that are not directly associated with the group of contracts resulting in the loss.

39. Some who argue that contract losses should be recognized currently believe that they should be determined on an aggregate basis for all contracts in force at the end of each period. They maintain that the losses should not be determined contract by contract, because the services provided under the contracts are similar, and losses on individual contracts are likely to be recovered from profits on other contracts.

40. Others believe that to determine the existence of a loss, contracts should be grouped on the basis of common characteristics such as geographic location or family or employer composition used to establish community premium rates (community rating). Federally qualified prepaid health care providers generally use community rating, and many local statutes require its use.

Conclusion

41. A loss should be recognized when it is probable that expected future health care costs and maintenance costs under a group of existing contracts will exceed anticipated future premiums and stop-loss insurance recoveries on those contracts. The estimated future health care costs and maintenance costs to be considered in determining whether a loss has been incurred should include fixed and variable,

direct and allocable indirect costs. Contracts should be grouped in a manner consistent with the provider's method of establishing premium rates, for example, by community-rating practices, geographical area, or statutory requirements, to determine whether a loss has been incurred.

Accounting for Stop-Loss Insurance

Discussion

42. In stop-loss insurance, prepaid health care providers transfer portions of their financial risks to insurance companies. A provider typically contracts with an insurance company to recover health care costs in excess of stated amounts during the contract periods.

43. Current accounting and financial reporting literature does not address accounting for stop-loss insurance by prepaid health care providers. Paragraphs 38 to 40 and 60f of SFAS No. 60, *Accounting and Reporting by Insurance Enterprises*, describe the reporting requirements for reinsurance transactions of insurance enterprises.

Present Practices

44. In their income statements, some providers report stop-loss insurance costs as operating expenses, whereas others report them as reductions of gross premium revenues. Some providers report amounts recovered or recoverable from insurers as additional revenue, while others reduce health care costs by these amounts.

45. In their balance sheets, some providers report amounts recoverable from insurers as reductions of accrued health care costs. Others report all amounts recoverable from insurers as assets, subject to appropriate valuation allowances.

Views on the Issues

46. Prepaid health care providers generally view stop-loss insurance premiums as operating expenses and normal and recurring business transactions incurred to provide protection from excessive loss. In turn, they view stop-loss insurance recoveries as additional revenue. These views are consistent with uniform reporting practices adopted by provider regulators. Others consider the insurers to be providing portions of the members' coverage for premiums. Consequently, they

view a portion of the gross premiums collected as due to the insurer and accordingly, the stop-loss premiums as a deduction to arrive at net premium revenue reported. Because the insurer is considered to have assumed a portion of the risk and to be responsible for that portion of the loss, reported health care costs are reduced by the amounts recovered or recoverable from insurers.

47. Some believe that amounts recoverable from insurers for unpaid losses should be applied to reduce reported health care costs because they believe that stop-loss insurance is inextricably linked to the basic contract.

48. Others believe that all amounts recoverable from insurers should be reported as assets. They base their views on GAAP, which generally prohibits the offsetting of receivables and payables to unrelated parties.

Conclusion

49. Stop-loss insurance premiums should be included in reported health care costs. Stop-loss insurance recoveries should be reported as reductions of related health care costs. Receivables representing amounts recoverable from insurers should be reported as assets, reduced by appropriate valuation allowances. In addition, the nature, amounts, and effects of significant stop-loss insurance contracts should be disclosed.

Accounting for Contract Acquisition Costs

Discussion

50. Providers of prepaid health care services incur costs in connection with writing new contracts and obtaining premiums. The accounting issue is whether—and the extent to which—such costs should be deferred. Currently, insurance companies defer certain acquisition costs and amortize them as the related revenues are earned.

Present Practices

51. Many prepaid health care providers incur costs that vary with and are primarily related to the acquisition of subscriber contracts and member enrollment. These costs, sometimes referred to as marketing costs, consist mainly of commissions paid to agents or brokers

and incentive compensation based on new enrollments. Commissions and incentive compensation may be paid when the contracts are written, at later dates, or over the terms of the contracts as premiums are received. Some providers incur additional costs directly related to the acquisition of specific contracts such as the costs of specialized brochures, marketing, and advertising. Providers also incur costs that are related to the acquisition of new members but that do not relate to specific contracts. These costs include salaries of the marketing director and staff, general marketing brochures, general advertising, and promotion expenses. Currently, most providers report all acquisition costs as expenses when incurred regardless of whether they vary with or are primarily related to the acquisition of business.

Views on the Issues

52. Some favor continuing the current practice of expensing all acquisition costs as incurred. They believe that such costs may not provide discernible and measurable future benefits and, therefore, should not be reported as assets. Furthermore, they believe that the costs of identifying acquisition costs for reporting as assets on a group or specific contract basis would outweigh any benefits to be derived from deferring such costs. They also believe that other industries report marketing costs as expenses when incurred and that reporting such costs as assets might create diverse reporting under similar circumstances.

53. Others favor deferring acquisition costs such as commissions, incentive compensation based on production, and incremental marketing costs directly related to a successful campaign to obtain specific contracts. Such costs would be charged to expense over the initial contract term in proportion to the premium revenue recognized. They believe that only incremental costs directly related to the acquisition of business should be deferred. They cite the principle in paragraph 157 of APB Statement No. 4, *Basic Concepts and Accounting Principles Underlying Financial Statements of Business Enterprises*, which states that "some costs are recognized as expenses on the basis of a presumed direct association with specific revenue. . . . Recognizing them as expenses accompanies recognition of the revenues."

Conclusion

54. Although there is theoretical support for deferring certain acquisition costs, acquisition costs of providers of prepaid health care services should be expensed as incurred.

Effective Date and Transition

55. This statement is effective for fiscal years beginning on or after June 15, 1989, with earlier application encouraged. Accounting changes adopted to conform to the provisions of this statement should be applied retroactively, if practicable. In the year during which this statement is first applied, the financial statements should disclose the nature of any restatement and its effect on income before extraordinary items, net income, and related per share amounts for each year restated.

56. If retroactive restatement of all years presented is not practicable, the financial statements presented should be restated for as many consecutive years as practicable. The cumulative effect of applying the statement should be included in determining net income of the earliest year presented. If it is not practicable to restate any prior year, the cumulative effect should be included in net income in the year in which the statement is first applied, in conformity with paragraph 20 APB Opinion 20, *Accounting Changes*.

APPENDIX

Description of Health Maintenance Organizations

Overview

A-1. A health maintenance organization (HMO) is a formally organized system of health care that combines the functions of delivery and financing. The HMO contracts with subscribers to provide comprehensive health care services in return for a fixed periodic (generally monthly) premium for a fixed period (generally one year).

A-2. HMOs are categorized by federal regulation as one of three types: staff, group, or individual practice association. Other types are also possible. Regardless of the type, the HMO is the umbrella organization that administers the operation of the plan, monitors the use of services, and interacts with the medical staff and other personnel as well as with the enrolled members. The HMO services a geographic area in which members are able to obtain services from the organized health care delivery service.

A-3. Many HMOs are not-for-profit entities. The following types of organizations, with and without federal financial assistance, have sponsored the development of HMOs: consumer groups, employees, labor unions, medical schools, insurance carriers, Blue Cross/Blue Shield service plans, medical groups, partnerships and professional corporations, independent community hospitals, for-profit and not-for-profit hospital chains, cities, medical societies, neighborhood health centers, and business coalitions.

A-4. HMOs exist in a regulated environment. They are not required to be federally qualified (that is, an entity that has been found by the Secretary of the Department of Health and Human Services to meet the applicable requirements of Title XIII of the Public Health Service Act and its regulations), but there are two significant advantages to qualification:

a. Federally qualified HMOs benefit from the legislative mandate of "mandatory dual choice." This provision requires most employers in the HMO's service area to include the option of an IPA and a group model HMO, if available, in any of their health care benefit plans.

b. Many employers believe that federal qualification is a prerequisite for including the HMO in their health care benefit plans. Federally qualified HMOs must comply with complex federal reporting requirements. Most HMOs are under the control of state agencies—typically the department of insurance or the department of corporations. Those departments impose certain operating requirements as a condition for continued licensure, qualification, or contractual relationships.

A-5. Enrollment in HMOs is recruited from the following specific groups as defined by principal sources of payment for medical care: large group employers, public employers, Medicaid and Medicare beneficiaries, small group aggregates, and individuals.

A-6. The services that HMOs offer vary. To be federally qualified, the HMO must include the basic health services required by the HMO Act of 1973, and the services must be provided to members without restrictions on time and cost, except for certain prescribed limitations (for example, maximum visits for mental health and copayments). The basic health services include (a) diagnostic and therapeutic services, (b) inpatient hospital services, (c) short-term rehabilitation, (d) emergency health care services, (e) services for abuse of or addiction to alcohol or drugs, (f) diagnostic laboratory and diagnostic and therapeutic radiological services, (g) home health services, and (h) preventive health services, such as prescription drugs, dental care, and vision care.

A-7. A member may have health care coverage under more than one health care plan or insurer. In those cases, responsibility for the payment of costs is allocated among the parties, based on provisions of law, regulation, or contract in a process called coordination of benefits.

A-8. Prepaid periodic premiums are designed to cover the costs of health care services, the costs of acquiring and enrolling members, and general and administrative expenses, as well as to provide a margin for profit and adverse experience. To remain competitive, some HMOs require member copayments to supplement the premiums. Typical copayments range from two dollars to five dollars for an office visit to a physician.

HMO Models

A-9. There are four basic HMO models. They are differentiated by the type of relationship that has been established between the physicians who deliver the services to members and the legal corporate entity (the HMO).

