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EXPOSURE DRAFT

PROPOSED AUDIT AND ACCOUNTING GUIDE

AUDITS OF PROVIDERS OF HEALTH CARE SERVICES

MARCH 15, 1988

Prepared by the Health Care Committee and
the Health Care Audit Guide Task Force of the
American Institute of Certified Public Accountants

Comments should be received by June 30, 1988, and addressed to
Ian A. MacKay, Federal Government Relations Division, File G-1-500
AICPA, 1455 Pennsylvania Avenue, N.W., Washington, D.C. 20004-1007

G00288

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American Institute of Certified Public Accountants

AICPA

American Institute of Certified Public Accountants
1211 Avenue of the Americas, New York, New York 10036 (212) 575-6200

March 15, 1988

Accompanying this letter is an exposure draft of a proposed AICPA audit and accounting guide, Audits of Providers of Health Care Services. The proposed guide is a revision of the 1972 Hospital Audit Guide. A summary of the proposed guide also accompanies this letter.

Commentators on the guide are requested to give particular attention to the discussion of the scope of entities covered by this guide. Specific health care entities to which this guide applies include:

- Clinics and other ambulatory care organizations
- Continuing care retirement communities
- Health maintenance and similar organizations
- Home health agencies
- Hospitals, including those operated by state and local governmental entities
- Nursing homes that provide skilled, intermediate, and less intensive levels of health care

Commentators are also requested to give particular attention to the discussion of donated property and equipment, which recommends that those assets are considered as capital contributions and are recorded as additions to the general fund balance.

Appendix G of this guide consists of SOP 87-1, Accounting for Asserted and Unasserted Medical Malpractice Claims of Health Care Providers and Related Issues. The recommendations of this document will be incorporated within the guide once the guide becomes final. The AICPA Task Force on Health Maintenance Organizations is considering a proposed Statement of Position on accounting for prepaid health care services. The task force's conclusions will be included in the final guide or an SOP will be issued amending the guide.

Comments or suggestions on the issues contained in the exposure draft will be appreciated. The committee's consideration of responses will be helped if the comments refer to specific paragraphs, explain the problems, and include supporting reasons for any suggestions or comments.

Recently the Auditing Standards Board voted to ballot on ten new Statements on Auditing Standards. The guidance in those standards has not been reflected in this guide, but will be incorporated into the guide when it becomes final.

In developing guidance, the Health Care Committee considers the relationship between the cost imposed and the benefits reasonably expected to be derived from services rendered by accountants. It also considers differences that may be encountered in rendering such services to small entities and, when appropriate, makes special provisions to meet those needs. The committee would particularly appreciate comments on those matters.

An AICPA task force on not-for-profit organizations is presently considering the implications of FASB Statement of Financial Accounting Concepts No. 6, Elements of Financial Statements, on financial statement presentation for not-for-profit organizations. The final results of the task force's deliberations are expected to be incorporated into this guide.

Responses should be addressed to Ian A. MacKay, AICPA, Federal Government Relations Division, File G-1-500, 1455 Pennsylvania Avenue, N.W., Washington, DC 20004-1007, in time to be received by June 30, 1988. Written comments on the exposure draft will become part of the public record of the AICPA Auditing Standards Division and will be available for public inspection at the offices of the AICPA after July 31, 1988, for one year.

Sincerely,

Robert E. Schimmel
Chairman
Health Care Audit Guide Task Force

Joseph F. Moraglio
Vice President
Federal Government Relations Division

SUMMARY

This proposed guide has been prepared to assist the independent auditor in examining and reporting on the financial statements of entities whose principal operations consist of providing health care services to individuals. It describes relevant matters or procedures unique to those entities and focuses on specific problems of auditing and reporting on the financial statements of the health care entities covered by the scope.

This proposed guide supersedes the Industry Audit Guide titled Hospital Audit Guide (1972) and the following statements of position:

- Clarification of Accounting, Auditing, and Reporting Practices Relating to Hospital Malpractice Loss Contingencies
- 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

This proposed guide includes illustrations of the form and content of financial statements for the health care entities considered and the auditor's reports thereon.

The exposure draft has been sent to--

- State society and chapter presidents, directors, and committee chairpersons.
- Organizations concerned with regulatory, supervisory, or other public disclosure of financial activities.
- Health care entities, individuals and firms identified as having an interest in health care accounting and auditing.
- Persons who have requested copies.

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The Health Care Committee also gratefully acknowledges the contributions of former committee chairmen Clark A. Cable and Robert A. Cerrone; former committee members Shirley D. Cheramy, Raymond J. Cisneros, M. Heinzeller, Charles L. Kampmann, Durrell E. Kelley, Edmund C. King, Merlyn E. Knapp, Darwin W. Schlag, Jr., James P. Tyler, Miles L. Watson, Larry S. Westfall, Gary M. Wetstein, and Joel M. Ziff; and former staff aides William J. Holmes and Frank S. Synowiec.

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PREFACE AND SCOPE

This guide has been prepared to assist the independent auditor in examining and reporting on the financial statements of entities whose principal operations consist of providing health services to individuals. It describes relevant matters or procedures unique to those entities. Specific health care entities to which this guide applies include the following:

- Clinics and other ambulatory care organizations
- Continuing care retirement communities
- Health maintenance and similar organizations
- Home health agencies
- Hospitals, including those operated by state and local governmental entities
- Nursing homes that provide skilled, intermediate, and less intensive levels of health care

Some recommendations included herein also may be applicable to transactions of other entities that involve the financing or provision of health care services.

This guide focuses on specific problems of auditing and reporting on 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 examination of the financial statements of the entities considered here.

Certain auditing procedures are suggested, but detailed internal accounting control questionnaires and audit programs are not included. The nature, timing, and extent of auditing procedures are a matter of professional judgment and will vary according to the size of the entity, the organizational structure, the existing system of internal accounting control, and other factors of a particular engagement.

This guide also includes (1) illustrations of the form and content of financial statements for the health care entities considered and the auditor's reports thereon and (2) SOP 87-1, Accounting for Asserted and Unasserted Medical Malpractice Claims of Health Care Providers and Related Issues. In addition, the AICPA Task Force on Health Maintenance Organizations is considering a proposed SOP on accounting for prepaid health care services. Its conclusions will be included in the final guide or an SOP will be issued amending the guide.

Finally, this guide supersedes the Industry Audit Guide titled Hospital Audit Guide (1972) and the following related statements of position:

- Clarification of Accounting, Auditing, and Reporting Practices Relating to Hospital Malpractice Loss Contingencies
- 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

The provisions of this guide are effective for examinations of financial statements for years beginning after December 15, 1988. Accounting adjustments that may be required to conform with the accounting and reporting procedures set forth in this guide should be retroactively applied to prior-period financial statements.

Health Care Committee

March 15, 1988

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 10 percent in 1983. 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 Generally, the federal government was not deeply 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 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 (a) by an individual practitioner of medicine, (b) by public and private universities, (c) by voluntary organizations, (d) by medical service and retirement institutions, (e) by commercial enterprises, and (f) by government-supported 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 Third-party insurers, 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

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* The Hospital Survey and Construction Act of 1946, P.L. 79-725, August 1946.

regions of the United States today, third parties pay as much as 90 percent of hospital-provided health care services.

1.6 As many as four 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 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.)

CLASSIFICATION OF HEALTH CARE ENTITIES

1.7 Health care entities may be classified by sponsorship or legal structure within three broad categories: voluntary, governmental, and investor-owned.

1.8 Voluntary, or not-for-profit, 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.

1.9 Governmental health care entities (often called public entities) receive varying levels of financial support from federal, state, or local governments, and they may provide medical treatment for specific diseases or assist the chronically ill. Currently, the Veterans Administration operates the largest governmental health care system in the United States.

1.10 Investor-owned health care entities (also called proprietary entities) are operated as for-profit organizations. They are subject to income and other taxes.

CLINICS AND OTHER AMBULATORY CARE ORGANIZATIONS

1.11 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

1.12 Continuing care retirement communities (CCRCs)--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.

HEALTH MAINTENANCE AND SIMILAR ORGANIZATIONS

1.13 A health maintenance organization (HMO), or a similar prepaid health care plan, is a formally organized health care system that combines delivery and financing functions. An HMO contracts to provide its enrolled members with comprehensive health care services for a fixed period (generally one year) in return for fixed monthly premiums.

1.14 The Public Health Services Act and the regulations of the Department of Health and Human Services specify the features of and the reporting requirements for federally qualified HMOs, but HMOs are not required to be federally qualified. Most HMOs are also regulated by state agencies, typically the department of insurance or the department of corporations.

1.15 Four basic models of HMOs exist, differentiated by their relationships with physicians and enrolled members.

a. In the staff model, physicians are employees of an HMO. All premiums and other revenues accrue to the HMO, which compensates the physicians.

b. In the group model, physicians are organized as a partnership, professional corporation, or other association that contracts to provide services to members of one or more HMOs. The HMOs compensate the medical group at a negotiated per capita rate, and physicians are compensated by the group.

c. An individual practice association (IPA) is an entity that contracts with an HMO to provide identified health care services in return for a fee (generally a predetermined capitation fee). The IPA in turn contracts with physicians who continue in their existing individual or group practices. The IPA may compensate the physicians on a per capita, flat retainer, or fee-for-service basis.

d. In the network model, physicians are organized in single-specialty or multispecialty group practices. An HMO contracts with various groups to provide identified health care services over the contract term. Unlike the other models, the network model is not recognized for purposes of federal qualification.

1.16 An HMO usually provides financial incentives to physicians to control health care costs. Physicians or health care providers compensated on a capitation basis have incentives to keep total costs below the fees received. Contracts may also provide for bonuses if use of hospital and outpatient services is lower than expected. In the IPA model, a physician usually receives a percentage of a fee; the remaining amount is held by the IPA in a risk pool for later distribution based on cost experience.

1.17 Preferred provider organizations (PPOs), which are similar to HMOs, arrange packages of health care benefits and services for marketing to employers. Through arrangements with certain preferred physicians and health care facilities, a PPO may obtain services for its enrolled members at amounts below the usual and customary charges of those preferred providers, or through capitation payments.

HOME HEALTH AGENCIES

1.18 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, or other assistance, such as homemaker services, and the rental and sale of durable medical equipment.

HOSPITALS

1.19 Of the approximately 7,000 hospitals in the United States, most provide short-term, acute-care services, although some specialize in long-term care, such as rehabilitative and psychiatric services.

1.20 Health care services provided by hospitals include these three levels of care:

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

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

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

NURSING HOMES

1.21 Approximately 21,000 nursing homes in the United States 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 (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 are health-related services to a person who does not require hospital or SNF care, but whose mental or physical condition requires services above the level of room and board that can be made available only through institutional facilities.

c. Custodial or personal care services are prescribed by a physician and provided by a person who is (1) qualified to provide the services, (2) supervised by a registered nurse, and (3) not a member of the recipient's family.

OWNERSHIP AND ORGANIZATION

1.22 Most of the health care entities to which this proposed guide applies 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. Also, in recent years there has been an increasing trend toward the creation of separate organizations (frequently referred to as foundations) to raise and hold funds for hospitals, nursing homes, and other health care entities. Chapter 13 of this guide discusses consolidated and combined financial statements as well as other related subjects.

LEGISLATION AND REGULATION

1.23 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 not static and is characterized by continuous and often significant change.

Licensure

1.24 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, scope of services offered, education and training standards for medical staff and employees, and minimum safety and staffing requirements.

Accreditation

1.25 Various independent organizations and agencies evaluate programs and services of health care entities to determine compliance with their standards. For example, the Joint Commission on Accreditation of Hospitals (JCAH) 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

1.26 As part of the Social Security Amendments of 1965, Congress enacted a three-part program for medical care for the aged and needy. The Social Security Act (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.

1.27 Part A is financed largely through a portion of FICA taxes imposed by the Internal Revenue Code. It provides certain benefits for hospital, nursing care, home health care, and related health care services. Officially, this program is 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.

1.28 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. Officially, Part B is called "Supplementary Medical Insurance Benefits for the Aged." Together, Parts A and B are referred to as "Health Insurance for the Aged."

1.29 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.

1.30 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 September 30, 1983, Medicare payments to hospitals for covered services rendered to program beneficiaries were generally based on allowable cost 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 is effective with the 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, or DRGs. Certain allowable costs incurred by hospitals subject to PPS will continue, at least temporarily, to be reimbursed by Medicare on a reasonable-cost basis. 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 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.

1.31 Medicare reimbursement to nursing homes and home health agencies is based on 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.

1.32 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 screens (limits) are established on a periodic basis by the Medicare program.

1.33 Some physicians accept assignment of benefits from Medicare beneficiaries (participating physicians) entitling those physicians to bill the program for covered services. 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 (nonparticipating physicians) bill the beneficiary directly for services provided.

1.34 States use various methods to pay health care providers for covered services under Medicaid. Some use the 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.

1.35 The Medicare program and state-administered Medicaid programs have adopted various cost-reporting principles and forms to determine reimbursable costs. Hospitals included in 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

1.36 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. Those exemptions include a stipulation

that aggregate payments applicable to Medicare beneficiaries may not exceed prescribed limits. If an excess occurs, the excess is recoverable by the federal government.

Other Legislation and Regulation

1.37 The following section briefly summarizes other important legislation and regulation affecting health care entities. The auditor should refer to the appropriate law or regulation to obtain a more complete understanding of the provisions.

- Public Law 79-725, the Hospital Survey and Construction Act of 1946 (often referred to as the Hill-Burton Act) (August 1946). This act provided grants for construction, renovation, and modernization of nonprofit hospitals and required provision of uncompensated care.

- Public Law 89-97, the Social Security Amendments of 1965 (July 1965). Congress enacted a three-part program for medical care for the aged and needy. The Social Security Act (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. 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.

- Public Law 92-603, the Social Security Amendments of 1972 (October 1972). Significant provisions currently in effect 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.

- Public Law 93-222, the HMO Act of 1973 (December 1972). This act was designed to encourage HMO development and provide support for federally qualified HMOs. Significant provisions are that--

- Under certain conditions, employers are required to offer an HMO option to their employees in their benefit packages (mandated dual choice).

- Grants and loans may be provided to HMOs serving medically underserved populations.

o Public Law 93-641, the National Health Planning and Resources Development Act of 1974 (January 1975). This act's most significant provisions are the development of national guidelines for health planning and the establishment of health system agencies (HSAs) to serve as regional planning bodies. The main functions of HSAs are to--

  - Determine the status of health care delivery systems and their effects on residents

  - Develop a detailed statement of goals and an annual implementation plan

  - Review and approve applications for government program funds to support the development of health resources

  - Recommend and approve projects for construction or modernization of health facilities

o Public Law 95-142, the Medicare-Medicaid Anti-Fraud and Abuse Amendments (October 1977). Significant provisions of these amendments 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.