A-10. *Staff Model.* Physicians are organized as employees who devote their practices to the HMO. All revenues, including premiums and fee-for-service revenues, accrue to the HMO. Physicians are compensated by an arrangement other than fee-for-service, such as salary or retainer. The physicians generally practice as a group in a centralized facility and share common support personnel, medical records, and equipment. This model is also referred to as a "closed panel," because enrollees may select only from among these physicians to receive contracted benefits.

A-11. *Group Model.* Physicians and other licensed health care professionals are organized as a partnership, a professional corporation, or

another association that executes an agreement or contract with one or more HMOs. The physicians and health care professionals are not salaried employees or "staff" of the HMO, but this model is still considered a "closed panel." As their principal professional activity, they engage in a coordinated practice; as a group, they devote a significant amount of their aggregate activity to the delivery of health care service to HMO members. Like the staff model, members of the medical group share records, equipment, and professional, technical, and administrative staff. The HMO compensates the medical group at a negotiated rate, which is then distributed to the physician group members according to a prearranged schedule.

A-12. *Individual Practice Association Model.* An IPA is a partnership, association, corporation, or other legal entity that delivers, or arranges for the delivery of health care services in accordance with a contract with an HMO. The IPA accepts a fee (generally a predetermined capitation fee) and a corresponding obligation to provide identified health care services over the contract term. To provide the services, the IPA enters into service and compensation arrangements with health care professionals. This model differs from the previous two in that physicians continue in individual or group practice and maintain their existing offices. Many IPAs originally were sponsored by local medical societies as "foundations for medical care," and all or most of the physicians in an area usually were invited to participate. Thus, the IPA became associated with the concept of an "open panel" practice. Membership in an IPA does not limit a physician's practice to treatment of HMO enrollees.

A-13. The HMO may compensate the IPA at a negotiated per capita rate for enrolled members. Likewise, the IPA's compensation arrangement with member physicians may be at a negotiated rate per capita, on a flat retainer fee, or on a fee-for-service basis. To reconcile fee-for-service compensation to physicians with the fixed prepaid revenue the IPA receives from the HMO, the physician often agrees to a discounted fee schedule or an acceptance of a degree of financial risk. That is, the physician will agree to accept a percentage of his or her regular fee or a discounted fee with the balance held in reserve. At year end, if the use of the health care services has been within the projected limits, the physicians may receive the balance of their claims after provision for contingencies. If premiums are inadequate, the physician may agree to accept a pro rata decrease in fees and may even be liable for inappropriate hospital costs. The HMO may also compensate physicians directly.

A-14. *Network Model.* As with the group model HMO, physicians and other licensed health care professionals are organized as partnerships, professional corporations, or other associations for the group practice of medicine. These group practices may be multi-specialty or single-specialty practices. The HMO contracts with various group practices to provide

identified health care services over the contract term. As compensation for providing these services, the groups receive a fixed capitation fee per member per period, regardless of the number of visits the members make to the groups. This income is then distributed to the individual physician-group members according to a prearranged schedule. Unlike other models, a network model is not a recognized category for purposes of federal qualification. Network models applying for federal qualification have generally been categorized as IPAs when qualified. However, network model characteristics are generally similar to the group model characteristics.

Cost and Use Control

A-15. To control health care costs and the use of services, an HMO generally assigns each member, or allows a member to choose, a primary care physician. This physician typically authorizes all services, including hospitalization and referral to member specialists and nonmember physicians. Under a capitation system, the physician has an incentive to maintain costs at or below the capitation fee received. Most group models are on a capitation basis. Additionally, financial incentives are usually provided to physicians to reduce health care costs. Contracts may provide for a sharing of any savings realized from lower-than-expected use of hospital and outpatient services. In the IPA model, the physician usually receives a percentage of the agreed fee, with the remaining amount held by the IPA in a risk pool. If usage of hospital and outpatient facilities for the year is as expected, the physicians receive the remaining amount. If usage is lower than expected, the physicians may share in a risk pool; if higher than expected, they receive a lower percentage of the billed fee. In addition, the IPA may share in a hospital risk pool, if any, and the physicians would share in any savings realized as a result of lower hospital use. Furthermore, an HMO may control use through medical review boards, prehospitalization certification, or prereferral screening.

Hospitalization Services

A-16. A few HMOs own and operate hospitals or other inpatient facilities. However, inpatient hospitalization, except for bona fide emergency care services, is usually provided by hospitals that have contracted with the HMO. The relationship between hospitals and HMOs may be informal, with the hospital granting admitting privileges to a plan's physicians, or there may be a formal contract under which the hospital guarantees the availability of a predetermined number of beds, regardless of whether the beds are actually used. Several financial arrangements are possible. The HMO may pay the hospital a periodic amount, similar to a retainer, for a given number of beds. The HMO may make a prospective payment with or without retrospective adjustment at the end of the accounting period; or it may retrospectively reimburse the hospital. In the last two cases, the HMO

pays according to a fee-for-service arrangement, which may be either full or discounted costs and charges. In addition, HMOs may compensate hospitals based on costs incurred or on a specific fee basis.

Risk Evaluation

A-17. An HMO's contractual arrangements with IPAs, groups, and hospitals determine which entity bears the financial risk for adverse experience if actual health care costs exceed the premium or capitation fee received and the extent of that risk. For example, the HMO may continue to bear the risk of adverse experience for hospitalization and related inpatient charges, but it may shift the risk for physician and outpatient services to the group or IPA by a capitation-compensation arrangement. Drug costs may be retained by the HMO or may be capitated to the medical group or IPA. In the latter situation, the extent of risk borne by the group or IPA depends primarily on the physician compensation arrangement. Compensation on a fixed-salary basis, provided enrollment is sufficient to cover those salaries, generally limits risk to the amount of outside costs incurred for specialists who are not members of the group. Likewise, compensation of IPA physicians on a capitation basis limits the IPA's risk. If the IPA or group provides for fee-for-service or incentive compensation, respectively, its risk exposure is greater because its claims may exceed capitation fees, and the IPA may be unable to lower the fees paid to physicians. Additionally, the IPA may not be able to retain physicians since they have the option of withdrawing from the IPA.

A-18. A few HMOs function primarily as marketing and facultative agencies and bear no risk for adverse experience. This type of HMO contracts with one or more IPAs and hospitals on a capitation basis, retaining a portion of the fee to cover marketing and administrative costs. In this situation, the adverse experience risk is borne by the IPAs and hospitals. This shifting of risk may be of short-term benefit to the HMO, since the hospitals, groups, or IPAs with adverse experience are likely to demand higher capitation fees or refuse to renew the contract.

A-19. By contractual agreement, the HMO may shift the burden of providing and paying for services to the medical group or IPA. In this situation, the HMO pays the medical group or IPA a capitation fee to provide a predetermined range of physician and other outpatient services. In the group and staff model HMOs, physician and other outpatient services are period expenses and are relatively fixed, because the physicians and medical-support personnel are salaried employees. Although the number of employees will vary with the level of enrollment, this variance is a step increment.

A-20. In the group or staff model HMO, incremental costs consist primarily of nonemployee specialized services that must be purchased (for

example, the services of a specialist in open heart surgery). In an IPA model, physician service costs will be fixed for the HMO if the IPA is compensated on a capitation basis. In this situation, incremental costs would be incurred only if services must be purchased from nonmember providers. Similarly, incremental costs generally are limited to costs incurred at nonmember facilities, such as out-of-area or emergency services, if an HMO owns its own hospital or compensates its member hospital on a capitation or other fixed basis. If member hospitals, IPAs, groups, or individual physicians are compensated on a fee-for-service basis, each service may be viewed as an incremental cost.

Comparison of HMOs and Insurance Companies

A-21. Both HMOs and insurance companies provide coverage for health care services. The fundamental difference between HMOs and insurance companies is that HMOs also undertake to provide, or arrange for the provision of, the covered health care services. In providing such services, the HMO exercises some control over the use of these services and frequently must approve coverage of certain services before they are provided. The insurance company provides an indemnity and does not have the ability to approve services or, therefore, to refuse a covered claim before the services are provided.

A-22. HMOs and insurance companies consider the following similar factors in determining the premium charged for coverage.

A-23. *Cost Assumption.* Premium rates are established by HMOs and insurance companies, for either a group or an individual policy, by projecting the anticipated costs of providing the health care services, expenses, and a margin for adverse experience. The projections include, in addition to anticipated price changes, estimates of hospital days, physician visits, outpatient services, maternity, and policyholder or member termination. Also included are estimates for extended care beyond the contract or policy period.

A-24. *Risk Assumption.* HMOs and insurance companies frequently differ in their risk-rating approach to setting premiums. Insurance companies aggregate claims experience and estimate experience ratings for each insured group. Federally qualified HMOs generally use community-rating methods based on geographic area or actuarial classes, whereas nonqualified HMOs may use individual-contract group ratings (experience-rating methods). As a result, federally qualified HMOs and HMOs that do not use contract group rating methods are susceptible to a greater risk of adverse experience than are insurance companies.

A-25. *Coverage Period and Payment Mode.* Premiums are typically set by HMOs and insurance companies for a contract period of one year and are

designed to cover the anticipated costs for that period. Some believe that HMOs differ from insurance companies in that the premiums cover the anticipated costs on a monthly basis. This is a somewhat artificial distinction because health care services show seasonal variations, and premiums are designed to cover health care costs over the contract term. Both insurance companies and HMOs experience seasonal variation in claims throughout the contract period.

A-26. HMOs and insurance companies recognize premium revenues in essentially the same manner. Premiums generally are paid on a monthly basis in advance. If the participant cancels coverage, the cancellation generally takes effect as of the last day of the month to which the last paid premium applies.

A-27. A policyholder or member may cancel an insurance policy or HMO contract at any time. Generally, cancellation may be made only by the insured, not by the HMO or insurance company. The insurance company or HMO is committed to provide coverage during the contract period as long as the premiums are paid and may not terminate coverage, even if they have had or will have adverse experience.