  - Uniform reporting systems for health service facilities.

o Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 (August 1982). 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.

o Public Law 98-21, the Social Security Amendments of 1983 (April 1983). This law overhauled the Social Security program and completely restructured the system for reimbursing hospital inpatient services to Medicare beneficiaries by creating the Medicare Prospective Payment System. The more significant provisions are--

  - Establishment of the concept of paying a fixed price per discharge for a series of medical categories

  - Repeal of the cost-per-case limits established under Public Law 97-248

  - Introduction of peer review organizations (PROs) to monitor portions of the prospective payment system

o Public Law 98-369, the Deficit Reduction Act of 1984 (July 1984). (This act includes Medicare and Medicaid Budget Reconciliation Amendments of 1984.) One of the more significant provisions of this law is the prohibition of Medicare reimbursement of capital costs resulting from an increase in basis of assets after an acquisition or a merger.

o 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.

o Financing authorities. Some states 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. Those authorities normally issue tax-exempt bonds, the proceeds of which are used by health care providers. The bonds are issued usually as an obligation of the financing authority but are collateralized by the revenues and defined assets of the benefited health care providers.

CHAPTER 2

UNIQUE OPERATING CONSIDERATIONS OF HEALTH CARE ENTITIES

DIFFERENTIATING VOLUNTARY, GOVERNMENTAL, AND INVESTOR-OWNED HEALTH CARE ENTITIES

2.1 Health care entities may be voluntary (not-for-profit), governmental, or investor-owned.

2.2 Voluntary (Not-for-Profit). Voluntary organizations operate under the direction of governing boards that may be self-perpetuating or elected by corporate members or sponsoring organizations. Usually such organizations are exempt from income taxes on revenue derived from activities related to their exempt purposes and 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.

2.3 Governmental Units. Governmental 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.

2.4 Investor-owned and Operator-owned (Proprietary). Investor-owned and operator-owned entities may be stock corporations, partnerships, or sole proprietorships.

2.5 Many health care entities are charitable 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 (accountability) responsibility upon the health care entity to comply with the specific restrictions. To account for funds received from donors and grantors and satisfy fiduciary responsibilities, some not-for-profit organizations use fund accounting. The application of that concept to health care entities is described in the section "Fund Structure" in chapter 3.

REVENUE AND ACCOUNTS RECEIVABLE FROM HEALTH CARE SERVICES

2.6 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 those third parties pay health care entities according to cost or a predetermined (prospective) contractual rate rather than according to the health care entities' established rates for service. Therefore, many health care entities have 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.

2.7 Generally, gross service revenue is recorded on an accrual basis at established rates, regardless of whether the health care entity expects to collect that amount. Allowances recognizing established charge or third-party payor differences (contractual allowances), allowances for uncompensated services, and other allowances are recorded on an accrual basis and deducted from gross service revenue to determine net service revenue. For financial reporting purposes, service revenue is reported net of such allowances in the statement of revenues and expenses. Total deductions from gross service revenue or specific components of deductions from gross service revenue may be disclosed if deemed necessary.

2.8 Uncompensated services represent charity care and services that result in bad debts. Charity care (free care) reflects an inability to pay for all or part of the services rendered. Bad debts reflect an unwillingness to pay for services, although the ability to pay may exist. If bad debts are distinguishable from charity care, the provision for bad debts may be reported as an operating expense rather than as a deduction from gross service revenue.

THIRD-PARTY PAYOR CONSIDERATIONS

2.9 Some third-party payors retrospectively determine final amounts reimbursable for services rendered to their beneficiaries based on allowable costs. Sometimes those 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 those payors should be made and recorded in the same period that the related services are rendered.

DONATED ASSETS

2.10 Donated assets are recorded at fair market value as of the date of contribution. Voluntary and governmental health care entities record donated assets as nonoperating revenue if unrestricted or as an addition to the

appropriate fund balance if restricted. Donations of property and equipment to a voluntary or governmental entity are recorded as additions to the general fund balance (unless the donor specifies that they are for endowment or for other restricted purposes) because they are considered to be capital contributions.

DONATED SERVICES

2.11 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 program. 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 should be recorded as an expense and a corresponding amount credited to contributions.

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.

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

UNRESTRICTED GIFTS, BEQUESTS, AND GRANTS

2.13 Gifts and bequests that are not restricted by donors may be a significant source of revenue for health care entities, particularly those that are not investor-owned. Such revenue is reported as nonoperating revenue in the statement of revenues and expenses.

2.14 Grants, tax support, and other subsidies from governmental or community agencies may be received for general support of the health care entity. Ordinarily, those items are recorded as nonoperating revenue. However, when the grantor specifies that this revenue is to be used for indigent care, it is recorded as a restricted gift when received and as a reduction of the related allowance when used.

DONOR-RESTRICTED RESOURCES

2.15 Resources received from donors or grantors that bear restrictions on their use are classified as donor-restricted funds. They generally fall into five categories: (a) funds for specific operating purposes; (b) funds for additions to property and equipment; (c) endowment funds; (d) loan funds; and (e) annuity and living trust funds. Accounting and disclosure considerations for those resources 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 Accounting Research Bulletins (ARBs) are applicable to financial statements prepared by health care entities. As noted in paragraph 3.23, health care entities operated by state and local governments are subject to pronouncements of the Governmental Accounting Standards Board (GASB). In the absence of GASB pronouncements covering a specified transaction or event, any FASB pronouncement dealing with the subject is presumed to apply. That presumption includes APB Opinions and ARBs, to the extent they have not been superseded.

FUND STRUCTURE

3.2 Fund accounting is an accounting technique used for purposes of internal recordkeeping and managerial control. The number of funds established may be numerous.

3.3 In applying fund accounting, not-for-profit 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).

3.4 As stated in FASB Concepts Statement No. 6, Elements of Financial Statements, 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 multicolumn presentations or disclosures in the notes) are not addressed in that statement, but may be the subject of a future FASB project.

GENERAL FUNDS

3.5 General funds represent resources not restricted for identified purposes by donors and grantors, and 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

3.6 Assets whose use is limited appear in the general funds section of the balance sheet and include--

- 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. (Sometimes these assets are described 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 document.

- 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

3.7 A health care entity may receive and hold assets owned by others under agency relationships (for example, it may receive and hold resources for patients, residents, physicians, students, and others). In accepting responsibility for those funds, the entity incurs a liability to the principal under the agency relationship to return them in the future or to disburse them to another party on behalf of the principal. Agency funds are recorded in general funds, and transactions involving receipt and disbursement of agency funds are not included in results of operations.

Property and Equipment

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

DONOR-RESTRICTED FUNDS

3.9 Funds restricted by donors and grantors include funds for specific operating purposes, funds for additions to property and equipment, endowment funds, loan funds, and annuity and life income funds.

3.10 Each restricted resource should be accounted for in accordance with instructions of the donor or grantor placing the restrictions on the resources. Restrictions on many resources are such that the funds can be grouped for reporting purposes even though they may require separate accounting in the records. Generally, restricted resources are grouped for reporting purposes in several categories as discussed below.

Specific-Purpose Funds

3.11 Specific-purpose funds are resources restricted for specific operating purposes by donors and grantors. They are recorded as additions to fund balance when received and as transfers to other operating revenue in the period in which expenditures are made for the particular purpose intended by the donor or grantor. Examples are education grants, research grants, or contributions to cover specific operating purposes.

Property and Equipment Funds

3.12 Resources restricted by donors for additions to property and equipment are considered to be capital contributions and are included in the restricted plant, replacement, and expansion fund. A transfer of resources from the donor-restricted fund balance to the general fund balance is shown in the financial statements for the period in which expenditures are made for the purpose intended by the donor. Examples are funds for building construction, renovation, equipment purchases, and capital debt retirement.

Endowment Funds

3.13 Endowment resources include pure endowment funds (the principal of which may not be expended by the governing board) and term endowment funds (the principal of which may be expended after a certain period or on completion of certain requirements). Upon receipt, both types of endowment funds are accounted for as donor-restricted funds.

3.14 Pertinent information about term endowment funds, such as the term of the endowment and the purposes for which the funds may be used during the term, is disclosed. When term endowment funds become available to the governing board for general operating purposes, they are reported as nonoperating revenue in the general fund. If such funds are further restricted under the provisions of the term endowment, they are shown as a transfer to the appropriate donor-restricted fund.

Other Donor-Restricted Funds

3.15 Other donor-restricted funds include student grants and annuity and living trust funds.

DONATED FUNDS HELD IN TRUST

3.16 Funds that are held in trust by others under a legal trust instrument created by a donor independently of the reporting entity, and that are neither

in the possession nor under the control of the entity but are held and administered by outside fiscal agents, with the entity deriving income from such funds, should not be included in the balance sheet with funds administered by the entity. The funds contemplated by this paragraph are those of which the reporting entity is not the remainderman in the trust. Their existence should be disclosed.

3.17 When the trustee is required to make distributions to the health care entity, the entity reports the distributions on an accrual basis as nonoperating revenue; also, footnote disclosure of the right to future income may be appropriate, depending on the circumstances. If the distribution that the trustee makes to the entity is discretionary, the entity reports the distribution as a contribution in accordance with the terms of the trust or the directions of the trustee.

TIMING DIFFERENCES

Third-Party Reimbursement

3.18 Transactions may enter into the determination of accounting income either before or after they become determinants of reimbursement. These timing differences should be 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, so interperiod reimbursement allocation is not appropriate for such differences.

3.19 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 do become permanent are recorded in the financial statements in the period when it is determined that they will not be recovered or realized.

3.20 The following reimbursement timing differences are examples of those that may be encountered during audits of health care entities:

- 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 example, 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 recorded for accounting purposes (for example, the use of the

method required by Medicare for Medicare reimbursement purposes and FASB Statement No. 34, Capitalization of Interest, for accounting purposes)

- Amounts of losses from uninsured medical malpractice claims recorded under the accrual method for accounting 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 accounting purposes and in future periods for reimbursement purposes

Deferred Income Taxes

3.21 The FASB, in its project Accounting for Income Taxes, is currently examining the accounting treatment of tax-related timing differences.

REPORTING ENTITY

3.22 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. Accordingly, pending resolution by the FASB, those matters are not within the scope of this guide.

HEALTH CARE ENTITIES AS A PART OF OTHER ORGANIZATIONS

3.23 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) hospitals, whether operated by governmental entities or independently, and (b) other health care entities not operated by governmental entities.*

RELATED ORGANIZATIONS

3.24 Other organizations, such as foundations, auxiliaries, and guilds, frequently assist and, in many instances, are related to health care entities. Chapter 13 addresses accounting and reporting matters with respect to those relationships.

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* As noted in paragraph 3.1, GASB pronouncements take precedence over FASB pronouncements for governmental entities. The GASB is currently considering the appropriate method of accounting and reporting for state and local health care entities other than hospitals.

OTHER PRINCIPLES OF MEASUREMENT AND DISCLOSURE

3.25 Other significant accounting principles of measurement and disclosure are discussed in separate chapters of this guide, as follows:

- Investments and investment income, chapter 6
- Service revenue and receivables, chapters 7 and 12
- Malpractice loss contingencies, risk contracting, and accounting by prepaid health care plans, chapter 10 and appendix G
- Reporting entity and related organizations, chapter 13

FINANCIAL STATEMENTS

3.26 The basic financial statements of voluntary and governmental health care entities consist of a balance sheet, a statement of revenues and expenses, a statement of changes in fund balances, and a statement of changes in financial position of general funds. (See note in appendix A under Sample Hospital Statements of Changes in Financial Position of General Funds.)

3.27 Illustrations of these basic financial statements are included in the appendices. Illustrative statements for other investor-owned (proprietary) health care entities are not included because they generally follow reporting requirements of other investor-owned businesses.

CHAPTER 4

AUDIT CONSIDERATIONS--GENERAL

SCOPE OF THE ENGAGEMENT

4.1 For each audit engagement, the auditor and the health care entity should establish a clear understanding, preferably in writing, concerning the scope of audit services to be performed and the 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 auditor may be asked to examine 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.

4.2 Except for any special requirements of the entity, the auditor's responsibility for reporting on information contained in documents outside the basic financial statements that the auditor submits to the client or to others is specified in Statement on Auditing Standards (SAS) No. 29, Reporting on Information Accompanying the Basic Financial Statements in Auditor-Submitted Documents. When the auditor's standard report is included in a client-prepared document and when the auditor is not engaged to report on information accompanying the basic financial statements, the auditor's responsibility with respect to such information is described in SAS No. 8, Other Information in Documents Containing Audited Financial Statements, and in SAS No. 27, Supplementary Information Required by the Financial Accounting Standards Board.

4.3 In addition, SAS No. 14, Special Reports, applies to auditors' reports issued in connection with the following:

- Financial statements that are prepared in accordance with a comprehensive basis of accounting other than generally accepted accounting principles
- Specified elements, accounts, or items of a financial statement
- Compliance with aspects of contractual agreements or regulatory requirements related to audited financial statements
- Financial information presented in prescribed forms or schedules that also prescribe a form of auditor's report

INHERENT RISK

4.4 SAS No. 47, Audit Risk and Materiality in Conducting an Audit, provides guidance on the auditor's consideration of audit risk and materiality when planning and performing an examination of financial statements in accordance with generally accepted auditing standards.

4.5 In determining the scope of audit procedures to be performed, the auditor should be aware that certain aspects of health care entity operations are usually subject to a greater-than-normal level of inherent risk.

4.6 Risks are associated with revenue recognition and the valuation of related receivables because of the monetary amounts and the complexity of determining those amounts. A significant portion of services is usually paid by third parties (for example, 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 entities' established service charges.

4.7 Risks are associated with recognizing the liability for costs that have been incurred by prepaid health care plans and entities providing health care services to enrollees under capitation arrangements. Such costs may have been incurred but not yet reported (IBNR) to the plans and providers. Accordingly, it is necessary to estimate the liability for those costs. Those estimates often require a high degree of management judgment, which must consider historical experience as well as the effect of any changed conditions, such as seasonality trends, changes in contract population, or changes in services and benefits. Similarly, risks are associated with evaluating risk contract agreements in determining whether a loss should be recognized.

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

4.9 In addition are the usual audit risks inherent in any audit engagement, including the possibility of errors and irregularities or illegal acts by clients.

PLANNING THE AUDIT

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

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

- Articles of incorporation
- Bylaws

- Chart of accounts
- References to laws and regulations pertaining to the entity and its operations
- Organization chart
- Documents relating to restrictions on gifts and bequests
- Contracts and agreements, such as leases, agreements with physicians, third-party payors, HMOs, PPOs, and affiliated and related organizations
- Tax-determination letters and filing requirements
- Description of the accounting system and system of internal accounting control
- Loan agreements, bond indentures, and other debt instruments
- Minutes of board and committee meetings

4.12 The 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.

4.13 The auditor should understand the specific cost-finding or other rate-setting methods used by third-party payors to determine final amounts reimbursable to a 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, beds, square footage, pounds of laundry, and other operating statistics. Accordingly, in planning the engagement the auditor should consider whether the scope of the examination includes tests of statistical data.

4.14 In planning the examination, the auditor might also consider--

- Matters relating to the entity's business and the industry in which it operates.
- The entity's accounting policies and procedures.
- Anticipated reliance on internal accounting controls.
- Preliminary judgment about materiality levels for audit purposes.
- Financial statement items likely to require adjustment.
- Conditions that might require extension or modification of audit tests, such as the possibility of material errors or irregularities, the existence of related party transactions, or the existence of uninsured malpractice risks.

- The entity's experience with payment denials and other financial issues 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).

- Comparative industry and historical financial and statistical data.

4.15 Planning procedures usually involve reviewing the auditor's files relating to the entity and holding discussions with other firm personnel and personnel of the entity. Following are examples of those procedures:

- Review correspondence files, the prior year's working papers, permanent files, financial statements, and auditor's reports.

- Discuss matters that may affect the examination with firm personnel responsible for nonaudit services to the entity.

- 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 examination with management of the entity, the board of directors, or its 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.

- Establish and coordinate staffing requirements.

- Determine how revenue recognized under third-party payment programs will be tested.

ELECTRONIC DATA PROCESSING (EDP) SYSTEMS

4.16 Many health care entities use some form of 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

patient 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 and third-party-payor billing logs and cost report preparation. In addition, hospitals may have applications to determine DRG assignments for the Medicare PPS.

4.17 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.

4.18 Guidance on auditing records for which electronic data processing is significant is contained in the following documents: (a) SAS No. 44, Special-Purpose Reports on Internal Accounting Control at Service Organizations; (b) SAS No. 48, The Effects of Computer Processing on the Examination of Financial Statements; (c) AICPA Audit and Accounting Guide The Auditor's Study and Evaluation of Internal Control in EDP Systems; (d) AICPA Audit and Accounting Guide Audits of Service-Center-Produced Records; and (e) AICPA Audit and Accounting Guide Computer-Assisted Audit Techniques.

INTERNAL ACCOUNTING CONTROL

4.19 The second standard of fieldwork states: "There is to be a proper study and evaluation of the existing internal control as a basis for reliance thereon and for the determination of the resultant extent of the tests to which auditing procedures are to be restricted." The nature of the audit procedures selected, their timing, and the extent of their applications depend to a considerable extent on the degree of reliance the auditor intends to place on the system of internal accounting control. The auditor's study and evaluation of the system, as a basis for restricting the scope of substantive audit tests to be performed, involves (a) the initial inquiry necessary to ascertain the health care entity's procedures and (b) those additional investigations, tests, and inquiries performed during the audit to evaluate compliance with established internal accounting control procedures--that is, to ascertain that controls are functioning as represented.

4.20 Section 320 of SAS No. 1 and SAS No. 43, Omnibus Statement on Auditing Standards, discuss the study and evaluation of internal accounting control. If the health care entity has an internal audit function, the auditor should also consult SAS No. 9, The Effect of an Internal Audit Function on the Scope of the Independent Auditor's Examination.

4.21 The auditor should acquire an understanding of the significant classes of transactions and their related transaction types. Transactions may be grouped in a variety of ways--for example, by cycles of business activity or by business function. Major transaction cycles of health care entities include revenue, purchasing, and payroll. In addition, the contribution and investment cycles may be significant transaction cycles.

4.22 The auditor should obtain an understanding of all relevant aspects of the system, including the various classes of transactions and the methods by which each significant class of transactions is authorized, executed, processed, and recorded as assets, liabilities, revenue, or expense. The study and evaluation of a class of transactions should be designed to provide the auditor with an understanding of the control environment and the flow of transactions through the accounting system. If the internal accounting control system is to be relied on to restrict substantive tests, tests of compliance of internal accounting controls should be made for each major class of transactions to provide reasonable assurance that control procedures are being applied as prescribed. Preparation of flowcharts may help in reviewing the internal accounting control system.

4.23 If material weaknesses are detected in internal accounting control, an auditor is required by SAS No. 20, Required Communication of Material Weaknesses in Internal Accounting Control, to communicate, either orally or in a written report, to senior management and the governing body or its audit committee, material weaknesses in internal accounting control that come to the auditor's attention during an examination of financial statements made in accordance with generally accepted auditing standards. The auditor should also consider SAS No. 16, The Independent Auditor's Responsibility for the Detection of Errors or Irregularities, and SAS No. 17, Illegal Acts by Clients, for guidance on the detection of errors, irregularities, and illegal acts. In addition, SAS No. 30, Reporting on Internal Accounting Control, provides guidance on reporting on internal accounting control based solely on a study and evaluation made as a part of the audit of the financial statements.

4.24 SAS No. 19, Client Representations, provides guidance to the 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. Health care entities might also include representations that--

- The health care entity (if applicable) is described in Internal Revenue Code Section 501(c)(3) and is therefore exempt from federal income tax under Section 501(a) of the Revenue Code of 1954 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 were 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 may have a material effect on the financial statements of the entity are properly disclosed.

CHAPTER 5

CASH

TYPES OF CASH

5.1 Cash may include money on hand, money in checking accounts and time deposits, temporary cash investments (cash equivalents), and uninvested funds held by investment custodians. One or more cash accounts may be maintained in general funds for operating purposes, in addition to separate cash accounts in various restricted funds.

Operating Accounts

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

5.3 A checking account 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 funds in the form of checking or savings accounts, or time deposits such as certificates of deposit.

Personal Fund Accounts

5.6 The entity may receive and hold personal funds of patients, residents, or others under an agency arrangement. Personal funds are included in the financial statements as assets of general funds, with the related liability reported in the liabilities section of the general funds balance sheet. If material, the amount of personal funds is disclosed parenthetically, in the notes or as a separate caption in the balance sheet.

Temporary Cash Investments

5.7 Cash may be invested temporarily in certificates of deposit, money market funds, or other short-term instruments. Those accounts may be presented separately in the balance sheet or combined with other cash accounts.

AUDITING

Audit Objectives

5.8 The significant audit objectives relating to cash are to determine (a) its existence, (b) whether the balances are properly stated, and (c) that restrictions, if any, are properly disclosed.

Internal Accounting Control

5.9 Internal accounting control considerations for cash of health care entities are similar to those for other business organizations. In addition, the auditor may wish to consider the following questions:

- Are donations received, recorded, and deposited by someone other than the cashier?
- Are controls sufficient to identify and properly record restricted and unrestricted contributions?
- Are controls related to the application of receipts to specific accounts adequate?
- Are suspense accounts used to record receipts not initially identified as applicable to a specific account balance? Are they reviewed by a person independent of the receipts function and then reconciled to control accounts?
- Is the entity in compliance with statutory and contractual requirements related to personal funds held under agency arrangements?

Audit Procedures

5.10 Auditing procedures applicable to cash accounts usually include (a) direct confirmation of balances with depository banks, (b) testing the accuracy of reconciliations prepared by the entity's personnel, (c) testing for proper cutoff of receipts and disbursements, and (d) testing interbank transfers to determine that they are properly recorded. If pooled cash accounts are used, the auditor should determine that the equity of each participating fund is accounted for properly and that interest income is allocated equitably. In addition, the auditor should consider reviewing loan agreements, compensating balance arrangements, and correspondence from donors and grantors for the existence of any restrictions, as well as to consider whether they are disclosed properly.

CHAPTER 6

INVESTMENTS

ACCOUNTING AND FINANCIAL STATEMENT PRESENTATION

6.1 Investments may include government obligations and securities such as equity securities. Health care entities initially record investments at acquisition cost or, if received as a donation or gift, at fair market value at the date of the gift, which is thereafter treated as cost. Investments of general funds are classified as current or noncurrent assets in conformity with generally accepted accounting principles.

6.2 Investments of health care entities are reported in the financial statements as follows:

a. Marketable securities are (1) equity securities in accordance with the requirements of FASB Statement No. 12, Accounting for Certain Marketable Equity Securities, and (2) debt securities at amortized cost if there is the intent and ability to hold for the foreseeable future or at lower of cost or market if not intended to be held, unless an impairment in value is deemed to be other than temporary.

b. Other securities (for example, real estate or oil and gas interests) are reported at the lower of amortized cost or a reduced amount if an impairment in value is deemed to be other than temporary.

6.3 Some noteworthy features related to investments of not-for-profit health care entities are (a) accounting by fund type to recognize donor or grantor restrictions; (b) pooling of investments; and (c) valuation of marketable equity securities.

6.4 In addition to imposing restrictions on use of gifts and grants, donors and grantors may impose restrictions on investment practices and may require separate accounting for principal and income transactions. Also, not-for-profit health care entities may pool resources of various funds for investment purposes, or may 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.

6.5 Investment pools should use the market-value method to accomplish an equitable allocation of investment income and gains and losses. Under the market-value method, each participating fund is assigned a number of units based on the percentage it owns of the total pool. When the pool is established, units are initially assigned to the participating funds based on the current market value of investments placed in the pool by each fund. Current market value is used to determine the number of units allocated to additional funds placed in the pool and to calculate equity of funds withdrawn

from the pool. Income from investments and gains or losses of the pool are allocated to participating funds based on the funds' equity or share in the pool.

6.6 Investor-owned hospitals are subject to the requirements of FASB Statement No. 12, Accounting for Certain Marketable Securities, and related interpretations, which specify the accounting and disclosure requirements applicable to portfolios of marketable equity securities. Under Statement No. 12, cost is no longer an acceptable accounting method for marketable equity securities, and the carrying amount of a marketable equity security portfolio is the lower of its aggregate cost and market values. Similarly, cost is no longer an acceptable accounting method for use by not-for-profit health care entities for marketable equity securities. This chapter includes guidance on the application of FASB Statement No. 12 to the financial statements of not-for-profit health care entities.

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

6.7 The carrying amount of a marketable equity security portfolio of a not-for-profit health care entity is the lower of its 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 accounted for as valuation allowances.

6.8 Marketable equity securities owned by a not-for-profit health care entity are grouped into separate portfolios for the purpose of comparing aggregate cost and market value to determine carrying amount. 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).

6.9 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 combined portfolio. Similar donor-restricted fund portfolios of entities combined in financial statements are treated as single portfolios. For example, portfolios of marketable equity securities included in 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.

6.10 If there is a change in a marketable equity security's classification between current and noncurrent assets in general funds, the security is transferred between the corresponding portfolios at the lower of its cost and market values at the date of 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.

6.11 If the 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 to the allocation of the market value of the pooled marketable equity securities for purposes of implementing the method just described. To apply those provisions properly, marketable equity securities and other investments are accounted for separately.

6.12 The following information about marketable equity securities is disclosed either in the body of a not-for-profit health care entity's financial statements or in the accompanying notes.

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

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

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

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

c. For each period for which a statement of revenues and expenses is presented, the following information is provided:

   - Net realized gain or loss that is included in nonoperating revenue

   - The basis on which cost was determined in computing realized gain or loss (average cost or other method)

6.13 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 covered in paragraph 6.14). However, significant net realized and net unrealized gains and losses arising after the date of the financial statements but before their issuance, applicable to marketable equity securities owned at the date of the most recent balance sheet, are disclosed.

6.14 For those marketable securities for which the effect of a change in carrying amount is included in the statement of changes in fund balances rather than in the statement of revenues 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 cost basis of the individual security is written

down to a new cost basis and the amount of the write-down is accounted for as a realized loss. The new cost basis is not changed for subsequent recoveries in market value.

Income From Investments

6.15 A loss recognized because of a change in a marketable equity security's classification between current and noncurrent assets in general funds is included in the nonoperating revenue section of the statement of revenues and expenses. For each period for which a statement of revenues 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 nonoperating revenue section of 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 statements 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.

6.16 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 separately as operating revenue. Alternatively, they may be netted with the related expense and reported as operating expense or operating revenue, with the offsetting amount disclosed parenthetically. Investment income on malpractice trust funds is reported as other operating revenue. Investment income and realized gains and losses from all other general fund investments are included in the statement of revenues and expenses as nonoperating revenue. (See chapter 12.)

6.17 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 those funds is accounted for in accordance with the donors' instructions (for example, as resources for specific operating purposes if restricted or as nonoperating revenue if unrestricted).

6.18 Income and net realized gains or losses on investments of restricted funds other than endowment funds are charged or credited to the respective fund balance, unless such amounts are legally available for or chargeable against other funds. If such amounts are legally available for unrestricted purposes, they are included in nonoperating revenue. 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 funds) are recognized as realized gains or losses and separately disclosed in the financial statements. Gains or losses that result from transactions between various portfolios classified as assets and whose use is limited in the general funds section of the balance sheet, such as between board-designated assets and assets set aside under agreements with third-party payors, are not recognized.

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

AUDITING

Audit Objectives

6.20 The significant audit objectives for investments are to obtain reasonable assurance that--

a. Securities owned exist and are safeguarded or held in custody or safekeeping by others for the account of the entity.

b. Valuation allowances applicable to marketable equity securities and related realized and unrealized gains or losses are presented properly in the financial statements.

c. Declines that are other than temporary in the carrying value of the investments are recorded.

d. Donor- and grantor-imposed restrictions on the nature or type of investments that may be acquired are recognized.

e. When investments of various funds are pooled--

   - o Provisions of donor and grantor restrictions do not prohibit pooling of investments.
   - o Legal restrictions do not prohibit pooling.
   - o Income and gains or losses are distributed equitably among the participating funds.

f. Investments and the related income, gains, and losses are properly accounted for and presented in the financial statements, including disclosure of amounts pledged as collateral and cost and market value.

g. All required disclosures have been made.

Internal Accounting Control

6.21 Investment securities on hand (including those in a safe-deposit box) should be properly safeguarded. Securities not on hand are usually held by a custodian or by a trustee or lender as collateral.

6.22 Contributions in the form of securities may be received directly by the entity, or delivered to a custodian for deposit into an account of the entity.

6.23 Generally, transactions in the investment portfolios of the various funds or of investment pools require the approval of a designated person, an

investment committee, or another specified committee of the board. Ratification of the purchase or sale of investments is often reflected in the minutes of the board or its investment committee. Securities received as donations may be acknowledged in writing by a designated person or by the fund-raising department of the entity.