A-28. An insurance company is liable for coverage of an insured incident that occurs while the policy is in force, even though some of the costs related to the incident may be incurred after the policy is terminated. For an insurance company, extended coverage would include the following:

- Hospitalization and physician services directly related to the incident.
- Extended benefit provisions (typically included in major medical policies) for a limited duration, such as to the end of the calendar year in which the policy terminates plus one year, and may include maternity extensions. Many insurance companies are no longer offering this feature.
- Total disability and care incident to a specific occurrence, for which the duration of coverage is usually limited.

A-29. An HMO has an obligation to provide health care services during the premium period, provided the premiums are paid. Generally, the HMO does not have an obligation to provide services after a member has stopped premium payments, even though the accident or condition for which the member obtains health care occurred during the premium period. However, an obligation may extend beyond the premium period depending on the specific contract terms or federal or state regulation. Certain contracts provide for extension of coverage for specific items such as pregnancy. The HMO may have an obligation for extension of benefits to hospitalized participants, including not only hospital charges and related inpatient services, but also physician and referral fees through the date of discharge. The HMO, however, does not have an obligation for extended care beyond the period of hospitalization.

A-30. Under a group contract with an insurance company, it is likely that the employer, depending on its disability policy, will continue to pay premiums while the employee is disabled. Similarly, it is also reasonable to assume that an individual HMO member requiring continued health care will continue to pay premiums because the premium cost would be far less than the related health care costs. A member may not continue to pay premiums as a result of inability, ignorance, or incapacitation.

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Appendix C

Statement of Position 90-8

Financial Accounting and Reporting by Continuing Care Retirement Communities

November 28, 1990

Amendment to
AICPA Audit and Accounting Guide
Audits of Providers of Health Care Services

Issued by
Accounting Standards Division
American Institute of
Certified Public Accountants

AICPA

NOTE

Statements of position of the Accounting Standards Division present the conclusions of at least a majority of the Accounting Standards Executive Committee, which is the senior technical body of the Institute authorized to speak for the Institute in the areas of financial accounting and reporting. Statements of position do not establish standards enforceable under rule 203 of the AICPA Code of Professional Conduct. However, paragraph 7 of Statement on Auditing Standards (SAS) No. 5, *The Meaning of "Present Fairly in Conformity With Generally Accepted Accounting Principles" in the Independent Auditor's Report*, as amended by SAS No. 43, *Omnibus Statement on Auditing Standards*, and SAS No. 52, *Omnibus Statement on Auditing Standards—1987*, includes AICPA statements of position among the sources of established accounting principles that an AICPA member should consider if the accounting treatment of a transaction or event is not specified by a pronouncement covered by rule 203. If an established accounting principle from one or more of these sources is relevant to the circumstances, the AICPA member should be prepared to justify a conclusion that another treatment is generally accepted.

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SUMMARY

This statement of position provides guidance to continuing care retirement communities (CCRCs) on applying generally accepted accounting principles in accounting and reporting for fees, for the obligation to provide future services and the use of facilities to current residents, and for costs of acquiring initial continuing-care contracts. Briefly, the statement recommends that—

- The estimated amount of refundable advance fees that is expected to be refunded to current residents under the terms of the contracts should be accounted for and reported as a liability. The estimated amount should be based on the individual facility's own experience or, if records are not available, on the experience of comparable facilities. The remaining amount of refundable advance fees should be accounted for as deferred revenue. Adjustments to the estimated liability should be accounted for as deferred revenue. The deferred revenue should be amortized to income over future periods based on the estimated lives of the residents or the contract term, if shorter. In most cases, the straight-line method should be used to amortize deferred revenue. The gross amount of contractual refund obligations under existing contracts at the balance-sheet date and the CCRC's refund policy should be disclosed for each year that the balance sheet is presented. Amounts refunded should be disclosed in the statement of cash flows as financing transactions.
- The portion of the advance fee that is refundable to the resident on death or withdrawal only on the condition that a new entrance fee is received for the same unit should be reported as deferred revenue, provided that law and management policy and practice support the withholding of refunds under this condition. The amount reported as deferred revenue should be amortized over the useful life of the facility.
- Nonrefundable advance fees should be accounted for and reported as deferred revenue and amortized to income over future periods based on the estimated lives of the residents or the contract term, if shorter. The period of amortization should be adjusted annually based on the actuarially determined remaining life expectancy of each individual, or joint and last survivor life expectancy of each pair of residents occupying the same unit, or the contract term, if shorter. The amortized amount should not exceed the amount actually available to the CCRC under state regulations, contract provisions, or management policy.
- A liability recognizing an obligation to provide future services and the use of facilities to current residents in excess of related anticipated revenues should be reported when the present value of future net cash

outflows plus depreciation of facilities to be charged related to the contracts and unamortized costs of acquiring the related continuing-care contracts exceeds unamortized deferred revenue.

- Costs of acquiring initial continuing-care contracts incurred through the date of substantial occupancy but no later than one year from the date of completion of construction should be capitalized and amortized to expense on a straight-line basis over the average expected remaining lives of the residents, or the contract term, if shorter. Costs of acquiring continuing-care contracts when a CCRC is substantially completed and occupied should be expensed when incurred.

The provisions of this statement are effective for fiscal years beginning on or after December 15, 1990.

Financial Accounting and Reporting by Continuing Care Retirement Communities

Introduction

1. There are over one thousand continuing care retirement communities (CCRCs) in the United States. Most CCRCs are operated by not-for-profit organizations, and many are affiliated with religious organizations.

2. CCRC facilities may be independent or they may be affiliated with other health care facilities. They usually provide less intensive care than hospitals do, and they generally supply required nursing service continuously or appropriate assistance to residents who have a wide range of medical conditions and needs.

3. Some states regulate CCRCs, although most states currently do not. There is, however, a growing trend toward regulation in this rapidly developing industry. Those states that do require some form of regulation specify that the CCRC be certified by a state authority, such as a department of insurance or a department of social services. In addition, some states mandate that escrow or reserve funds be maintained for the protection of residents.

4. There are three basic types of contracts used by CCRCs. They include all-inclusive (type A), modified (type B), and fee-for-service (type C) contracts.

- An *all-inclusive* continuing-care contract includes residential facilities, meals, and other amenities. It also provides long-term nursing care for little or no increase in periodic fees, except to cover normal operating costs and inflation.
- A *modified* continuing-care contract also includes residential facilities, meals, and other amenities. However, only a specified amount of long-term nursing care is provided for little or no increase in periodic fees, except to cover normal operating costs and inflation. After the specified amount of nursing care is used,

residents pay either a discounted rate or the full per diem rates for required nursing care.

- A *fee-for-service* continuing-care contract includes residential facilities, meals, and other amenities as well as emergency and infirmary nursing care. Access to long-term nursing care is guaranteed as it may be required at full per diem rates.

5. CCRCs offer to residents different types of living accommodations, such as single or shared apartment units or individual homes. They also provide a variety of amenities, including social, recreational, dining, and laundry services.

6. CCRCs may provide long-term nursing-care services, either at the same location or, by agreement, with another facility. Residents are transferred to or from a nursing center as medical care is required. As the health of a resident declines, he or she may be transferred permanently to a nursing center.

7. Continuing-care contracts contain a number of different approaches to providing delivery of services. Contract provisions, for example, may stipulate the amount of the advance fee, whether periodic fees will be required, and, if so, whether they can be adjusted. In addition, contracts generally do the following: detail the future services that will be provided to residents; explain how a resident will be charged for services; describe the CCRC's refund policies and the formula for calculating the amount of the refund, which may be simple or complex; and describe the obligations of the CCRC and the resident if a contract is terminated or a residential unit is reoccupied.

8. A CCRC may require several different payment methods for services and the use of facilities. Three of the most prevalent methods are mentioned below.

a. *Advance fee only.* Under this method, a resident pays an advance fee in return for future services and the use of facilities. Such services generally include CCRC housing-related services (for example, meals, laundry, housekeeping, and social services) and health care and are usually provided to the resident for the remainder of his or her life or until the contract is terminated. Additional periodic fees are not paid, regardless of how long a resident lives or if the resident requires more services than

anticipated. Generally, the resident receives no ownership interest in the facility.

b. *Advance fee with periodic fees.* Under this method, a resident pays an advance fee and periodic fees for services and the use of facilities. Such periodic fees may be fixed, or they may be subject to adjustment for increases in operating costs or inflation or for other economic reasons.

c. *Periodic fees only.* Under this method, a resident pays a fee at periodic intervals for services and the use of the facilities provided by the CCRC. Such fees may be either fixed or adjustable.

9. An advance fee may be met by transferring a resident's personal assets (which may include rights to future income) or by paying a lump sum of cash to the CCRC.

10. Advance fees received for future services may be refunded at the occurrence of some future event, such as death, withdrawal from the CCRC, termination of the contract, or reoccupancy of a residential unit. The amount of the refund is generally based on contractual provisions or statutory requirements.

11. Many continuing-care contracts are similar to annuity contracts. Under those contracts, the CCRC assumes the risks associated with estimating the amount of the advance fee and other fees to be paid by a resident and with determining whether such fees will be sufficient to cover the cost of providing a resident's required services and the use of facilities. For some contracts, residents may share the future costs without limit.

12. The CCRC has an obligation to provide future services for the length of the contract or the life of the resident. In certain circumstances, this obligation continues regardless of whether advance fees or periodic fees are sufficient to meet the costs of providing services to a resident.

13. Diverse reporting practices related to refundable advance fees, fees refundable to residents from reoccupancy proceeds of a contract holder's unit, nonrefundable advance fees, the obligation to provide future services and the use of facilities, and costs of acquiring continuing-care contracts have developed in the absence of definitive guidance. The Accounting Standards Division believes that specific guidance is needed to achieve uniform reporting practices.