6.24 The following questions are among the internal accounting control considerations for investments:

- Are security purchases, exchanges, and sales approved by the board of directors or designated committee (or its designee) and reflected in the minutes?
- Does the board of directors receive regular reports on investment transactions showing such data as valuation and investment yield?
- Are securities received as donations acknowledged in writing?
- Are controls employed to provide reasonable assurance that--
  - Donated securities are promptly recorded?
  - Donated securities are recorded at market value at the date of the gift?
  - Persons receiving securities are bonded and do not have access to other negotiable assets?
  - Custodians receiving donated securities for the entity promptly report the transactions to the entity?
  - Securities received are transferred in the name of the entity?
- Are subsidiary records for investments maintained and reconciled to the general ledger?
- Are statements showing detailed investment holdings received from custodians and reconciled to detailed records by individuals who are independent of the transaction execution and recording functions?
- Are securities on hand under dual control to ensure segregation of duties?
- Are securities in a safe-deposit box periodically inspected and checked against the records at regular intervals by individuals not involved in the receiving and recording functions?
- Is access to the safe-deposit box restricted to authorized persons?
- Are securities held by others periodically verified by physical examination, confirmation, or other procedures by persons independent of those responsible for control over the securities?

- Is documentation retained to support the classification of donated securities as either restricted or unrestricted? Does the written acknowledgment to the donor indicate the nature of the donation?

Audit Procedures

6.25 Because investment securities may be negotiable, the auditor should consider controlling securities that are on hand or kept in safe-deposit boxes until they have been accounted for by physical inspection. Confirmations or other verification from independent custodians of securities held for the entity should be obtained.

6.26 Furthermore, the auditor may wish to test, by referring to the underlying documentation, the entries recorded in the investment ledgers or other subsidiary records, as well as the market values assigned by the entity or custodians to reliable published sources.

6.27 If investments are pooled, the auditor should consider reviewing and testing the method used to allocate gains or losses and investment income to determine that amounts have been properly recorded and presented in the financial statements. The auditor should also consider reviewing valuation allowances applicable to marketable equity securities to determine that they are properly recorded and that changes in valuation allowances are presented properly in the financial statements.

6.28 The auditor may examine the documentation related to donated securities to determine the nature of the gift and its restrictions, if any.

CHAPTER 7

RECEIVABLES

7.1 Receivables include amounts due for health care services from patients, residents, and employers; premiums and reinsurance; and interfund and intercompany transactions, pledges, grants, and amounts due from employees or others.

ACCOUNTS RECEIVABLE FOR HEALTH CARE SERVICES

7.2 Amounts received from third-party payors on accounts receivable for health care services are usually less than the provider's full established rates for those services. The payments received may be determined (a) by contractual agreement with others (such as Blue Cross plans, Medicare, Medicaid, HMOs, and so on); (b) by legislation or regulation (worker's compensation, no-fault insurance); or (c) by provider policy such as courtesy discounts to medical staff members and employees, charity allowances to qualifying individuals, and other administrative adjustments.

7.3 Although revenue for health care services is usually recorded at the provider's full established rates at the time those services are rendered, a contractual adjustment (that is, the difference between established rates and the contractual amount to be received) or discount (that is, the difference between established rates and the amount collectible under entity policy) is usually recorded at a later date. This later date 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 is actually received. In addition, health care entities usually incur bad debts. To report health care service revenue and receivables at net realizable value, estimates of the allowance for contractual adjustments, other adjustments, and the allowance for bad debts are recorded.

7.4 Contractual and other allowances may be calculated and posted through a data processing or a manual system. Usually, the allowance for uncollectible accounts is estimated by basing it on aged trial balances, which are normally classified by type of payor, historical collection trends, the current economic environment, and other relevant factors.

7.5 The Medicare Prospective Payment System (PPS) requires a change in the way the allowance for contractual adjustments for Medicare inpatients hospitalized at the balance sheet date is determined. Under PPS, revenue is based on a per case discharge and, therefore, the calculation of the contractual allowance is complicated because a clear cutoff for revenue recognition cannot be established. The length of stay of a particular patient has little or no effect on realizable revenue because the price per case is based upon a national mean length of stay (LOS). If a patient stays longer than the national mean, the hospital will not receive additional revenue even

though additional costs may be incurred (with the exception of special consideration for extreme cases). A methodology should be employed by the hospital to properly estimate the revenue earned for Medicare inpatients hospitalized at the balance sheet date. This calculation could be estimated based on the actual or national mean LOS or any methodology that properly matches revenue with expenses.

Rate Setting

7.6 The auditor should understand 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 rates determine what an entity may charge or what third parties will pay for health care services. Prospective rate setting may result from a contractual agreement with third parties, such as a Blue Cross plan or HMO, or may be mandated through legislation. The intent of prospective rate setting is that payment rates are established before the period to which they will apply and are not subject to change. However, the auditor should be aware 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 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 and 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 reimbursable costs actually incurred. Although final settlements are not made until a subsequent period, they are usually subject to reasonable estimates and are recorded in the financial statements for the period during which services were rendered. When final settlements are made, differences between the estimates reported in the financial statements for the period during which services were rendered and the final settlements are included in the statement of revenues and expenses as an adjustment to the appropriate deduction from revenue account. 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 Those rate-setting methods that are described as prospective but have provision for retrospective adjustments are accounted for as retrospective rate-setting systems for the services to which they apply.

Advances and Deposits

7.11 To improve an entity's cash flow, third-party payors may advance funds to a health care entity. Advances from third-party payors are reported in the financial statements as a liability unless the right of offset 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, a common practice is to require a deposit from a charge-paying maternity patient when an advance registration form is completed, or from a charge-paying patient at the time of an elective admission. Deposits received from patients are reported in the financial statements as a liability.

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 (a) errors in calculation, (b) new or expanded services not recognized in existing rates, (c) rate-setting adjustments, (d) interpretation of regulations or (e) other reasons. Guidance with respect to accounting for gain and loss contingencies under those rate-setting systems is contained in FASB Statement No. 5, Accounting for Contingencies, as amended and interpreted.

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. Typically, a condition for Medicare participation in a state waiver program requires that Medicare expenditures in that state not exceed prescribed limits. If Medicare expenditures exceed prescribed limits, the excess is recoverable by the federal government. With respect to accounting for loss contingencies arising under state Medicare waivers, guidance is contained in FASB Statement No. 5.

PREMIUMS AND REINSURANCE RECEIVABLES

7.15 Some health care entities undertake the responsibility to provide comprehensive health care services for a fixed period in return for fixed monthly premiums. Many of those entities may transfer a portion of their risks to another organization by purchasing reinsurance. Receivables of those entities may include uncollected premiums and amounts recoverable from reinsurers reduced by appropriate valuation allowances.

FINANCIAL STATEMENT PRESENTATION AND DISCLOSURE

Accounts Receivable for Health Care Services

7.16 Receivables for health care services (net of allowances for estimated uncollectibles and contractual adjustments) are reported as current assets in general funds unless the terms of payment have been extended beyond a year from the date of the balance sheet, in which case 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 generally are reported separately in the financial statements.

Interfund Receivables

7.17 Interfund receivables or payables are reported separately by fund. If general fund receivables (payables) are to be collected (paid) over an extended period, they are classified as current or noncurrent in conformity with generally accepted accounting principles.

Pledges

7.18 All pledges, less an allowance for amounts uncollectible, are accounted for in the financial statements. Pledges are appropriately classified in the financial statements as unrestricted (general) or donor-restricted. Unrestricted pledges (less an allowance for uncollectibles) are reported in the financial statements of the period in which the pledge is made as nonoperating revenue. If part of the pledge is to be applied during some future period, that part is reported in the financial statements of the period in which it is received as deferred revenue or as additions to donor-restricted funds. If pledges are restricted in any other way, they are reported as donor-restricted funds.

Reinsurance

7.19 Amounts recoverable from reinsurers that relate to health care costs are classified as assets, reduced by appropriate valuation allowances. The nature of significant reinsurance activities, the amount of reinsurance premiums reported as health care costs, the amount of reinsurance recoveries reported as revenue, and the estimated amounts recoverable from reinsurers that are related to health care costs are disclosed.

Other Receivables

7.20 Other receivables are reported separately in the financial statements minus the related allowance for estimated uncollectibles.

AUDITING

Audit Objectives

7.21 Generally, receivables, particularly those arising from health care services, are material to the financial position and results of operations of health care entities. The significant audit objectives for receivables are to obtain reasonable assurance that--

- Amounts reflected in the financial statements represent receivables of the entity.
- Adequate allowances have been established for estimated uncollectibles and contractual adjustments so that receivables are stated at estimated net realizable value.
- Receivables are properly classified.
- Receivables from third-party payors for changes in rates resulting from final settlements, appeals, or other changes required by the rate-setting method are properly calculated and recorded.
- Patient deposits and third-party payor advances are properly recorded and classified.
- Adequate disclosures have been made for receivables that have been pledged as collateral, discounted, or assigned.
- Interfund borrowings and transfers are proper and have been approved by the governing board or its designee.
- Interfund receivables are in agreement with payables and are realizable.

Internal Accounting Control

7.22 Accounts receivable for health care services are usually recorded based on the full established rates of the entity even though the amount realizable from third-party payors or others may be less than the full rates. The difference between the full rates and the amount realizable may result from contractual arrangements, regulation, courtesy or charity discounts, or other entity policies.

7.23 In evaluating internal accounting control and in determining the resultant extent of auditing procedures to be applied, the auditor should review the entity's procedures for determining amounts that are collectible for services and evaluate the entity's method of determining (a) the provision and allowance for contractual adjustments, (b) the provision and allowance for uncollectible accounts, and (c) the provision and allowance for discounts based on entity policy.

7.24 In studying and evaluating internal accounting control related to patient receivables the auditor may consider, among others, the following questions:

- o Do admission or registration procedures provide reasonable assurance that complete and accurate billing, accounts receivable, and collection and medical (DRG-related) information is gathered?
  - Does the admitting department require (a) an admitting diagnosis that refers to an ICD-9-CM (indexing and health statistical collection system) code, (b) verification of the patient's age, and (c) other pertinent clinical data necessary to establish a preliminary DRG assignment?
- o Does the system of internal accounting control provide reasonable assurance that services rendered to patients are approved for medical necessity?
- o Are procedures in effect to provide assurance that charges are properly controlled and recorded?
- o Are services and supplies charged at the correct price, and is the related revenue properly recorded and classified?
- o Is the appropriate patient or third party promptly billed for services rendered, and are statements routinely sent?
- o Are amounts that are due from third parties for individual accounts valid receivables and supported by approvals, billings, and subsequent receipts?
- o Are procedures effective to assure proper recording and application of cash receipts?
- o Are third-party contractual allowances calculated and recorded properly?
- o Are allowances, such as bad debts and charity, approved in accordance with the entity's established policies?
- o Is the adequacy of the allowance for uncollectible accounts periodically reviewed?
- o Are operating statistics properly accumulated to fulfill the requirements of third-party cost-report and other filings?
- o Are deposits and advances properly recorded?
- o Are differences between third-party interim payment rates and estimated final rates properly calculated and recorded?

- o Are pledges receivable supported by appropriate documentation and periodically reconciled to detailed records?

- o Are controls established to determine that medical records information will result in proper DRG assignments in connection with the Medicare PPS?

  - Do medical records personnel have the educational background to ensure accuracy, and are they properly trained and supervised to understand the importance of coding in achieving proper payment under PPS?

  - Does the medical records department follow up on all Medicare admissions to ensure prompt coding of Medicare patient data?

  - Is a final face sheet prepared based on a completed medical record, including the physician's discharge summary and the physician's statement attesting to the narrative description of the principal diagnosis and other clinical data?

  - Are medical records (primarily for Medicare patients) subject to a second independent coding review?

Audit Procedures

7.25 Confirmations. Confirmation requests for amounts due from discharged patients and third-party payors are an appropriate audit procedure to obtain evidence as to their existence and accuracy. 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, an attempt to obtain 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 or are no longer receiving services.

7.26 When confirmation of balances is impracticable, the auditor should use alternate procedures such as the following:

- o Review and test subsequent receipts, including amounts received from third-party payors.

- o Analyze accounts that have been written off and authorized to be written off as uncollectible and those contractual allowances recorded in the subsequent period.

- o Confirm third-party payment rates with third-party payors.

- o Compare patient accounts to documentation contained in medical records.

7.27 With respect to pledges receivable the auditor should apply procedures similar to those used in the examination of other receivables.

7.28 Estimated Third-Party Settlements. Amounts due from third-party payors represent the excess of estimated final payment rates over interim payment rates received or receivable. Those amounts may be based on cost reports prepared after the end of the period or on calculations used to determine final payment rates.

7.29 Audit activities applicable to estimated third-party settlements may include the following procedures:

- Test computations made to estimate the amount of retroactive adjustments provided for in the accounts.

- Request confirmations from major third-party payors as to (a) the interim payment rates related to cost reporting periods for which final settlement has not been made, (b) the amount of interim or final settlements made during the period, and (c) the amount of advances outstanding at the balance sheet date.

- Review applicable rate-setting and reimbursement methods to determine if revenue has been properly recorded.

- Test cost reimbursement reports and other reports used to establish third-party payment rates to determine that they are prepared based on the appropriate principles of reimbursement.

- Review third-party payor audit reports and adjustments for prior years' cost reports to consider (a) whether similar adjustments are applicable and have been considered in the current year and (b) the propriety of appropriate administrative review board and judicial appeals.

- Determine that amounts and disclosures related to pending claims or appeals for additional reimbursement are properly reflected in the financial statements in accordance with FASB Statement No. 5.

- Determine that the effects of timing differences under third-party payor reimbursement methods have been properly recorded.

- Determine that the effect of Medicare payment denials because of PRO reviews for medical necessity, appropriateness, or quality of care is properly recorded.

- Test the entity's procedures used to assign DRGs.

7.30 Allowances. Procedures applicable to allowances for uncollectible accounts, contractual allowances, charity and free care, and other allowances may include these activities:

- Review patient accounts for appropriate financial classification by payor (for example, Medicare or self-pay) and collectibility.

- Test the method used to determine that adequate provision has been made for differences between interim billing rates and full established rates.

- Test and analyze aged trial balances, collection trends, past-due accounts, subsequent period write-offs, and economic or other factors used to determine the allowance for estimated uncollectibles.

- Analyze collection activity for accounts previously written off to ascertain that collections on those accounts have been properly recorded.

- Review pledges and other receivables to determine that payments are being received in accordance with the terms of the pledge or receivable, as well as testing the method used to determine the allowance for estimated uncollectibles.

CHAPTER 8

SUPPLIES, PROPERTY AND EQUIPMENT, AND OTHER ASSETS

8.1 Supplies are not usually significant to the financial position of health care entities. However, because of the volume and dollar amount of supply transactions, they may significantly affect operations.