Scope

14. This statement addresses accounting and reporting practices related to transactions resulting from contracts to provide services and the use of facilities to individuals under continuing-care contracts, and to accounting for costs of acquiring initial continuing-care contracts. Other accounting and reporting practices affecting CCRCs are included in the AICPA Audit and Accounting Guide, *Audits of Providers of Health Care Services.*

15. For the purposes of this statement, the following definitions apply:

Advance fee. A payment required to be made by a resident prior to, or at the time of, admission to a CCRC for future services and the use of facilities specified in a contract that remains in effect for as long as the resident resides in the community.

Anticipated revenues. Amounts including third-party payments (for example, those from Blue Cross/Blue Shield), contractually or statutorily committed investment income from sources related to CCRC activities, contributions pledged by donors to support CCRC activities, periodic fees expected to be collected, and the balance of deferred nonrefundable advance fees.

Continuing-care contract. An agreement between a resident and a CCRC specifying the services and facilities to be provided by the community to a resident over an established period of time (usually the remaining life of the resident).

Continuing care retirement community. An organization providing or guaranteeing residential facilities, meals, and health care services for persons who may reside in apartments, other living units such as condominiums, or a nursing center. (Also referred to as a "residential care facility.")

Costs of acquiring initial continuing-care contracts. Costs incurred to originate a contract that result from and are essential to acquire initial contracts and are incurred through the date of substantial occupancy but no later than one year from the date of completion of construction.
These costs include the following:

- Costs of processing the contract, such as evaluating the prospective resident's financial condition; evaluating and recording guarantees, collateral, and other security arrangements; negoti-

ating contract terms; preparing and processing contract documents; and closing the transaction.

- Costs from activities in connection with soliciting potential initial residents (such as model units and their furnishings, sales brochures, semi-permanent signs, tours, grand openings, and sales salaries). These costs do not include advertising, interest, administrative costs, rent, depreciation, or any other occupancy or equipment costs.
- The portion of an employee's compensation and benefits that relates to the initial contract acquisitions.

Nursing center. A facility that provides nursing care to residents with a variety of needs or medical conditions. The nursing center may be a component of the CCRC. (Also referred to as a "health center," "skilled-nursing facility," "intermediate-care facility," "continuing-care facility," or "basic-care home.")

Periodic fees. Amounts paid to a CCRC by a resident at periodic intervals for continuing-care services. Such fees may be fixed or adjustable. (Also referred to as "maintenance fees" or "monthly fees.")

Refundable advance fees. The portion of the advance fee that is payable to a resident or the resident's estate.

Estimated costs of future services. Amounts that are expected to be incurred to provide services and the use of facilities to individuals over their remaining lives under continuing-care contracts. Examples include resident-care, dietary, health-care, facility, general and administrative, interest, depreciation, and amortization costs.

Relevant Literature

16. The sources in the accounting literature that provide guidance on the issues discussed in this statement are the following:

- Financial Accounting Standards Board (FASB) Statement No. 5, *Accounting for Contingencies*
- FASB Statement No. 45, *Accounting for Franchise Fee Revenue*
- FASB Statement No. 60, *Accounting and Reporting by Insurance Enterprises*
- FASB Statement No. 67, *Accounting for Costs and Initial Rental Operations of Real Estate Projects*

- FASB Statement No. 91, *Accounting for Nonrefundable Fees and Costs Associated With Originating or Acquiring Loans and Initial Direct Costs of Leases*
- FASB Interpretation No. 5, *Reasonable Estimation of the Amount of a Loss*
- FASB Statement of Financial Accounting Concepts (SFAC) No. 6, *Elements of Financial Statements*
- AICPA Accounting Research Bulletin (ARB) No. 45, *Long-Term Construction-Type Contracts*
- AICPA Statement of Position (SOP) No. 78–10, *Accounting Principles and Reporting Practices for Certain Nonprofit Organizations*
- AICPA SOP No. 81–1, *Accounting for Performance of Construction-Type and Certain Production-Type Contracts*

Accounting for Refundable Advance Fees

Discussion

17. Payment of an advance fee is generally required before a resident acquires a right to reside in an apartment or residential unit for life. A portion of advance fees may be refundable by rescission within a legally set time period, or if a certain future event occurs, such as the death or withdrawal of a resident, or termination of the contract. Some refunds are paid only if a residential unit is reoccupied.

18. CCRC refund policies vary either by region or according to statutory requirements, but generally the amount of the refund is based on provisions specified in a contract. For example, some contracts require a refund of the advance fee, less a reasonable processing fee. Amounts refunded may be based on a fixed amount or percentage, an amount that declines to a fixed amount over time, an amount that declines to zero, or an amount based on resale amount. Refunds may be contingent on vacating the unit, resale of the unit, or passage of a fixed period of time if the unit is not resold.

Present Practices

19. Present accounting and reporting practices for refundable advance fees by CCRCs are diverse. Some credit a liability account for the refundable advance fees because there is an obligation to refund money; others credit refundable advance fees to a deferred

revenue account because there is deferred recognition of revenue while providing future services to residents. All agree that immediately reporting refundable advance fees as income is unacceptable.

Views on the Issue

20. Some believe that, because of contractual or statutory requirements or moral obligations, there is a probable future sacrifice of an economic benefit and consequently that refundable advance fees should be accounted for as a liability. They believe that the CCRC has little or no discretion in avoiding a future obligation and has a duty or responsibility to make a refund. Refunds may be required to be paid due to circumstances beyond the control of the CCRC such as the death or withdrawal from the facility of a resident or termination of the contract. In most cases, no income accrues to the CCRC for refundable fees, although this depends on the policy of the CCRC, on statutory requirements, or on the terms of the contract. Further, they believe that if a portion of refundable advance fees is nonrefundable at the balance sheet date, a transfer from the liability for refundable fees to deferred revenue would be recorded for the amount nonrefundable and then would be amortized proportionately to income over future periods.

21. Others contend that refundable advance fees should be credited to a deferred revenue account because the fees have been collected in advance and, consequently, that there is a deferred recognition of revenue. Contractual obligations vary, but generally the contract specifies that some portion of the advance fees will be refunded pro rata on the basis of the resident's length of occupancy. The balance of the deferred amount is amortized proportionately into income.

Conclusion

22. The estimated amount of advance fees that is expected to be refunded to current residents under the terms of the contracts should be accounted for and reported as a liability. The estimated amount should be based on the individual facility's own experience or, if records are not available, on the experience of comparable facilities. The remaining amount of advance fees should be accounted for as deferred revenue within the liability section of the balance sheet. Adjustments to the estimated liability should be accounted for as

deferred revenue and amortized together with nonrefundable advance fees as discussed in paragraph 23. The gross amount of contractual refund obligations under existing contracts and the CCRC's refund policy should be disclosed in the notes to the financial statements. Amounts refunded should be disclosed in the statement of cash flows as a financing transaction.

23. The deferred revenue should be amortized to income over future periods based on the estimated life of the resident or contract term, if shorter. The period of amortization should be adjusted annually based on the actuarially determined estimated remaining life expectancy of each individual or joint and last survivor life expectancy of each pair of residents occupying the same unit. The straight-line method should be used to amortize deferred revenue except in certain circumstances where costs are expected to increase at a significantly higher rate than future revenues in the later years of residence. In those situations, deferred revenue may be amortized to income using a method that reflects the disproportionate ratio between the costs of the expected services and expected revenues. The amortized amount should not exceed the amount available to the CCRC under state regulations, contract provisions, or management policy. Unamortized deferred revenue from nonrefundable advance fees should be recorded as revenue upon a resident's death or termination of the contract. The method of amortization should be disclosed in the notes to the financial statements.

Accounting for Fees Refundable to Residents Only From Reoccupancy Proceeds of a Contract Holder's Unit

Discussion

24. Some contracts between a CCRC and a resident stipulate that all or a portion of the advance fee may be refundable if the contract holder's unit is reoccupied by another person. The source of money for the payment is from the proceeds of the advance fees collected by the CCRC from the next resident of the reoccupied unit. The terms governing how the proceeds from the next resident are to be paid to the previous resident vary from contract to contract. In effect, the CCRC acts as if it were an agent for present and future residents.

Present Practices

25. Current accounting practices for amounts refundable from reoccupancy proceeds are diverse. Some credit a liability account for the amount refundable; others credit a deferred revenue account. Still others designate a section of equity as tenants' equity or reduce facility cost.

Views on the Issue

26. Some believe that amounts refundable from reoccupancy proceeds of a contract holder's unit should be accounted for as a liability. They believe that such fees are similar to a contingency as defined in FASB Statement No. 5, *Accounting for Contingencies*: There is "an existing condition, situation, or set of circumstances involving uncertainty as to possible gain or loss to an enterprise that will ultimately be resolved when one or more future events occur or fail to occur." They believe that an obligation has been incurred and that the CCRC has little or no discretion in avoiding it. They also believe that the obligation meets the definition and has the characteristics of liabilities contained in SFAC No. 6, *Elements of Financial Statements*.

27. Others believe that, under similar circumstances, amounts refundable to residents that are contingent on reoccupancy should be accounted for as deferred revenue. This view presumes that the entity will always refund money if a contract holder's unit can be reoccupied. They contend that the terms of the contract specify how the resident is to be repaid. Although specific contract terms vary from one entity to another, such terms generally specify that residents will be repaid a portion or all of the advance fee depending on whether advance fees are collected from new residents who will reoccupy a contract holder's unit. Because of this they believe that there is an economic benefit to the CCRC over the life of the facility that should result in deferred recognition of revenue. Such amounts should be amortized over future periods based on the expected remaining life of the facility. This period reflects the utilization of an asset that benefits all residents, regardless of the expected remaining lives of the residents. They claim that the straight-line method of amortizing the amounts is easy to apply but recognize that other methods consistent with the facility's depreciation policy are also appropriate. Similarly, they also believe that the amount received from new residents in excess of the amount to be paid to previous residents should be deferred and amortized into income over the remaining life of the facility.

28. Still there are those who contend that neither a liability nor deferred revenue for amounts refundable from reoccupancy proceeds should be recorded if the contract or agreement specifies that payment of a refund will be made from the proceeds of the advance fees of future residents. They argue that a CCRC would never incur a liability or suffer a loss under such circumstances and that the accounting for the repayable amount, if any, would be between a previous resident and a future resident.

29. Some also take the position that although advance fees are not contributed to the CCRC, a portion of such amounts nevertheless should be considered equity and accounted for in the equity section of the balance sheet. They claim that amounts refundable from reoccupancy proceeds will not be repaid unless another resident occupies an apartment or living unit. There is, in effect, a permanent deferral of the payment. Thus, accounting for such amounts as a liability or deferred revenue would distort the balance sheet.

30. Finally, there are those who believe that when fees are refundable from reoccupancy proceeds of a contract holder's unit, the amount paid should be accounted for as a reduction in the cost of the facility. They consider that amount to be a return of investment that should be reflected appropriately in the cost of the facility. Opponents of this position note that reducing facility cost would not be in conformity with GAAP because the original historical cost of the facility recorded would be misstated and depreciation would fluctuate from year to year. If this method were to continue annually, the cost of the facility could possibly be reduced to a negative amount.

Conclusion

31. That portion of fees that will be paid to current residents or their designees only to the extent of the proceeds of reoccupancy of a contract holder's unit should be accounted for as deferred revenue, provided that law and management policy and practice support the withholding of refunds under this condition. Similar amounts received from new residents in excess of the amount to be paid to previous residents or their designees should also be deferred. The deferred revenue should be amortized to income over future periods based on the remaining useful life of the facility. The basis and method of amortization should be consistent with the method for

calculating depreciation and should be disclosed in the notes to the financial statements.

32. Exhibit A illustrates the application of the conclusion in paragraph 31.

EXHIBIT A

Implementation Aid
Accounting for Refundable and Nonrefundable Advance Fees

The example below illustrates the implementation of the conclusions contained in paragraphs 31 and 43.

Assumptions

a. Unit is occupied for twenty years.
b. Facility has an estimated thirty-year life.
c. Resident is admitted on first day of year indicated and dies on last day of year indicated.
d. Estimated remaining life expectancy is taken from an appropriate actuarial table.
e. Costs of providing future services are expected to be incurred equally over the remaining life.

Example

Year Admitted	Dies	Resident	Entry Age	Advance Fees: Total	Advance Fees: Nonrefundable 25%	Advance Fees: Refundable 75%	Refund to Previous Occupant*
1	4	A	68	$100,000	$25,000	$ 75,000	—
5	8	B	82	120,000	30,000	90,000	$75,000
9	13	C	79	150,000	37,500	112,500	90,000
14	—	D	80	130,000	32,500	97,500	97,500

*Per contract, the amount is limited to 75% of proceeds of reoccupancy up to amount originally paid by previous occupant.

Amortization of Advance Fees Refundable to Residents

$75,000/30 yr. = $2,500 or $2,500 per year for years 1 through 4
15,000/26 yr. = $577 additional or $3,077 per year for years 5 through 8
22,500/22 yr. = $1,023 additional or $4,100 per year for years 9 through next change in occupancy

Amortization of Nonrefundable Advance Fees

Resident A	*Unamortized Deferred Revenue*	*Estimated Remaining Lives (Years)*		*Income*
Year 1 –	$25,000	12.1	=	$ 2,066
2 –	22,934	11.5	=	1,994
3 –	20,940	11.1	=	1,886
4 –	19,054	10.6	=	1,798
Unamortized deferred revenue recognized upon death of resident				17,256
			TOTAL	$25,000

Resident B				
Year 5 –	$30,000	6.1	=	$ 4,918
6 –	25,082	5.8	=	4,324
7 –	20,758	5.5	=	3,774
8 –	16,984	5.3	=	3,205
Unamortized deferred revenue recognized upon death of resident				13,779
			TOTAL	$30,000

Resident C	*Unamortized Deferred Revenue*	*Estimated Remaining Lives (Years)*		*Income*
Year 9 –	$37,500	7.0	=	$ 5,357
10 –	32,143	6.7	=	4,797
11 –	27,346	6.4	=	4,273
12 –	23,073	6.1	=	3,783
13 –	19,290	5.8	=	3,324
Unamortized deferred revenue recognized upon death of resident				15,966
			TOTAL	$37,500

Resident D				
Year 14 –	$32,500	6.7	=	$4,851
15 –	27,649	6.4	=	4,321
16 –	23,328	6.1	=	3,824
17 –	19,504	5.8	=	3,363
18 –	16,141	5.5	=	2,935
19 –	13,206	5.3	=	2,492
20 –	10,714	5.1	=	2,100
Amortization continues until death				

Accounting for Nonrefundable Advance Fees

Discussion

33. This issue addresses whether a CCRC should account for nonrefundable advance fees as (a) current-period revenue or (b) deferred revenue. If nonrefundable advance fees are accounted for as deferred revenue, what should be (a) the appropriate method of amortization and (b) the period of amortization?

Present Practices

34. Presently, a wide diversity of practice exists among CCRCs when accounting for nonrefundable advance fees under a continuing-care contract. Some CCRCs recognize the entire nonrefundable advance fee as revenue when due or received. Others account for nonrefundable advance fees as deferred revenue and amortize the fees into income by using a systematic method, such as a straight-line or increasing-credit method (reverse sum-of-the-years-digits) over a specified future period. Those specified future periods may be one of the following: (a) the estimated remaining life of each resident; (b) the estimated or average remaining lives of all residents; or (c) the number of years specified by the contract or statutory requirements. Other CCRCs account for nonrefundable advance fees as deferred revenue and amortize them into income at an amount that is equal to the current-year cost or the normal charge for the services rendered, regardless of the remaining life expectancies of residents. To a lesser extent, some use a variety of complex methods to account for nonrefundable advance fees, which can vary depending on the region, statutory requirements, terms of the contract, the policies of the CCRC, or other factors.

Views on the Issue

35. Those CCRCs that recognize nonrefundable advance fees as revenue when due or received believe that in the absence of legal or contractual restrictions or limitations on the use of the assets, such assets represent the transfer or sale of specified rights in exchange for specified consideration. They claim that such treatment is the most objective because accounting practice generally recognizes revenue when a sale takes place. They also contend that nonrefundable advance fees should be recognized as revenue in the period the fees are receivable if future periodic fees can reasonably be expected to cover the cost of future services. Most CCRCs are contractually allowed to increase periodic fees to cover all operating costs. Further-

more, because the life expectancies of residents and the cost of services that the CCRC will incur in providing services in the future can be reasonably estimated at the time the contracts are made, those CCRCs have sufficient data to adequately set fees to cover all costs of operations, including depreciation, amortization, and interest on debt.

36. CCRCs that account for nonrefundable advance fees as deferred revenue believe that those fees represent consideration for providing future services to residents. They contend that nonrefundable advance fees are intended to cover future costs that are not recoverable from other revenue sources and should be recorded as deferred revenue and amortized into income. Some CCRCs use actuarial methods to amortize the nonrefundable fees over the estimated remaining lives of residents, while others amortize the fees over a specified future period. They prefer deferral to immediate income recognition in order to meet the objective of matching revenues with the future costs that will be incurred in rendering the required services. They maintain that accounting for nonrefundable advance fees as revenue when received is not appropriate because substantially all of the services specified in the continuing-care contracts have not been performed or satisfied by the CCRC and there are remaining obligations to provide services to residents. Consequently, revenues and costs would not be properly matched.

37. Some also believe that a certain portion of periodic fees should be deferred because there is an element of health care costs attributable to health care services to be rendered. If such services are not rendered until a future period, they contend the related revenue should be allocated to the periods over which they are expected to provide a benefit to the resident. Opponents recognize that periodic fees are expected to cover operations and related health care costs. They note, however, that the ability of the CCRC to increase periodic fees eliminates the need to defer any periodic fees to be matched with future health care costs. They also argue that the recordkeeping and time-consuming process needed to accumulate the data is impractical, burdensome, and would outweigh any benefit to be derived from such precise accounting.

38. Some who support the deferral of nonrefundable advance fees believe that the most reasonable amortization period should be the actuarially determined remaining life span of each resident or of the residents, based on a CCRC's historical experience and statistical

data or on national industry statistics. They claim that this is the period during which related costs are most likely to be incurred. They also argue that amortizing advance fees on a contractual or statutory basis would result in an improper matching of revenues and costs because such a basis fails to recognize with reasonable accuracy the future costs of providing services to residents. However, others claim that the amortization period should be based on the length of time specified by contractual or statutory requirements because those periods can be readily determined.

39. Some CCRCs that amortize advance fees over the remaining life expectancies of residents use a group method. They believe that such a method is relatively simple to apply. Under such a method, residents are grouped by (a) average age, (b) entry year, (c) type or size of unit, or (d) some other reasonable method. The remaining life expectancy of the group is determined using life-expectancy tables, and the nonrefundable advance fees relating to the group are amortized over the remaining life expectancy of the group of residents. No adjustment of the amortization period or the rate is made after the death of a resident. Opponents note that, when the incidence of actual deaths varies significantly from mortality tables, the remaining life expectancy of the group is distorted, which would have a material effect on the amount amortized.