8.2 Classification of supplies typically includes these groupings:

- o Medical and surgical supplies
- o Pharmaceuticals
- o Linens, uniforms, and garments
- o Food and other commodities
- o Housekeeping, maintenance, and office supplies

8.3 Health care entities use various types of property and equipment. Those assets may be significant to the financial position of institutional health care entities (for example, hospitals and nursing homes). Typical accounts used to record property and equipment transactions include the following:

- o Land
- o Land improvements
- o Buildings and improvements
- o Leasehold improvements
- o Equipment (fixed and movable)
- o Leased property and equipment
- o Accumulated depreciation and amortization
- o Construction in progress

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

ACCOUNTING

8.5 Accounting for property and equipment and other assets of health care entities is similar to methods used by other business organizations. Supplies may be inventoried and expensed when utilized or sold to patients or others.

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

FINANCIAL STATEMENT PRESENTATION

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

8.8 Except as indicated in paragraph 8.9, property and equipment 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. Proceeds from the disposition of property and equipment that are subject to donor or legal restrictions should be disclosed in the financial statements.

8.9 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.

AUDITING

Audit Objectives

8.10 Audit objectives for supplies, property and equipment, and other assets of health care entities are similar to those of other organizations, including obtaining sufficient evidential matter related to those assets.

8.11 In addition, with respect to property and equipment, the auditor should consider whether--

- o Donated assets are recorded at fair market value at date of donation.
- o Property and equipment not used for health care operations are separately reported.
- o Appropriate health care planning agency approvals, where required, have been obtained for property and equipment additions.

Internal Accounting Control

8.12 Internal accounting control considerations related to supplies and other assets are similar to those of other business organizations.

8.13 Significant considerations in evaluating internal accounting control related to property and equipment include these questions:

- Is there written authorization for additions and deletions?
- Do detailed property records support general ledger balances?
- Are gains and losses on sale or abandonment of property or equipment recorded properly?
- Is movable equipment periodically inventoried?
- Is there adequate documentation to support the determination of the fair market value of property and equipment received as donations?
- Is property held for investment or for future expansion distinguished in the accounting records from assets acquired for operating purposes?
- Is there an effective procedure to monitor and determine compliance with health care planning agency requirements?
- Are procedures in effect to assure that assets under construction are capitalized in conformity with generally accepted accounting principles?

Audit Procedures

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

8.15 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.

8.16 A health care entity also may have access to the use of property and equipment under a variety of arrangements. It may (a) own the property and equipment outright; (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 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 health care property. With respect to leases, FASB Statement No. 13, Accounting for Leases, as amended and interpreted, provides the necessary accounting guidance.

8.17 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.

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

8.19 In evaluating the entity's depreciation policies, the auditor may wish to refer to the American Hospital Association's Guidelines for Assigning Useful Lives, which 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.

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* The document is revised periodically.

CHAPTER 9

CURRENT LIABILITIES AND LONG-TERM OBLIGATIONS

9.1 Current liabilities may include the following categories: (a) notes payable to banks; (b) the current portion of long-term debt; (c) accounts payable; (d) advances from and amounts payable to third-party payors for estimated and final reimbursement settlements; (e) refunds to patients and others; (f) deferred revenue; (g) accrued salaries and payroll taxes; and (h) other accruals such as pension or profit-sharing contributions, compensated absences, vacation and sick pay, and income taxes. In addition, there may be a current portion of estimated malpractice costs, discussed in chapter 10 and appendix G.

9.2 Long-term obligations may include notes, mortgages, capital leases, bonds, and obligations under continuing-care contracts. Estimated malpractice costs and risk-contract-recognized losses are also discussed in chapter 10. (See appendix G.)

ACCOUNTING

9.3 Accounting for current liabilities of health care organizations is similar to 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 voluntary 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.

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

Obligations Under Continuing Care Contracts

9.7 A CCRC may use several methods to charge a resident for services. The three most prevalent methods are as follows:

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 CCRC housing-related services (for example, meals, laundry, housekeeping, social, or 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. 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 for future services may be refundable, either fully or partially, depending on the occurrence of some future event. Because of contractual or statutory requirements--or moral obligations--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 Even though advance fees and periodic fees are insufficient to meet the cost of providing services to a resident, the CCRC's liability or obligation to provide future services continues, generally without additional compensation, for the length of the contract or the life of the resident.

9.10 Because of diversity in accounting and reporting for the obligation to provide future services, refundable fees, and advance fees, the AICPA Accounting Standards Executive Committee is considering how to apply to those transactions the accounting guidance contained in FASB Statements No. 60, Accounting and Reporting by Insurance Enterprises, and 45, Accounting for Franchise Fee Revenue.

FINANCIAL STATEMENT PRESENTATION

9.11 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 the refund policy for refundable fees is generally disclosed in the financial statements.

AUDITING

Audit Objectives

9.12 Audit objectives for current liabilities and long-term obligations are similar to other organizations.

Internal Accounting Control

9.13 Generally, internal accounting control considerations for current liabilities of health care entities are similar to those for other business organizations, to which the auditor should add the following questions:

- Are procedures in effect to assure that interfund borrowings are (a) approved by the governing board and (b) in compliance with applicable legal restrictions?
- Are advances from third-party payors properly controlled and accounted for?

9.14 In the study and evaluation of the internal accounting control for long-term obligations the auditor should consider, among others, the following:

- Is there a management policy that limits the amount of borrowings and is that policy adhered to?
- Are long-term obligations properly authorized by the governing board?
- Is the health care entity in compliance with restrictive debt covenants?
- Are redeemed notes, bonds, and coupons properly canceled?
- Are interest computations independently checked?

Audit Procedures

9.15 In addition to auditing procedures usually performed in connection with current liabilities of other business organizations, the auditor should consider the following audit procedures:

- Determine that interfund accounts are in balance and that the transactions are recorded properly.
- Request confirmation of Medicare, Medicaid, and other third-party payor advances.
- Read contracts with physicians, specialists, related parties, and others who perform services for the entity to determine if liabilities are properly stated.

- Test deferred revenues that are related to educational programs and grants to determine that they have been accounted for properly.

- Determine that leases, pensions, compensated absences, and income tax liabilities are accounted for in conformity with generally accepted accounting principles.

9.16 With respect to long-term obligations, the auditor may wish to consider the following procedures:

- Determine whether long-term obligations and the amount of borrowings are authorized by the governing board, and that they are properly classified and described in the financial statements.

- Request lenders to confirm the terms of borrowings--including, for example, outstanding balance, interest rate, and collateral provisions.

- Request confirmation of the existence and terms of lines of credit and compensating balance arrangements.

- Read loan agreements, bond indentures, and other applicable documents to determine compliance with covenants and with fund requirements (such as sinking funds, debt-retirement funds, construction funds, and replacement funds). If events of default on violations of restrictions exist, determine whether they have been cured or waived, as well as their effects (if any) on the financial statements.

- Test interest expense and accrued interest payable.

- Review redeemed notes and bonds for proper cancellation.

- Determine whether premiums, discounts, and imputed interest have been properly recorded.

- Review refundable fee arrangements regarding stipulations for repayment, and determine that such arrangements are properly classified and described in the financial statements.

CHAPTER 10

COMMITMENTS AND CONTINGENCIES

10.1 Commitments and contingencies may include these categories:

- Losses arising from malpractice and other claims
- Contingencies related to risk contracting, third-party payment, and rate-setting programs
- Construction contract commitments
- Commitments and guarantees that include contractual agreements with physicians, specialists, and others who perform services by arrangement with health care entities
- 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 for health care entities is discussed in the following sections and appendix G.

UNINSURED ASSERTED AND UNASSERTED MEDICAL MALPRACTICE CLAIMS AND RELATED ISSUES

10.3 Appendix G contains Statement of Position 87-1, Accounting for Asserted and Unasserted Medical Malpractice Claims of Health Care Providers and Related Issues. That SOP applies to all health care providers and provides guidance concerning medical malpractice insurance financial-reporting issues.

ACCOUNTING BY PREPAID HEALTH CARE PLANS

10.4 An AICPA task force is considering a proposed statement of position, Accounting for Prepaid Health Care Services. The proposed SOP would apply to providers of prepaid health care services, such as HMOs and associated entities (including IPAs and medical groups) and organizations that have characteristics or arrangements similar to HMOs. It provides guidance on applying generally accepted accounting principles in accounting for health care costs, contract losses, reinsurance, and acquisition costs of providers of prepaid health care services. The conclusions of the proposed SOP will be incorporated within this proposed guide once the guide becomes final, or an SOP will be issued amending the guide.

RISK CONTRACTING--OTHER PROVIDERS OF HEALTH CARE

10.5 Some hospitals, physicians, and other health care providers contract with HMOs, employers, and others to provide health care services to enrolled members of those organizations under a variety of payment arrangements. When payment to the provider is on a fee-for-service arrangement, the accounting for revenue and related receivables is the same as for other third-party contracts. When payment to the provider is determined on a capitation basis, the provider is at risk for health care costs in excess of the capitation revenue; this type of arrangement is generally referred to as a risk contract.

10.6 Hospitals and other health care providers that participate in risk contracts recognize a loss when it is probable that expected future costs under the contracts will exceed anticipated capitation revenue and reinsurance recoveries on those contracts.

DISCLOSURES

10.7 Appendix G contains specific disclosure requirements regarding accounting for asserted and unasserted medical malpractice claims of health care providers and related issues. In addition, the AICPA has issued a report, "Disclosure Concerning Insurance Coverage," recommending, among other things, disclosure of the circumstances in which an entity is exposed to the risks of future material loss and those risks have not been transferred to unrelated third parties through insurance.

10.8 An example of financial statement disclosure of uncertainties arising from possible malpractice follows:

> Malpractice claims in excess of insurance coverage have been asserted against the hospital 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 the hospital. Incidents occurring through [balance sheet date] may result in the assertion of additional claims. Other claims may be asserted arising from services provided to patients in the past. Management is unable to estimate the ultimate cost, if any, of the resolution of such potential claims, and, accordingly, no accrual has been made for them; however, management believes that these claims, if asserted, would be settled within the limits of insurance coverage.

10.9 Disclosure requirements for other commitments and contingent liabilities of health care entities are similar to those of other business organizations.

AUDITING

Audit Objectives

10.10 Audit objectives for commitments and contingencies are similar to other organizations.

Internal Accounting Control

10.11 In evaluating internal accounting control for commitments and contingencies, the auditor may wish to consider the following questions:

- Are records of open purchase orders maintained to determine potential commitments, guarantees, or contractual obligations in excess of normal requirements (for example, construction contract guarantees and purchase commitments)?
- Is there a system in effect to identify, evaluate, and report incidents that may potentially lead to malpractice and other losses (that is, a risk management system)?
- Are procedures adequate to provide reasonable assurance that expenses and loss accruals are properly recorded?

Audit Procedures

10.12 Malpractice Loss Contingencies. In evaluating the reasonableness of the accrual for estimated losses from malpractice claims, the auditor should consider the amount of insurance coverage, the type of coverage (claims-made or occurrence), the amount of deductible provisions, the possibility of retrospective adjustments, the evaluation of known claims and reported incidents, the method of estimating IBNR claims, and related legal and other costs.

10.13 A letter of audit inquiry to the entity's legal counsel is a 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 are in excess of insurance coverage.

10.14 With respect to litigation, claims, and assessments, the auditor should follow the guidance in SAS No. 12, Inquiry of a Client's Lawyer Concerning Litigation, Claims, and Assessments, that relates to obtaining adequate evidential matter.

10.15 It would be appropriate for the auditor to consider prior estimates and historical loss experience, analyses of the frequency of past claims, and other actuarial considerations in evaluating the reasonableness of management's estimate of the loss (if any) that occurred with respect to unasserted claims before the date of the financial statements.

10.16 When the health care entity's malpractice risks are insured on a claims-made basis, the auditor determines that (a) the estimated cost of claims and incidents not reported or (b) the cost of tail coverage* has been accounted for properly.

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* See AICPA Statement of Position 87-1, Accounting for Asserted and Unasserted Medical Malpractice Claims of Health Care Providers and Related Issues (appendix G herein).

10.17 In estimating losses from unreported incidents, a health care entity may obtain the assistance of a specialist in using industry experience. In such circumstances, the independent auditor should be guided by the provisions of SAS No. 11, Using the Work of a Specialist.

10.18 The auditor may wish to consider the following additional procedures:

- Evaluate the effectiveness of policies and procedures of the risk management system to identify and report incidents that may result in malpractice and other losses.

- Send letters of inquiry to malpractice insurance carriers and legal counsel to determine the existence of contingent liabilities, and evaluate responses thereto.

- Determine adequacy of disclosures regarding risk contracting and malpractice risks.

10.19 Risk Contracting. In evaluating the reasonableness of the accrual for health care costs of prepaid health care plans and other health care providers, the auditor should consider whether an appropriate amount has been included for costs IBNR at the balance sheet date. The following procedures should be considered:

- Analyze previous claims experience and related trends.

- Evaluate the effects on the financial statements of changing conditions including:

  - seasonality
  - contract population
  - scope of service and benefit coverages
  - delivery modes (for example, ambulatory versus inpatient)

- Evaluate the effectiveness of policies and procedures used by the entity to identify proper cutoff.

10.20 In evaluating the reasonableness of the amount of loss (if any) recognized under risk contracts, the following procedures are among those to be considered:

- Identify and determine the effects of contract periods that differ from the reporting period.

- Determine the effect of payment arrangements that are subject to retroactive adjustment through various risk-sharing mechanisms, such as risk pools, incentive bonuses, and holdback provisions.

10.21 Other Commitments and Contingent Liabilities. Auditing activities related to other commitments and contingent liabilities may include these procedures:

- o Send letters of inquiry to attorneys who have been engaged or to whom retainers or fees have been paid.

- o Examine invoices for legal fees during the period for indications of possible contingent liabilities (for example, claims threatened, pending, or asserted).

- o Read minutes of meetings of board of directors, including special committees.

- o Obtain representation letters.

- o Read replies to bank confirmation requests for possible contingent liabilities.

- o Review health planning agency approvals necessary for qualifying additions to property and equipment.

- o Evaluate contingencies under rate-setting systems and reimbursement and risk-contracting arrangements.

- o Examine contracts and agreements for provisions that may create material contingencies.

- o Make inquiries of management with respect to--

  - contractual commitments

  - guarantees under contractual agreements with physicians, specialists, technicians or others who perform services by arrangement with health care entities

  - pending acquisitions or mergers

  - liquidity or going concern considerations

  - taxes or potential taxes on unrelated business income

10.22 Subsequent Events. In addition, SAS No. 1, Codification of Auditing Standards and Procedures, section 560, entitled "Subsequent Events," provides useful guidance for events or transactions that occur subsequent to the balance sheet date, but before the issuance of the financial statements and auditor's report, that may have a material effect on the financial statements and therefore require adjustment or disclosure in the statements.