40. Other CCRCs amortize nonrefundable advance fees over each individual's remaining life expectancy. They note that this method is similar to the guidance provided in FASB Statement No. 91 and FASB Statement No. 45. The former states that certain nonrefundable advance fees (as described) associated with lending activities "be deferred and recognized over the life of the loan. . . ." The latter states that "a portion of the initial franchise fee shall be deferred and amortized over the life of the franchise." Although the individual method may appear to be a time-consuming process and require substantial recordkeeping, they believe that it smooths out fluctuations of other methods and results in a more accurate accrual of earned revenue than the group method. They note that the calculation to determine the obligation to provide future services requires that future costs of providing services to individuals be calculated at the end of each period based on remaining individual life expectancies. Once such data is developed, calculated, and accumulated, it would not require a significant period of time to calculate deferred nonrefundable advance fees for each individual.

41. Some CCRCs that support deferral of nonrefundable advance fees maintain that those fees should be amortized on a systematic and rational basis, such as the straight-line method. Such a method matches equal periodic revenues with incurred costs—and it is easy to apply. They also believe that additional revenues from third-party insurers (i.e., Medicare) generally are sufficient to cover health care costs incurred in the latter years of a resident's life and that if a resident is permanently transferred to a nursing facility, the resident's unit can be resold to generate additional period fees. Others believe that this method is appropriate when costs incurred are related to providing a significantly greater amount of residential care services than health care services. Others contend that an increasing-credit method, such as reverse sum-of-the-years-digits method, should be used to amortize advance fees. That method amortizes a lower amount of revenue in the earlier years of the residents' terms at a CCRC with a proportionately higher amount in later years. Such an approach also matches revenues with incurred costs more accurately than the conventional straight-line method in circumstances under which the cost of providing health care services increases the longer the residents live. Still others believe that nonrefundable advance fees should be amortized by basing them on the amount of current-year costs or normal charges; they maintain that this method results in a better matching of revenues and expenses. Under such an approach, the balance of the deferred nonrefundable fee is adjusted annually for current-year costs or normal charges to reflect current economic conditions, increased costs in caring for the residents, and inflation. Opponents of this latter method note that it ignores estimated remaining life expectancies of residents, is not systematic, and may be subject to large fluctuations in revenues and costs from year to year.

42. A small number of CCRCs use a variety of other methods to amortize deferred revenue, such as the following: (a) reserve requirements stipulated by state laws; (b) an equal or arbitrary percentage over a specified number of years; (c) refund policies of the CCRC; or (d) the determination, on an as-needed basis at each balance-sheet date, of the liability equal to the present value of the cost of future services and, accordingly, an adjustment of the revenue or expense for the difference between the liability and the deferred revenue from advance fees. Such methods, however, are generally not applied consistently from year to year and may not match revenues and costs properly.

Conclusion

43. The Accounting Standards Executive Committee believes that under provisions of continuing-care contracts entered into by a CCRC and residents, nonrefundable advance fees represent payment for future services and should be accounted for as deferred revenue. If a CCRC has sufficient historical experience and relevant statistical data about life expectancies, then it should consider that information when determining the remaining life of residents. A CCRC with insufficient historical experience or reliable actuarial data may use relevant data of similar communities within that area, relevant national industry statistics, or other appropriate data. Nonrefundable advance fees should be amortized in the manner discussed in paragraph 23.

44. Exhibit A illustrates the application of the conclusions in paragraph 43.

Accounting for the Obligation to Provide Future Services and the Use of Facilities to Current Residents

Discussion

45. A CCRC expects to provide services and the use of facilities to individuals over their remaining lives under continuing-care contract agreements. The nature and extent of such services depend on such variables as the individual's age, health, sex, and economic status on entering the CCRC. Thus, the CCRC assumes a risk in estimating the cost of future services and the use of facilities. Although many CCRCs are contractually allowed to increase periodic fees, some contracts may restrict increases in periodic fees and require continuing services without additional compensation. If the advance fees and periodic fees charged are insufficient to meet the costs of providing future services and the use of facilities, the CCRC has a liability to provide future services and use of facilities that is equal to the estimated cost of providing future services and use of facilities in excess of the related anticipated revenues. The liability is based on actuarial assumptions (such as mortality and morbidity rates), on estimates of future costs and revenues, and on the specific CCRC's historical experience and statistical data.

Present Practices

46. Some CCRCs recognize the costs to provide future services by accruing a liability in their financial statements at the present

value of the estimated costs to provide future services in excess of the present value of anticipated revenues (future net cash flows). Others accrue the liability at the estimated cost of providing future services in excess of anticipated revenues but do not consider the time value of money.

47. Some CCRCs do not accrue the obligation to provide future services; rather, they disclose the estimated cost of future services in the notes to the financial statements. Others disclose in the notes to the financial statements that an obligation exists.

Views on the Issue

48. If costs of future services and use of facilities to be provided to residents (for example, resident-care, dietary, health-care, facility, general and administrative, interest, depreciation, and amortization costs) are estimated to exceed anticipated revenues (for example, third-party payments, investment income from all sources related to CCRC activities, contributions from sponsoring organizations, periodic fees expected to be collected, and the balance of deferred nonrefundable advance fees), some CCRCs accrue a liability to reflect the obligation to provide future services. They maintain that such treatment is necessary in order to recognize anticipated losses and is in accordance with the provisions of paragraph 8 of FASB Statement No. 5. They believe that the liability to be accrued should recognize the time value of money and should be reported as the difference between the present value of the estimated costs of providing future services and the present value of related anticipated revenues (future net cash flows), if any. They claim that discounting the obligation is a means of matching all elements of revenues, including investment income, and costs over the related contract term or lives of the residents.

49. Others do not consider the time value of money and claim that only the estimated costs of providing services expected to be incurred in the future should be accrued because such costs can be reasonably determined. They argue that determining the present value of the costs of providing future services requires—among other uncertainties—imprecise estimates. Estimating future price changes may be inherently subject to unpredictable events and be more difficult to do than estimating costs. They believe that although the obligation to provide future services may require payments of cash, the amount and timing of the payments are not fixed or determinable. Thus, such amounts do not meet the criteria of Accounting Principles Board

(APB) Opinion 21, *Interest on Receivables and Payables.* Furthermore, they question whether a discounted amount would be relevant and reliable to users of financial statements given the factors needed to calculate an amount to be included in the financial statements. In addition, they believe that professional literature is unclear and is not specific on whether to apply discounting to similar transactions or events that involve the obligation to pay money in the future. For example, SOP 81–1 states that "for a contract on which a loss is anticipated, generally accepted accounting principles require recognition of the entire anticipated loss (not discounted) as soon as the loss becomes evident." Although the guidance in SOP 81–1 applies to entities engaged on a continuing basis in the production and delivery of goods or services under contractual arrangements, they believe that guidance should be applied to CCRCs. Thus, they record the entire anticipated loss and disclose the accounting policy in the notes to the financial statements.

50. Those who would recognize the time value of money believe it is inconsistent to recognize as an expense today the anticipated effects of future costs, but not to recognize the time value of money. They believe that estimating future service costs without recognizing the time value of money produces an improper measurement of the cost of services being provided.

51. Some who accrue a liability believe that it should be reevaluated annually based on statistical data, historical experience, or other pertinent information. Adjustment to the recorded liability should be recognized as a gain or loss in the year the liability is reevaluated. Others maintain that, once estimated, the obligation should be reduced by actual costs only and that no reevaluation or adjustment is necessary.

52. Those who argue against accruing a liability maintain that, even with sufficient experience and statistical data, the amount of the obligation cannot be reasonably estimated; some suppositions that must be made, such as estimating the remaining life expectancy of a resident or determining the discount rate, are inherently subjective and difficult to apply. They assume that increased periodic fees will adequately offset rising expenses incurred in future periods. Thus, they prefer to disclose an estimated obligation in the notes to the financial statements. Because of the imprecise nature of applying discounting and the difficulty of estimating the cost of future services, others disclose, in the notes to the financial statements, that an

obligation to provide future services to residents exists. They do not estimate the amount of that obligation, however.

Conclusion

53. The obligation to provide future services and use of facilities to current residents should be calculated annually in order to determine whether a liability should be reported in the financial statements. The liability related to continuing-care contracts is the present value of future net cash flows, minus the balance of unamortized deferred revenue, plus depreciation of facilities to be charged related to the contracts, plus unamortized costs of acquiring the related initial continuing-care contracts, if applicable. The calculation should be made by grouping contracts by type, such as all contracts with a limit on annual increases in fees, contracts with unlimited fee increases, and so forth.

54. Cash inflows include revenue contractually committed to support the residents and inflows resulting from monthly fees including anticipated increases in accordance with contract terms. Cash outflows are comprised of operating expenses, including interest expense and excluding selling, and general and administrative expenses. Anticipated cost increases affecting these operating expenses should be considered in determining cash outflows. The expected inflation rate as well as other factors should be considered in determining the discount rate. In calculating the liability, the specific CCRC's historical experience or statistical data relating to residents' life spans should be used. The life spans used should be the same as those used to amortize deferred revenue (see paragraph 23). For a new CCRC, either relevant data of similar communities in the area or relevant national industry statistics may be used if deemed to be representative.

55. In October 1988, the FASB added the issue of discounting to its agenda. Until the discounting issue is resolved, CCRCs should disclose in the notes to their financial statements the carrying amount of the liability to provide future services and use of facilities related to continuing-care contracts that is presented at present value in the financial statements—if not separately disclosed in the balance sheet—and the interest rate used to discount that liability.

56. Exhibit B illustrates the application of the conclusions in paragraph 53.

EXHIBIT B

Implementation Aid

Accounting for the Obligation to Provide Future Services and Use of Facilities to Current Residents

Assumptions

a. All residents pay a $50,000 fee—refundable less 2% per month for first 36 months; after that none is refundable—CCRC opened 1/1/X4 (see exhibit A for illustration of how to compute refundable and deferred revenue).

b. An additional periodic fee of $1,000 is payable monthly with a 5% increase annually.

c. Unamortized (deferred) costs of acquiring related initial contracts at 12/31/X6 are assumed to be $17,000.

Note: This illustration calculates the obligation to provide future services and use of facilities for Residents A, B, C, and D from the illustration in exhibit A only.

Present value of net cash flow at 12/31/X6

Cash Inflows:

Resident	*Estimated Remaining Life (Months) At 12/31/X6*	*Estimated Cash Inflows*			
		19X7	*19X8*	*19X9*	*19X0*
A	36	$12,000	$12,600	$13,230	—
B	22	12,000	10,500	—	—
C	27	12,000	12,600	3,308	—
D	38	12,000	12,600	13,230	$ 2,315
Estimated cash inflows		$48,000	$48,300	$29,768	$ 2,315

Resident	*Estimated Remaining Life (Months) At 12/31/X6*	*Estimated Cash Outflows* 19X7	19X8	19X9	19X0
A	36	$10,000	$12,000	$15,000	—
B	22	15,000	11,000	—	—
C	27	14,000	17,000	5,000	—
D	38	8,000	12,000	14,000	$ 4,000
Estimated cash outflows		$47,000	$52,000	$34,000	$ 4,000
Recapitulation		*19X7*	*19X8*	*19X9*	*19X0*
Cash inflows		$48,000	$48,300	$29,768	$ 2,315
Cash outflows		(47,000)	(52,000)	(34,000)	(4,000)
		$ 1,000	$ (3,700)	$ (4,232)	$(1,685)
Present value of net cash flows discounted at 10%					$(7,137)

Depreciation of facilities to be charged to current residents

Original cost of facility		$17,000,000
Cost of facility allocable to revenue-producing service areas		$(2,000,000)
Cost of facility to be allocated to residents (including common areas)		$15,000,000
Useful life	40 years	
Annual depreciation using SL method		$375,000
Number of residents expected to occupy the facility	200	
Annual depreciation/ resident		$1,875
Monthly depreciation/ resident		$ 156

Resident	*Estimated Remaining Life (Months)*	*19X7*	*19X8*	*19X9*	*19X0*
A	36	$1,875	$1,875	$ 1,875	$ –
B	22	1,875	1,560	–	–
C	27	1,875	1,875	468	–
D	38	1,875	1,875	1,875	$ 312
Yearly estimated depreciation of facilities to be charged to current residents		$7,500	$7,185	$ 4,218	$ 312
Total estimated depreciation of facilities to be charged to current residents				$19,215	

Liability for future services to and use of facilities by current residents

Present value of future net cash outflows	$ 7,137
Minus:	
Unamortized deferred revenue at 12/31/X6	(27,027)
Plus:	
Depreciation to be charged to current residents	19,215
Unamortized costs of acquiring initial contracts – see assumption (c)	17,000*
Liability for future services to and use of facilities by current residents at 12/31/X6	$16,325

*These numbers are for illustrative purposes only, and no inference has been made as to the recoverability of the $17,000.

Accounting for Costs of Acquiring Initial Continuing-Care Contracts

Discussion

57. This issue addresses the question of whether a CCRC should currently expense or should defer the costs of acquiring initial continuing-care contracts. If such costs are accounted for as deferred charges, what should be the appropriate period of amortization?

Present Practices

58. CCRCs incur costs related to the acquisition and enrollment of residents through continuing-care contracts. Some CCRCs charge the costs of acquiring initial continuing-care contracts to expense in the period incurred; however, most account for these costs as deferred charges and amortize them to expense over a specified future period. That future period may be (a) the average remaining life of each resident or residents, (b) the life of the facility, or (c) some other period that is designed to reflect the utility or recoverability of the costs.

Views on the Issue

59. Those CCRCs that expense the costs of acquiring initial continuing-care contracts in the period incurred believe that such costs represent normal, recurring operating expenses that should be expensed currently. They claim that such treatment is the most objective and most conservative and believe that the costs incurred by a CCRC do not provide a discernible future benefit and, therefore, should not be capitalized. They also contend that the costs of reenrolling residents and renewing contracts, generally, are immaterial; further, they consider the time period over which to amortize such costs to be relatively short with an immaterial effect on the financial statements. They also believe that the time and expense incurred to identify the costs of acquiring initial continuing-care contracts for deferral on an individual or group contract basis would outweigh any benefits to be derived from deferring such costs.

60. Those CCRCs that defer the costs of acquiring initial continuing-care contracts argue that such costs benefit future periods and represent an investment that will result in future revenues from amortization of nonrefundable advance fees, as well as future periodic fees. They note that there is a similarity between costs

related to enrolling residents and obtaining contracts of CCRCs and costs incurred by lenders to originate loans. Therefore, they believe the guidance relating to direct loan origination costs provided in SFAS No. 91 is applicable to continuing-care contracts. Furthermore, they believe that the guidance on when to begin amortizing costs and the criteria and examples used for capitalizing costs contained in SFAS No. 67 should also be followed. They contend that such costs are material and amortizing them over the average remaining lives of the residents achieves an appropriate matching of revenues and costs. They believe that the average remaining lives of the residents is the most appropriate basis for amortization because it reflects the period of future revenue generation.

61. Others contend that the amortization period should be the estimated life of the facility because this better reflects the benefit period over which the costs of acquiring initial continuing-care contracts are recoverable. Opponents of this amortization period note, however, that it is not consistent with the period used to amortize nonrefundable advance fees.

62. Some believe that these costs should be deferred and charged to expense over a period designed to reflect the utility or recoverability of the cost. They believe the lives of residents or the life of the facility may be too long a period and the effect of the amortization each year would be immaterial; thus a shorter period such as three or five years would be more practical. Opponents note, however, that such periods are arbitrary and would affect comparability among CCRCs using different periods of amortization.

Conclusion

63. Costs of acquiring initial continuing-care contracts that are expected to be recovered from future contract revenues should be capitalized. These costs should be amortized to expense on a straight-line basis over the average expected remaining lives of the residents under contract or the contract term, if shorter. Costs of acquiring continuing-care contracts after a CCRC is substantially occupied or one year following completion should be expensed when incurred.

Effective Date and Transition

64. This statement is effective for fiscal years beginning on or after December 15, 1990. Accounting changes adopted to conform to

the provisions of this statement should be applied retroactively. In the year this statement is first applied, the financial statements should disclose the nature of any restatement and its effect on income before extraordinary items, net income, and related per share amounts for each year restated. If retroactive restatement of all years presented is not practicable, the financial statements presented should be restated for as many consecutive years as practicable. The cumulative effect of applying the statement should be included in determining net income of the earliest year restated, which is not necessarily the earliest year presented. If it is not practicable to restate any prior year, the cumulative effect should be included in net income in the year in which the statement is first applied, in conformity with paragraph 20 of APB Opinion 20, *Accounting Changes*. For that year, what should be disclosed is the following: the effect on income before extraordinary items, net income, and related per share amounts of applying this statement in a year in which the cumulative effect is included in determining that year's net income.

APPENDIX

Financial Statement Illustration

1. The following illustrate the financial statement presentations of certain issues discussed in this paper. A complete illustration of a CCRC's financial statements is included in the AICPA Audit and Accounting Guide, *Audits of Providers of Health Care Services.*

Balance Sheet

The accounts, Deferred Revenue From Advance Fees and the Obligation to Provide Future Services Under Continuing-Care Contracts, should be presented separately as long-term liabilities on the balance sheet.

Liabilities and Fund Balance

	19X6	*19X5*
Current liabilities:		
Current maturities of long-term debt	$ 90,000	$ 77,000
Accounts payable	202,000	214,000
Accrued expenses	161,000	178,000
Total current liabilities	453,000	469,000
Long-term debt, less current maturities	8,871,000	8,935,000
Refundable fees	78,000	125,000
Obligation to provide future services and the use of the facilities in excess of amounts received or to be received for such services (Note X)	190,000	284,000
Deferred revenue from advance fees	4,770,000	4,680,000
Fund balance (deficit)	(952,000)	(1,489,000)
	$13,410,000	$13,004,000

Statement of Revenues and Expenses

Revenues and Expenses

The change in the Obligation to Provide Future Services should be presented separately in the Statement of Revenues and Expenses with appropriate footnote disclosure. Resident Fees Earned or a similar title should include the amortization of the Deferred Revenue from Advance Fees.

	19X6	*19X5*
Revenues:		
Resident fees earned, including amortization of deferred revenue from non-refundable advance fees of $935,000 and $915,000	$ 3,948,000	$ 3,155,000
Patient revenues from nonresidents	249,000	275,000
Other operating revenues	75,000	68,000
Total revenues	4,272,000	3,498,000
Operating expenses:		
Resident care	731,000	622,000
Dietary	722,000	679,000
Health care	185,000	170,000
Plant facility cost	491,000	421,000
Funeral and administrative	436,000	404,000
Depreciation	453,000	447,000
Amortization	65,000	44,000
Interest	960,000	921,000
Provision for uncollectible accounts	2,000	—
	4,045,000	3,708,000
	227,000	(210,000)
Change in obligation to provide future services	94,000	(82,000)
Income (loss) from operations	321,000	(292,000)
Nonoperating revenues—Contributions	216,000	151,000
Excess (deficit) of revenues over expenses	537,000	(141,000)
Fund balance (deficit), beginning of year	(1,489,000)	(1,348,000)
Fund balance (deficit), end of year	$ (952,000)	$(1,489,000)

2. The notes to the financial statements for each year presented should include—

- A description of the CCRC and the nature of the related continuing-care contracts entered into by the community.
- Statutory escrow or similar requirements.
- Refund policy and the general amount of refund obligation under existing contracts.
- The interest rate used to discount the liability to provide future services.