10.23 Additional guidance is provided in section 561 relating to the subsequent discovery of facts existing at the date of the auditor's report.

CHAPTER 11

NET ASSETS OR EQUITY

11.1 The equity accounts of an investor-owned health care entity are the same as other investor-owned businesses. Net assets of voluntary and governmental health care entities are displayed as general and donor-restricted fund balances. The general fund's fund balance represents the net assets of general funds.

11.2 Donor-restricted funds may include--

a. Specific-purpose resources.

b. Plant replacement and expansion resources.

c. Endowment resources held for the production of income.

d. Other donor-restricted resources (student loan, annuity, and living trust funds).

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

AUDITING

Audit Objectives

11.4 The audit objectives for equity accounts (net assets) usually include determining that--

- Funds are used for the purposes intended.
- Transactions (additions, deductions, and other changes) are properly recorded.
- Intrafund and interfund transactions are properly recorded.
- Each fund is in balance and financial statement disclosure is proper.
- Overhead charged to grant funds is in accordance with terms of grant agreements, and direct expenditures are not in excess of the amounts recoverable.

Internal Accounting Control

11.5 In the study and evaluation of internal accounting control, the auditor may wish to consider, among others, the following questions:

- Are restrictions by donors properly documented?

- Are all interfund transfers properly approved?

- Is there adequate control over the use of endowment and other donor- or grantor-restricted funds, and is there proper approval for disbursements of those funds?

- Is there adequate separation of duties related to the receipt and recording of donations and grants?

Audit Procedures

11.6 In addition to procedures normally applied to other business organizations, the auditor should--

- Test significant fund balance transactions to determine that they are in accordance with the donor's or grantor's restrictions and are properly authorized and recorded.

- Determine that investment income and gains (or losses) of restricted funds have been properly added to (or deducted from) the appropriate fund balance.

- Test to determine that grant expenditures are spent in accordance with terms of grant agreements.

- Test assets associated with donor-restricted funds to determine that they have been maintained in accordance with terms of agreements.

- Determine that each fund is in balance and that financial statement disclosure is adequate.

CHAPTER 12

REVENUE AND EXPENSES

REVENUE

12.1 Revenue for 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. Examples of revenue for health care services are:

- o 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, physician's care, laboratories, radiology, pharmacy, and renal dialysis).

- o Resident service revenue, which may be further classified as maintenance or rental fees and amortization of advance fees.

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

12.3 Revenue of HMOs and other prepaid health care plans includes premiums, reinsurance recoveries, and investment income.

12.4 For accounting purposes, health care entities may maintain other records to accumulate health care service revenue based on diagnosis and physician. For example, under the Medicare PPS for hospitals, DRGs are organized within a number of major diagnosis categories. That system classifies patients into DRGs based on principal diagnosis and other factors (such as age, sex, operative procedures, preexisting conditions, complications, and discharge status).

Other Operating Revenue

12.5 Other operating revenue normally includes revenue from services other than health care provided to patients and residents, as well as sales and services to persons besides patients. 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.

12.6 Other operating revenue may include the following:

a. Revenue from educational programs. This includes tuition for schools, such as nursing, and laboratory and X-ray technology.

b. Research and other specific-purpose grants. This includes revenue from grants, gifts, or subsidies specified by donors and grantors for research, educational, or other programs to the extent that related expenditures are included in operations.

c. Miscellaneous, sources of revenue. These might include--

- o Revenue from rental of health care facility space
- o Sales of medical and pharmacy supplies to employees, physicians, and others
- o Revenue from fees charged for transcripts for attorneys, insurance companies, and others
- o Proceeds from sale of cafeteria meals and guest trays to employees, medical staff, and visitors
- o Charges for personal telephone calls
- o Proceeds from sale of scrap, dietary waste, used X-ray film, and so forth
- o Revenue from gift shops, snack bars, newsstands, parking lots, vending machines, and other service facilities operated by the health care entity

Nonoperating Revenue

12.7 Revenue not directly related to an entity's ongoing or principal operations is classified as nonoperating revenue and may include the following:

a. Unrestricted gifts. This includes all gifts, grants, and bequests upon which there are no donor-imposed restrictions. Grants for general operating purposes from foundations and similar groups are placed in this classification.

b. Unrestricted income from endowment funds. This includes income earned on investments of those endowment funds without restrictions on income.

c. Income and gains from investments of general funds. This includes interest, dividends, rents, or other income on investments as well as net gains or losses resulting from investments.

There are certain circumstances under which investment income is directly related to specific operating costs. In those circumstances, the investment income is properly classified as operating revenue (or in some instances, as an offset to operating expenses). Chapter 6 includes examples of those circumstances and exceptions. In addition,

investment income is directly related to the ongoing principal operations of certain health care entities, like HMOs and CCRCs, and therefore those entities classify investment income as operating revenue.

d. Miscellaneous. This classification may include--

- o Gain or loss on sale of health care entity properties
- o Net rentals of facilities not used in the operation of the entity
- o Term endowment funds upon termination of restrictions

EXPENSES

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

12.9 Suggested major classifications of expenses are:

- o Nursing services
- o Other professional services
- o General services
- o Fiscal services
- o Administrative services
- o Depreciation
- o Interest

12.10 The classifications listed in paragraph 12.9 are subdivided by organizational unit (responsibility center).

12.11 An object or natural classification indicating the nature of the expense may also be used, such as:

- o Salaries and wages
- o Employee benefits
- o Fees to individuals and organizations
- o Supplies
- o Purchased services
- o Depreciation

- o Interest
- o Other expenses

12.12 The extent of classifications and subclassifications depends upon many factors, such as size of the health care entity, degree of management and accounting sophistication, and external requirements for cost reports or comparability with other health care entities.

12.13 Guidance for establishing general ledger charts of accounts for hospitals and nursing homes may be found in publications such as the American Hospital Association's Chart of Accounts for Hospitals or the American Nursing Home Association's Uniform Chart of Accounts for Long-Term Care Facilities. Other health care organizations, such as home health agencies, may use a chart of accounts that is modified based on the above referenced publications.

FINANCIAL STATEMENT PRESENTATION

12.14 For financial reporting purposes, service revenue is reported net of allowances in the statement of revenues and expenses. Contractual allowances are disclosed if deemed necessary. If material, the provision for uncompensated services (uncollectibles and charity care) is disclosed.

12.15 The provision for uncompensated services is reduced by revenue such as gifts, grants, or endowment income restricted for assistance to charity and other patients. Such revenue is generally disclosed in the financial statements.

12.16 Unrestricted gifts, grants, donations, and bequests are reported as nonoperating revenue regardless of the ultimate purpose for which the governing board designates them.

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

12.18 Expenses incurred in soliciting funds for a fund-raising campaign are disclosed separately in the financial statements. Showing these expenses as a deduction from related revenue is an acceptable manner of reporting.

AUDITING

Audit Objectives

12.19 The significant audit objectives for revenue and expenses are to obtain reasonable assurance that--

- o Revenue and expenses are properly recorded and classified.

- o Deductions from revenue are properly recorded and classified.

- o Required disclosures have been made in the financial statements or notes.

Internal Accounting Control

12.20 In evaluating internal accounting control, the auditor may seek to answer questions related to (a) health care service revenue, (b) deductions from revenue, (c) other operating and nonoperating revenue, and (d) expenses.

12.21 Health Care Service Revenue. The auditor might determine the following:

- o Are charges to patients evidenced by the proper authorization for services?

- o Are controls in effect to assure that charges for services and supplies provided to patients, residents, and others are properly recorded?

  - Are days of care used to record daily service charges reconciled to daily census reports prepared by nursing or medical records personnel?

  - Are postings for other nursing and ancillary services evidenced by completed service requisitions?

  - Are completed service requisitions received by the accounting department subject to batch or other controls and compared to departmental service logs or medical records?

  - Are charges for services checked to an approved list of rates?

- o Are units of service and statistics that affect revenue determination properly accumulated?

- o Are controls in effect to assure the accuracy and completeness of medical records information and DRG assignment?

12.22 Deductions From Revenue. The auditor might ask the following:

- o Is the authority to approve deductions from revenue separate from the cash and billing functions?

- o Are contractual adjustments properly authorized, controlled, and recorded?

- o Are charity allowances, bad debt write-offs, and courtesy and policy discounts properly authorized, controlled, and recorded?

12.23 Other Operating and Nonoperating Revenue. The auditor might ask:

- Does the revenue system account for other operating and nonoperating revenue transactions adequately, and is the cash receipts function independent of the recording function?

- Are miscellaneous revenues that result from the sale of used X-ray film, medical transcript fees, accommodation sales to employees, and revenue from gift shops, cafeterias, and so on, controlled by using a descriptive and timely (recorded daily) cash receipts system?

- Is revenue from educational programs controlled through enrollment statistics, registration records, or class-admission reports, and are such records reconciled with revenues periodically?

- Are specific research projects properly authorized, is a determination made about the specific-purpose funds available to cover related costs, and are research expenditures properly controlled and related to budgets and authorizations?

- Are internal controls over unrestricted gifts, grants, and donations exercised through written receipt and acknowledgment procedures?

- Are interest income from investments and gains and losses from investment transactions controlled through safekeeping procedures and the use of investment registers?

- Are inventories of equipment compared to asset records to help provide control over the proper recording of gains and losses on sales or disposals of equipment?

12.24 Expenses. Internal accounting control considerations for expenses are the same as for other business organizations: separation of duties, competent personnel, adequate payroll procedures, control over purchasing and stores, and so forth. Because health care entities are very labor intensive, payroll generally represents a major portion of expenses.

Audit Procedures

12.25 Health Care Service Revenue and Deductions. The auditor should make sufficient tests of both health care service revenue and deductions therefrom to obtain satisfaction that they are properly recorded and classified. The auditor should consider the following procedures with respect to health care service revenue:

- Test to determine that revenue is accrued as service is performed and that related contractual and charity allowances are accounted for in accordance with the respective contracts and the entity's policies.

- Test the propriety of charges to patients by comparing them to documentation contained in medical records.

- o Compare service revenue charges to the entity's standard billing rates on a test basis.

- o Compare revenues of the current period with those of the previous period and obtain an explanation for unusual variances.

- o Review statistical reports (of patient days and lab tests, for example) to consider reliability of statistical records.

- o Perform overall tests of revenue based upon days of care and other service statistics.

- o Test the accuracy of revenue recorded based on 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 (see the Glossary) days and service costs.

  - Recoding medical information to verify the DRG assignment on a test basis.

  - Removing the original face sheets from selected medical records and independently preparing new face sheets to compare them for consistency and accuracy.

  - Testing outlier revenue calculations.

12.26 With respect to deductions from revenue, auditing procedures for revenue deductions closely parallel those that are applicable to revenue and ordinarily are performed in conjunction with the examination of accounts receivable and revenue. The auditor should consider the following procedures:

a. Review third-party payor contracts and methods of payment and test the entity's computation of estimated adjustments to revenue required under such contracts by--

   - o Comparing prior-year settlements to prior-year estimates and determining that all differences have been accounted for properly.

   - o Comparing interim per unit (for example, patient days, discharges) payment rates established by third-party payors to estimated average allowable payments per unit and multiplying the difference in rates by the units served under the contract.

   - o Using other techniques that may be appropriate in the circumstances.

b. Test the entity's procedures for determining retrospective revenue adjustments as a result of third-party settlements or negotiations.

12.27 Other Operating and Nonoperating Revenue. The following audit tests are among those to be considered in connection with other operating revenue and nonoperating revenue:

- o Review supporting documentation underlying gifts, grants, and bequests, including correspondence, acknowledgment receipts and notifications, as well as minutes of the governing board and committee meetings.

- o Test research grants and receipts for other donor-restricted purposes by referring to appropriate contracts and documents, including budgets of related projects, cost reports, field audit reports prepared by representatives of grantors, and other supporting documentation.

- o Compare recorded revenue from educational activities with independently calculated estimates.

12.28 Expenses. Payroll is usually significant to operating costs of health care entities; therefore, appropriate tests of payroll to determine proper classification and calculation are usually important.

12.29 In addition, the auditor may wish to perform these other procedures:

a. Examine agreements between the entity and independent contractors (including physicians) and--

   - o Test contract amounts paid that were based on written agreements.

   - o Obtain written representation from management outlining terms of any verbal agreements, and, where appropriate, request confirmation of the details of agreements.

   - o Analyze the basis upon which the entity has segregated charges if it bills for physicians.

b. Test the entity's method of recording services and supplies furnished to employees, such as value of meals, housing, and laundry; and test the distribution of those items to various departments and the treatment thereof for Social Security, withholding tax, and insurance purposes.

c. Test procedures for recording costs for special nurses and the billing of those costs to patients.

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

   - o Test the compensation value assigned to services contributed by nonpaid persons based on time spent and job description by comparison with compensation paid to workers in similar positions.

   - o Determine that living and support costs for those nonpaid individuals have been considered in arriving at salary equivalents.

- o Test time records and test computations supporting the salary equivalent amount for voluntary services.

e. Test fund-raising costs and the propriety of their classification.

f. Review comparative operational statistics and the relationship of such statistics to expenses.

g. Review and, where necessary, analyze the following expense accounts:

- o Maintenance and Repairs
- o Operations of Plant
- o Professional Fees (other than medical)
- o Administration and General Expense
- o Laboratory Supplies and Expense
- o X-ray Supplies and Expense
- o Pharmacy Supplies and Expense
- o Dietary Supplies and Expense
- o Operating Room Supplies and Expense
- o Medical and Surgical Expense
- o Miscellaneous Expense
- o New or Unusual Expense Accounts

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. Accordingly, pending resolution by the FASB, 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. APB Opinion No. 18, The Equity Method of Accounting for Investments in Common Stock, provides guidance on accounting for investments in 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 the following conditions are met:

a. The health care entity controls the separate organization through contracts or other legal documents that provide the entity with the authority to direct the separate organization's activities, management, and policies;

and

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

   - The organization has solicited funds in the name of the entity and with the expressed or implied approval of the entity, and substantially all the funds solicited by the organization were intended by the contributor, or were otherwise required, to be transferred to the entity or used at its discretion or direction.
   - The 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 entity.
   - The 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 entity.