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Glossary

Acute care. Inpatient general routine care provided to patients who are in a phase of illness that does not require the concentrated and continuous observation and treatment provided in intensive-care units.

Allocated loss adjustment expense (ALAE). Claim expense that can be assigned to individual claims, (for example, attorney's fees, claim adjusting service fees, and court costs.)

Ambulatory care organization. A partnership, association, corporation, or other legal entity organized to deliver health care services to patients that come to or are brought to a health care facility for a purpose other than admission as an inpatient (for example, emergency room services, clinic services, and outpatient surgery).

Ancillary services. Services performed for diagnostic or therapeutic purposes. Ancillary services are generally those special services for which charges in addition to routine charges are customarily made, including laboratory, radiology, surgical, and other services.

Asserted claim. A claim made against a health care entity by or on behalf of a patient alleging improper professional service.

Bad-debt expense. The provision for actual or expected uncollectibles resulting from the extension of credit.

Capitation fee. A fixed amount per individual that is paid periodically (usually monthly) to a provider as compensation for providing comprehensive health care services for the period. The fee is set by contract between a prepaid health care plan and the provider. These contracts are generally with a medical group or independent practice association (IPA), but may also be with hospitals and other providers. Capitation fees may be actuarially determined or negotiated based on expected costs to be incurred.

Charity care. Health care services that were never expected to result in cash inflows. Charity care results from a provider's policy to provide health care services free of charge to individuals who met certain financial criteria.

Claims-made insurance policy. A policy that covers only malpractice claims reported to the insurance carrier during the policy term, regardless of the date of the incident giving rise to the claim.

Clinic. A freestanding facility or part of another health care entity used for diagnosis and treatment of outpatients.

Comprehensive medical plan (CMP). A health plan option that may be available to Medicare beneficiaries and provides a more limited range of services than HMOs, but includes physician services, laboratory, radiology, emergency, preventive, and inpatient services. A CMP assumes the financial risk for provision of services and out-of-area coverage.

Continuing care retirement community (CCRC). A legal entity sponsoring or guaranteeing residential facilities, meals, and health care services for a community of retired persons who may reside in apartments, other living units, or in some cases a nursing center. (Also referred to as a *residential care facility* or a *life-care retirement community*).

Contractual adjustments. Differences between revenue at established rates and amounts realizable from third-party payors under contractual agreements.

Courtesy and policy discounts. Differences between revenue recorded at established rates and amounts realizable for services provided to specific individuals such as employees, medical staff, and clergy.

Credibility. A measure of the statistical significance of a provider's own data, dependent on its stability and volume in relation to the stability and volume of industry data. Actuaries use credibility to blend an estimate from a provider's own experience with a broader estimate based on the experience of similar institutions. A provider's own experience may be assigned a credibility weight less than 100 percent due to year-to-year volatility. Such volatility is often a function of the size of the provider—large providers generally would have less volatility than small providers. In such an instance a broader and more stable body of experience of similar providers would be used to supplement the specific provider's experience.

Daily inpatient census. The number of inpatients present at the census-taking time each day. The inpatient census generally is taken each night. The census is adjusted for any inpatients who were both admitted and discharged after the census-taking time the previous day.

Deductions from revenue. Reductions in gross revenue arising from contractual adjustments, courtesy and policy discounts, and other adjustments and deductions.

Development factor. A computed factor used to project future changes in estimated losses from the date of the occurrence of the incident to the date-of-claim payment resulting from inflation, claimed cost growth, industry trends, and court awards. The development factor can be applied to incurred losses, paid losses, claim counts and average values, etc.

Diagnosis-related group (DRG). A patient classification scheme that categorizes patients who are medically related with respect to primary and secondary diagnosis, age, and complications.

Enrollee. An individual who is a subscriber or an eligible dependent of a subscriber in a prepaid health care plan.

Exposure. The amount of potential claim risk; the basis for reflecting differences in the claim potential among providers' bases for charging insurance premiums or allocating member contributions to a captive. Exposure bases for hospital professional liability include number of occupied beds, outpatient visits, emergency room visits, number of residents by specialty, etc.

Functional classification. The grouping of expenses according to the operating purposes (for example, patient care, education, or research) for which costs are incurred.

Fund. A self-contained accounting entity set up to account for a specific activity or project.

Fund balance. The excess of assets over liabilities (net equity). An excess of liabilities over assets is reflected as a deficit.

Health care services. Services provided to individuals related to the diagnosis or treatment of physical or mental illness.

Health maintenance organization (HMO). A generic set of medical care organizations organized to deliver and finance health care services. An HMO provides comprehensive health care services to enrolled members for fixed, prepaid fees (premiums).

Home health agencies. An agency organized to provide health and supportive services in the person's home. These services may include nursing, nutritional, and therapeutic aid (such as physical therapy and dialysis) and the rental and sale of medical equipment.

Increased limit factor. The relationship between losses limited to a per-occurrence limit at which the provider's own experience is meaningful to losses limited to the provider's total retained limit per occurrence.

Incurred but not reported claims (IBNR). Claims that have not been asserted and may relate to either reported or unreported incidents.

Indenture. An agreement between two or more persons specifying the reciprocal rights and duties of the parties under a contract (such as a lease, mortgage, or contract between bondholders and the issuer of the bond).

Individual practice association (IPA). A partnership, association, corporation, or other legal entity organized to deliver or arrange for the delivery of health care services to enrolled members of a prepaid

health care plan. In return, the IPA receives either a capitation fee (fixed amount per member) or a fee for services rendered.

Inpatient. Under most circumstances, a patient who is provided with room, board, and general nursing service and is expected to remain at least overnight and occupy a bed.

Maintenance costs. Costs associated with maintaining enrollment records and processing premium collections and payments.

Margin for risk of adverse deviation. Actuarially determined estimate of the additional funding requirement to obtain a specific confidence level that losses will not exceed the amount paid into the self-insurance fund. Margins are determined using statistical simulation techniques.

Multiprovider captive. An insurance company owned by two or more health care entities that underwrites malpractice insurance for its owners.

Object classification. A method of classifying expenditures according to their natural classification such as salaries and wages, employee benefits, supplies, purchased services, etc.

Occurrence-basis policy. A policy that covers claims resulting from incidents that occur during the policy term, regardless of when the claims are reported to the insurance carrier.

Outliers. In referring to the Medicare Prospective Payment System, additional payments that are made for cases that have either unusually long lengths of stay or have charges in excess of the cost outlier threshold.

Outpatient. A patient who is not confined overnight in a health care institution.

Peer review organization (PRO). Under federal statutory provision, peer review organizations are required in each state to monitor hospital activity under the prospective payment system. Each hospital must contract with a PRO, which will review (1) the validity of diagnostic information, which establishes the diagnosis-related group; (2) the appropriateness of admissions; (3) the appropriateness of care to outliers; and (4) the adequacy of care provided.

Periodic interim payment (PIP). A plan under which the health care entity receives cash payments from third-party payors (usually Medicare) in constant amounts periodically.

Premium (or subscriber fee). The consideration paid for providing contract coverage.

Prepaid health care plan. A plan in which the provider is compensated in advance by the sponsoring organization. The sponsoring organization pays or compensates the provider based on either a fixed sum or a per enrollee amount. Prepaid health care plans include health maintenance organizations, preferred provider organizations, eye care plans, dental

care plans, and similar plans. Under such plans, the financial risk of delivering the health care has transferred to the provider of services.

Prevailing charge. A charge that falls within the range of charges most frequently used in a locality for a particular service or procedure.

Prospective payment system (PPS). Medicare payment made at a predetermined, specific rate for each Medicare discharge, based on a patient's diagnosis. Each discharge is classified according to a series of diagnosis-related groups. (See **diagnosis-related group.**)

Provider. A person or entity that undertakes to provide health care services.

Reported incident. An occurrence identified by a health care entity as one in which improper professional service may be alleged, resulting in a malpractice claim.

Retrospectively rated insurance policy. An insurance policy with a premium that is adjustable based on the experience of the insured health care entity or group of health care entities during the policy term.

Risk contract. A contract between a provider of health care services and a prepaid health care plan that exposes the provider to the uncertainty of financial gain or loss by obligating the provider to provide specified health care services to enrollees of the plan for a negotiated price, which may be an amount per case, service, or day; the price may vary based on the volume of services furnished during the contract period.

Self-insurance. That portion of risk or loss assumed by a health care entity; no external insurance coverage.

Stop-loss (or reinsurance) insurance. A contract in which an insurance company agrees to indemnify the insured in accordance with the terms of the policy.

Subscriber. The person who is responsible for payment of premiums or whose employment is the basis for eligibility for membership in a prepaid health care plan.

Tail coverage. Insurance designed to cover malpractice claims incurred before, but reported after, cancellation or expiration of a claims-made policy.

Third-party payor. Any agency (such as Blue Cross, the Medicare program, or commercial insurance companies) that contracts with health care entities and patients to pay for the care of covered patients.

Trend factor. Factor used in actuarial methodology to adjust ultimate losses from historical experience periods to the loss cost levels of the projection period, due to the impact of economic, jurisdictional, and social changes affecting hospital professional liability loss costs.

Trust fund. A fund established with an outside entity to be used for a specific purpose, such as to pay malpractice claims and related expenses as they arise.

Unasserted claim. A medical malpractice claim that has not been asserted, but may in the future be asserted by or on behalf of a patient related to a reported or unreported incident.

Unreported incident. An occurrence in which improper professional service may have been administered by the health care entity, that may result in a malpractice claim, and that has not yet been identified by the health care entity. Also called *incurred but not reported.*

Wholly owned captive. An insurance company subsidiary of a health care entity that provides malpractice insurance primarily to its parent.

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