13.4 If the condition described in subparagraph (a) of paragraph 13.3 and at least one of the conditions described in subparagraph (b) are satisfied, and if the financial statements of the entity and the related organizations are

not consolidated or combined in accordance with ARB No. 51, Consolidated Financial Statements, then the entity's financial statements should disclose information concerning the related organizations. The entity presents summarized information about the assets, liabilities, results of operations, and changes in fund balances of the related organizations in the notes to the health care entity's financial statements. The entity also clearly describes the nature of the relationships between it and the related organizations. (Exhibit 13A illustrates this disclosure.) When a related organization makes its assets available to the entity, the 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 above requirements. If a related organization holds material amounts of funds that have been designated for the benefit of the entity or if there have been material transactions between the entity and the related organization, the entity's financial statements disclose the existence and nature of the relationship between the entity and the related organization. Further, if there have been material transactions between the entity and the related organization during the periods covered by the entity's financial statements, the following information is also disclosed:

a. A description of the transactions (summarized, if appropriate) for the period reported on, including amounts, if any, and any other information deemed necessary to an understanding of the effects on the 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 foregoing disclosures 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) a 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 an entity and the separate organization.

13.7 Exhibit 13C summarizes the requirements of the health care entity under the circumstances noted in paragraph 13.6.

RELATED PARTY TRANSACTIONS

13.8 FASB Statement No. 57, Related Party Disclosures, contains the disclosure requirements for related party relationships and transactions. 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

Audit Objectives

13.9 The significant audit objectives for related party organizations are to obtain reasonable assurance that the following conditions are met:

a. Related party transactions and organizations, whose relationship with the entity may have to be disclosed because of economic dependency, are identified.

b. The auditor is satisfied about both the substance of and the accounting for related party organization transactions.

c. Informative disclosures of the existence of related party organizations are made.

d. The adequacy of disclosures pertaining to related party organizations and transactions is evaluated.

Audit Procedures

13.10 In addition to auditing procedures usually performed in connection with related party organizations, the auditor should consider the following:

a. Determine the existence of related parties:

- Review related party questionnaires that the entity may have obtained from its management and governing body members within the last twelve months.

- Review filings of the entity's Medicare cost report and other regulatory reports for the names of related parties and for other businesses where officers and directors occupy directorship or management positions.

- Review articles of incorporation, bylaws, and minutes for board meetings to determine if the entity controls, or is controlled by, other organizations.

- Review material investment or asset transfer transactions during the period under examination to determine whether the nature and extent of investments during the period have created related parties.

b. Identify transactions with related parties:

- Provide the audit personnel who are performing segments of the examination or are examining and reporting separately on the accounts of related components of the reporting entity with the names of known related parties so that the personnel may become aware of transactions with such parties during their examinations.

- Review the minutes of meetings of the board of directors and the executive or operating committees for information about material transactions authorized or discussed at their meetings.

- Review proxy and other material filed with the SEC as well as comparable data filed with other regulatory agencies for information about material transactions with related parties.

- Review contributions or dividends received from other organizations to determine the existence of related parties and related party transactions.

- Review conflict-of-interest statements obtained by the health care entity from its management.

- Review the extent and nature of business transacted with major customers, suppliers, borrowers, and lenders for indications of previously undisclosed relationships.

- Consider the possibility that transactions are occurring but are not being given accounting recognition (such as receiving or providing accounting, management, or other services at no charge).

- Review accounting records for large, unusual, or nonrecurring transactions or balances, while paying particular attention to transactions recognized at or near the end of the reporting period.

- Review confirmations of compensating balance arrangements for indications that balances are, or were, maintained for or by related parties.

- Review invoices from law firms that have performed regular or special services for the entity for indication of the existence of related parties or related party transactions.

- Review confirmations of loans receivable and payable for indications of guarantees. When guarantees are indicated, determine their nature and the relationships, if any, of the guarantors to the reporting entity.

NOTE: SAMPLE HOSPITAL FOUNDATION

Note: Exhibit 13A illustrates the disclosure by a not-for-profit hospital that is considered to be related to a separate not-for-profit organization because the hospital controls it and is deemed to be its sole beneficiary.

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 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.

EXHIBIT 13A (cont'd)

	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
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

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

† 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

NOTE: RELATED PARTY TRANSACTIONS

Note: Exhibit 13B 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.

Because of the existence of common trustees and other factors, ABC Hospital controls 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:

	19X0	19X1
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 purposes	50,000	150,000

EXHIBIT 13C

Summary of Requirements of the Health Care Entity

Circumstances	Requirements
1. 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.
2. 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 hospital; and disclose the nature of the relationship between the health care entity and the related organization.
3. Neither of the above 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.
4. There have been material transactions between the health care entity and the related organization. (This could be present in any of the above circumstances.)	In the notes to the financial statement, (a) disclose the existence and nature of the relationship and (b) describe and quantify the transactions.

CHAPTER 14

AUDITOR'S REPORTS

14.1 The guidance in SAS No. 2, Reports on Audited Financial Statements, applies to audit reports on the financial statements of a health care entity. Such reports may contain an unqualified opinion, a qualified opinion, a disclaimer of opinion, or an adverse opinion. The facts and circumstances of each particular engagement 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 examining the financial statements of a health care entity.

QUALIFIED OPINION

14.2 As stated in SAS No. 2, a qualified opinion is expressed when a lack of sufficient competent evidential matter or restrictions on the scope of the auditor's examination have led the auditor to conclude that an unqualified opinion cannot be expressed or when the auditor believes, on the basis of the examination, that (a) the financial statements contain a departure from generally accepted accounting principles, the effect of which is material; (b) there has been a material change between periods in accounting principles or in the method of their application; or (c) there are significant uncertainties affecting the financial statements, and the auditor has decided not to express an adverse opinion or to disclaim an opinion.

14.3 Specific situations that may cause the auditor to issue a qualified opinion include these examples:

- An uncertainty relating to medical malpractice (exhibit 14A).
- An uncertainty relating to an appeal for disallowed reimbursement (exhibit 14B).
- An uncertainty concerning Medicare revenue because a PRO questioned the medical necessity of services rendered (exhibit 14C).

ADDITIONAL INFORMATION

14.4 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 outside the basic financial statements in an auditor-submitted document and is not considered necessary for presentation of financial position, results of operations, or changes in financial position 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 entity.

14.5 Additionally, with respect to supplementary and other information, other useful guidance may be found in SAS No. 27, Supplementary Information Required by the Financial Accounting Standards Board; SAS No. 28, Supplementary Information on the Effects of Changing Prices; and SAS No. 8, Other Information in Documents Containing Audited Financial Statements. Also, SAS No. 42, Reporting on Condensed Financial Statements and Selected Financial Data, contains reporting guidance when condensed financial statements or selected financial data are derived from audited financial statements.

14.6 Exhibit 14D illustrates an unqualified opinion on the basic financial statements, exhibit 14E illustrates reporting on additional information, and exhibit 14F illustrates reporting on both the basic financial statements and additional information.

EMPHASIS OF A MATTER

14.7 Certain matters may be of such significance to the financial statements that the auditor may wish to emphasize them in the auditor's report, even though an unqualified opinion will be rendered. In such cases, the explanatory information should be presented in a separate paragraph of the report.

14.8 When explanatory information is presented, phrases such as ". . . with the foregoing explanation . . ." should not be used in the opinion paragraph because they cause the opinion to appear qualified.

SPECIAL REPORTS

14.9 If a health care entity is required to follow reporting provisions of a government regulatory agency, to report under a cash receipts or disbursements basis of accounting, or to report on another basis of accounting other than that of generally accepted accounting principles, the auditor should follow the guidance in SAS No. 14, Special Reports. Additionally, SAS No. 14 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; and financial information presented in prescribed forms. Additional 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

AUDITOR'S REPORT

QUALIFIED OPINION--Subject to an Uncertainty Related to Medical Malpractice

[Date]

To the Board of Trustees
XYZ Health Care Entity

[Scope paragraph--standard wording, separate paragraph]

As more fully described in Note ___, claims in excess of professional liability insurance coverage have been asserted against the 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 has been made in the financial statements.

In our opinion, subject to the effects on the financial statements of such adjustments, if any, as might have been required had the outcome of the uncertainty referred to in the preceding paragraph been known, the financial statements referred to above present fairly . . .

EXHIBIT 14B

AUDITOR'S REPORT

QUALIFIED OPINION--Subject to Final Determination
Related to Appeal for Disallowed Reimbursement

[Date]

To the Board of Trustees
XYZ Health Care Entity

[Scope paragraph--standard wording, separate paragraph]

As more fully described in Note ___ to the financial statements, the Health Care Entity has recorded revenues of $XXX for the year ended December 31, 19X4, related to reimbursement of certain expenses by Blue Cross and Medicaid. During the year ended December 31, 19X5, the allowability of those expenses has been contested by Blue Cross and Medicaid. The Health Care Entity is pursuing administrative and legal remedies related to the issues involved. Because the outcome of this matter is uncertain, no provision for possible refund of the aforementioned revenue has been recorded in the financial statements for the year ended December 31, 19X5.

In our opinion, subject to the effects on the financial statements of such adjustments, if any, as might have been required had the outcome of the uncertainty referred to in the preceding paragraph been known, the financial statements referred to above present fairly . . .

EXHIBIT 14C

AUDITOR'S REPORT

QUALIFIED OPINION--Settlement of Medicare Claims

[Date]

To the Board of Trustees
XYZ Health Care Entity

[Scope paragraph--standard wording, separate paragraph]

As more fully described in Note ___ to the financial statements, during 19XX, the Peer Review Organization questioned, as medically necessary, certain claims aggregating $XXX, which amount has been recorded as revenue by the Health Care Entity for services rendered to Medicare patients. Resolution of this matter is dependent upon final determination of medical necessity by the Medicare intermediary.

In our opinion, subject to the effects on the financial statements of such adjustments, if any, as might have been required had the outcome of the uncertainty referred to in the preceding paragraph been known, the financial statements referred to above present fairly . . .

EXHIBIT 14D

AUDITOR'S REPORT

UNQUALIFIED OPINION--Comparative Financial Statements

[Date]

To the Board of Trustees
XYZ Health Care Entity

We have examined the balance sheets of XYZ Health Care Entity as of September 30, 19X5 and 19X4, and the related statements of revenues and expenses of general funds, changes in fund balances and changes in financial position of general funds for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the financial statements referred to above present fairly the financial position of XYZ Health Care Entity at September 30, 19X5 and 19X4, and the results of its operations, changes in fund balance, and changes in financial position of its general funds for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

EXHIBIT 14E

AUDITOR'S REPORT

Additional Information in an Auditor-Submitted Document

[Date]

To the Board of Trustees
XYZ Health Care Entity

Our examination was made for the purpose of forming an opinion on the basic financial statements taken as a whole. The [identify the accompanying information] is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information has been subjected to the auditing procedures applied in the examination of the basic financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole.

EXHIBIT 14F

AUDITOR'S REPORT

UNQUALIFIED OPINION--Comparative Financial Statements and Additional Information*

[Date]

To the Board of Trustees
XYZ Health Care Entity

We have examined the balance sheets of XYZ Health Care Entity as of September 30, 19X5 and 19X4, and the related statements of revenues and expenses of general funds, changes in fund balances, and changes in financial position of general funds for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the financial statements referred to above present fairly the financial position of XYZ Health Care Entity at September 30, 19X5 and 19X4, and the results of its operations, changes in fund balance, and changes in financial position of its general funds for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Our examinations were made for the purpose of forming an opinion on the basic financial statements taken as a whole. The accompanying schedules and related information on pages ___ and ___ are presented for purposes of additional analysis and are not a required part of the basic financial statements. Such information has been subjected to the auditing procedures applied in the examinations of the basic financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole.

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* The AICPA Task Force on Not-for-Profit Organizations is considering the implications of SFAC No. 6 on financial statement presentation of not-for-profit organizations. The conclusions of the task force deliberations are expected to be incorporated into the published guide.

SAMPLE HOSPITAL

Balance Sheets*

December 31, 19X7 and 19X6

Assets	19X7	19X6
	GENERAL FUNDS	
Current assets:		
Cash and short-term investments, at cost which approximates market	$ 1,703,000	$ 3,875,000
Assets whose use is limited and are required for current liabilities (notes 4, 6, and 7)	970,000	1,300,000
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
Estimated third-party payor settlements--Medicare (note 2)	441,000	600,000
Inventory of supplies at lower of cost (first-in, first-out) or market	1,163,000	938,000
Other current assets (note 3)	406,000	438,000
Due from donor-restricted funds, net	-	500,000
Total current assets	19,783,000	21,845,000
Assets whose use is limited (notes 4, 6, and 7):		
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
Under malpractice funding arrangement--held by trustee	3,007,000	2,682,000
Under indenture agreement--held by trustee	11,708,000	11,008,000
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
Noncurrent assets whose use is limited	33,979,000	28,541,000
Property and equipment, net (notes 5 and 6)	51,038,000	50,492,000
Other assets:		
Deferred financing costs	693,000	759,000
Investment in affiliated company (note 3)	917,000	576,000
Total other assets	1,610,000	1,335,000
	$106,410,000	$102,213,000

Liabilities and Fund Balances	19X7	19X6
Current liabilities:		
Current installments of long-term debt (note 6)	$ 1,470,000	$ 1,750,000
Accounts payable	2,217,000	2,085,000
Accrued expenses	3,396,000	3,225,000
Retainage and construction accounts payable	955,000	772,000
Estimated third-party payor settlements--Medicaid (note 2)	2,143,000	1,942,000
Deferred third-party reimbursement	200,000	210,000
Advances from third-party payors	122,000	632,000
Due to donor-restricted funds, net	300,000	-
Total current liabilities	10,803,000	10,616,000
Deferred third-party reimbursement	746,000	984,000
Estimated malpractice costs (note 7)	3,807,000	2,682,000
Long-term debt, excluding current installments (note 6)	23,144,000	24,014,000
Fund balance	67,910,000	63,917,000
Commitments and contingent liabilities (notes 2, 5, 7, 11, 12, and 13)		
	$106,410,000	$102,213,000

See accompanying notes to financial statements.

*See note on page 85.

(Continued)

SAMPLE HOSPITAL

Balance Sheets* (Continued)

Assets	19X7	19X6	Liabilities and Fund Balances	19X7	19X6
			DONOR-RESTRICTED FUNDS		
Specific-purpose funds:			Specific-purpose funds:		
Cash	$ 48,000	$ 75,000	Accounts payable	$ 205,000	$ 63,000
Investments, at cost which approximates market	728,000	455,000	Deferred grant revenue	50,000	-
Grants receivable	100,000	67,000	Due to general funds	-	255,000
			Fund balance	621,000	279,000
	$ 876,000	597,000		$ 876,000	$ 597,000
Plant replacement and expansion funds:			Plant replacement and expansion funds:		
Cash	$ 24,000	$ 321,000	Due to general funds	$ -	$ 345,000
Investments, at cost which approximates market	252,000	165,000	Fund balance	558,000	521,000
Pledges receivable, net of estimated uncollectibles of $60,000 in 19X7 and $120,000 in 19X6	132,000	380,000			
Due from general funds	150,000	-			
	$ 558,000	$ 866,000		$ 558,000	$ 866,000
Endowment funds:			Endowment funds:		
Cash	$1,253,000	$1,303,000	Fund balance	$6,659,000	$6,723,000
Investments, net of $175,000 valuation allowance in 19X7, market value $5,198,000 in 19X7 and $5,013,000 in 19X6 (note 8)	5,256,000	5,320,000			
Due from general funds	150,000	100,000			
	$6,659,000	$6,723,000		$6,659,000	$6,723,000
Student loan funds:			Student loan funds:		
Cash	$ 330,000	$ 303,000	Accounts payable	$ -	$ 9,000
Loans receivable, net of estimated uncollectibles of $90,000 in 19X7 and 19X6	513,000	468,000	Advance from U.S. Government	42,000	-
			Fund balance	801,000	762,000
	$ 843,000	$ 771,000		$ 843,000	$ 771,000

See accompanying notes to financial statements.

*See note on page 85.

SAMPLE HOSPITAL

Statements of Revenues and Expenses of General Funds*

Years Ended December 31, 19X7 and 19X6

	19X7	19X6
Net patient service revenue (note 2)	$91,646,000	$87,839,000
Other operating revenue	5,680,000	4,994,000
Total operating revenues	97,326,000	92,833,000
Operating expenses (notes 6, 7, 11, and 12):		
Wages, salaries, and benefits	65,891,000	60,091,000
Supplies and other	15,112,000	13,573,000
Purchased services	8,383,000	8,218,000
Medical malpractice costs	1,125,000	200,000
Depreciation and amortization	4,782,000	4,280,000
Interest expense	1,422,000	1,439,000
Total operating expenses	96,715,000	87,801,000
Income from operations	611,000	5,032,000
Nonoperating revenue (expense):		
Unrestricted gifts and bequests (note 10)	1,122,000	1,136,000
Loss on investment in affiliated company (note 3)	(53,000)	-
Income on investments:		
Whose use is limited by board for capital improvements	1,120,000	1,050,000
Whose use is limited under indenture agreement	100,000	90,000
Whose use is limited by agreements with third-party payors for funded depreciation	850,000	675,000
Nonoperating revenue, net	3,139,000	2,951,000
Excess of revenues over expenses	$ 3,750,000	$ 7,983,000

See accompanying notes to financial statements.

*See note on page 85.

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	Student Loan Funds	General Funds	Specific-Purpose Funds	Plant Replacement and Expansion Funds	Endowment Funds	Student Loan Funds
Balances at beginning of year	$63,917,000	$ 279,000	$521,000	$6,723,000	$762,000	$56,679,000	$221,000	$501,000	$5,973,000	$712,000
Additions:										
Excess of revenues over expenses	3,750,000	-	-	-	-	7,983,000	-	-	-	-
Gifts, grants, and bequests (notes 9 and 10)	-	842,000	220,000	-	27,000	-	518,000	290,000	-	40,000
Investment income	-	50,000	20,000	750,000	12,000	-	40,000	15,000	650,000	10,000
Gain on sale of investments	-	-	100,000	20,000	-	-	-	20,000	100,000	-
Transfer to finance property and equipment additions	243,000	-	(243,000)	-	-	255,000	-	(255,000)	-	-
	3,993,000	892,000	97,000	770,000	39,000	8,238,000	558,000	70,000	750,000	50,000
Deductions:										
Provision for uncollectible pledges	-	-	(60,000)	-	-	-	-	(50,000)	-	-
Transfer to Sample Health Systems (note 10)	-	-	-	-	-	(1,000,000)	-	-	-	-
Realized loss on sale of investments	-	-	-	(659,000)	-	-	-	-	-	-
Unrealized loss on marketable equity securities (note 8)	-	-	-	(175,000)	-	-	-	-	-	-
Transfer to other operating revenue	-	(550,000)	-	-	-	-	(500,000)	-	-	-
	-	(550,000)	(60,000)	(834,000)	-	(1,000,000)	(500,000)	(50,000)	-	-
Balances at end of year	$67,910,000	$ 621,000	$558,000	$6,659,000	$801,000	$63,917,000	$279,000	$521,000	$6,723,000	$762,000

See accompanying notes to financial statements.

*See note on page 85.

SAMPLE HOSPITAL

Statements of Changes in Financial Position of General Funds*

Years Ended December 31, 19X7 and 19X6

	19X7	19X6
Net cash flow from operating activities and nonoperating revenue:		
Income from operations	$ 611,000	$5,032,000
Noncash expenses and revenues included in income:		
Depreciation and amortization	4,782,000	4,280,000
Deferred third-party reimbursement	(238,000)	(281,000)
Amortization of deferred financing costs	66,000	45,000
Increase in estimated malpractice costs	1,125,000	200,000
Net increase in receivables, inventory, and payables	(956,000)	(1,651,000)
Net cash flow from operating activities	5,390,000	7,625,000
Nonoperating revenue, net	3,139,000	2,951,000
Noncash expense included in nonoperating revenue:		
Loss on investment in affiliated company	53,000	-
Net cash flow from operating activities and nonoperating revenue	8,582,000	10,576,000
Cash flows from investing activities:		
Acquisition of property and equipment	(5,328,000)	(5,012,000)
Less:		
Capital lease obligations incurred	600,000	-
Increase in retainage and construction accounts payable	183,000	175,000
Property and equipment financed by donor-restricted assets	243,000	255,000
Cash outflows for property and equipment	(4,302,000)	(4,582,000)
Increase in investment in affiliated company	(394,000)	(425,000)
Increase in assets whose use is limited	(5,108,000)	(1,030,000)
Increase (decrease) in due-to-donor-restricted funds	800,000	(193,000)
Net cash used by investing activities	(9,004,000)	(6,230,000)

(Continued)

SAMPLE HOSPITAL

Statements of Changes in Financial Position of General Funds* (Continued)

Years Ended December 31, 19X7 and 19X6

	19X7	19X6
Cash flows from financing activities:		
Repayment of long-term debt	(1,750,000)	(2,230,000)
Transfer to Sample Health Systems	-	(1,000,000)
Net cash used by financing activities	(1,750,000)	(3,230,000)
Net increase (decrease) in cash	(2,172,000)	1,116,000
Beginning cash and short-term investments	3,875,000	2,759,000
Ending cash and short-term investments	$1,703,000	$3,875,000

See accompanying notes to financial statements.

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* In November 1987, the Financial Accounting Standards Board issued Statement of Financial Accounting Standards (SFAS) No. 95, Statement of Cash Flows, which establishes standards for cash flow reporting. The statement is effective for annual financial statements for fiscal years ending after July 15, 1988. The statement excludes not-for-profit organizations from the scope only because the FASB has not decided whether not-for-profit organizations should be required to provide a statement of cash flows. The FASB has completed work on concepts of financial reporting for not-for-profit organizations and is currently considering certain standards issues. The FASB staff is currently working with an AICPA task force that is developing a paper on financial statement display for not-for-profit organizations. This paper will consider, among other things, whether not-for-profit organizations should report cash receipts and payments and, if so, how. Upon consideration of that paper, the FASB will decide whether to add to its agenda a project on financial statement display for not-for-profit organizations.

Accordingly, proprietary providers of health care services should comply with the provisions of SFAS No. 95. Upon consideration of the paper prepared by the FASB staff and the AICPA task force and consideration by the FASB to add to its agenda the project on financial statement display for not-for-profit organizations, the Health Care Committee will decide whether to provide guidance for display of cash flow statements by not-for-profit providers of health care services in this guide.

The Statements of Changes in Financial Position of General Funds presented herein are not intended to present the statement of cash flows in accordance with SFAS No. 95.

SAMPLE HOSPITAL

Notes to Financial Statements

December 31, 19X7 and 19X6

(1) Summary of Significant Accounting Policies

(a) Organization

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

(b) Donor-Restricted Funds

Donor-restricted funds are used to differentiate funds, the use of which are specified by donors, from general funds upon which donors place no restriction or that arise as a result of the operation of the Hospital for its stated purposes. Assets whose use is limited are not considered to be restricted funds. Restricted gifts and other restricted resources are recorded as direct additions to the appropriate restricted fund.

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

Funds restricted by donors for specific operating purposes are reported in other operating revenue to the extent used within the period.

(c) 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.

(d) Patient Service Revenue

Patient service revenue is recorded at the Hospital's established rates with contractual adjustments, charity allowances and policy discounts, and the provision for uncollectible accounts deducted to arrive at net patient service revenue.

Retroactively calculated contractual adjustments arising under reimbursement agreements with third-party payors are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

SAMPLE HOSPITAL

Notes to Financial Statements

(e) Investments and Investment Income

Donated investments are recorded 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.

Investment income on borrowed funds held by a trustee, to the extent not capitalized, is netted against interest expense. Investment income on the malpractice trust fund is reported as other operating revenue. Investment income from all other general fund investments is reported as nonoperating revenue. Investment income and gains (losses) on investments of donor-restricted funds are added to (deducted from) the appropriate restricted fund balance.

(f) Pledges

Pledges, less an allowance for uncollectible amounts, are recorded as receivables in the year made. Unrestricted pledges are recorded as nonoperating revenue; restricted pledges are recorded as additions to the appropriate donor-restricted fund balance.

(g) Property and Equipment

Property and equipment are recorded at cost, or if donated, at fair value at the date of receipt.

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.

(h) 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.

SAMPLE HOSPITAL

Notes to Financial Statements

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.

(i) 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.

(j) Transfers to Affiliates

Transfers to affiliated corporations are recorded as deductions to the appropriate fund balance.

(2) Net Patient Service Revenue

The Hospital has agreements with third-party payors that provide for reimbursement to the Hospital at amounts different from its established rates. Contractual adjustments under third-party reimbursement programs represent the difference between the Hospital's established rates for services and amounts reimbursed by third-party payors. A summary of the basis of reimbursement 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, outpatient services, and defined capital and medical education costs related to Medicare beneficiaries are paid based upon a cost reimbursement method. 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 by the Medicare fiscal intermediary.

- Medicaid. Inpatient and outpatient services rendered to Medicaid program beneficiaries are reimbursed based upon 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 by the Medicaid fiscal intermediary.

- Blue Cross. Inpatient services rendered to Blue Cross subscribers are reimbursed at an all-inclusive per diem rate. The prospectively determined per diem rates are not subject to retroactive adjustment.

SAMPLE HOSPITAL

Notes to Financial Statements

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

A summary of gross and net patient service revenue for the years ended December 31, 19X7 and 19X6, follows:

	19X7	19X6
Gross patient service revenue	$110,492,000	$103,832,000
Less provisions for:		
Contractual adjustments under third-party reimbursement programs	13,285,000	11,860,000
Uncollectible accounts, charity allowances, and policy discounts	5,561,000	4,133,000
	18,846,000	15,993,000
Net patient service revenue	$ 91,646,000	$ 87,839,000

(3) Investment in Affiliated Company

In 19X2, the Hospital entered into an agreement with two unrelated hospitals to develop an ambulatory care center. In accordance with this agreement, each hospital invested $970,000, which represents a 33 1/3% 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. The Hospital has recorded its share of the center's net loss for the period ended December 19X7 of $53,000 as a nonoperating expense with a related reduction in the carrying value of its investment.

During 19X7, the Hospital loaned $160,000 to the center to be used for operations. The noninterest-bearing note is due on demand after December 9, 19X8, and is included with other current assets at December 31, 19X7.

SAMPLE HOSPITAL

Notes to Financial Statements

(4) 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 below. Investments are stated at cost which 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	269,000	269,000
Securities	47,000	47,000
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

SAMPLE HOSPITAL

Notes to Financial Statements

(5) 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	222,000	472,000
Buildings and improvements	46,852,000	46,636,000
Equipment	29,540,000	26,260,000
Equipment under capital leases	2,751,000	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 remodeling of Hospital facilities. At December 31, 19X7, the remaining commitment on these contracts approximated $4,625,000.

(6) Long-Term Debt and Capital Leases

A summary of long-term debt inclusive of capital lease obligations 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

SAMPLE HOSPITAL

Notes to Financial Statements

(6) Continued

	19X7	19X6
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
Total long-term debt	24,614,000	25,764,000
Less current installments of long-term debt	1,470,000	1,750,000
Long-term debt, excluding current installments	$23,144,000	$24,014,000

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. At December 31, 19X7, the Hospital was in compliance with the requirements of the Revenue Note Indenture.

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
19X0	983,000	260,000
19X1	1,060,000	95,000
19X2	1,143,000	-
	$5,068,000	1,115,000
Less amount representing interest on obligations under capital leases		115,000
		$1,000,000

SAMPLE HOSPITAL

Notes to Financial Statements

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:

	Total	Capitalized	Charged to Operations
19X7:			
Interest cost	$2,492,000	$740,000	$1,752,000
Investment income	835,000	505,000	330,000
	$1,657,000	$235,000	$1,422,000
19X6:			
Interest cost	$2,565,000	$740,000	$1,825,000
Investment income	1,049,000	663,000	386,000
	$1,516,000	$ 77,000	$1,439,000

(7) Estimated Malpractice Costs

The Hospital is self-insured for the purpose of providing professional and patient care liability insurance. Professional insurance consultants have been retained to determine funding requirements. The amounts funded have been placed in a self-insurance trust account that is being administered by a trustee. The self-insurance trust account is reported in assets whose use is limited in the balance sheets.

The Hospital is involved in litigation arising in the ordinary course of business. Claims alleging malpractice have been asserted against the Hospital and are currently in various stages of litigation. Claims have been filed requesting damages in excess of the amount accrued for estimated malpractice costs. It is the opinion of management, however, that estimated malpractice costs accrued at December 31, 19X7, are adequate to provide for potential losses resulting from pending or threatened litigation. Additional claims may be asserted against the Hospital arising from services provided to patients through December 31, 19X7. The Hospital is unable to determine the ultimate cost of the resolution of such potential claims and, accordingly, no accrual has been made for them.

The charge to operating expenses for medical malpractice costs for 19X7 and 19X6 was $1,125,000 and $200,000, respectively.

SAMPLE HOSPITAL

Notes to Financial Statements

(8) 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 the 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 the endowment funds amounted to $10,000 in 19X7 and $50,000 in 19X6.

(9) Funds Held in Trust by Others

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. At 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.

(10) 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:

SAMPLE HOSPITAL

Notes to Financial Statements

(10) Continued

	19X7	19X6
Unrestricted gifts and bequests	$375,000	$525,000
Restricted contributions for:		
Specific purposes	500,000	200,000
Plant replacement and expansion	70,000	85,000

In addition, the Hospital transferred $1,000,000 to Sample Health Systems during 19X6.

(11) Pension Plan

The Hospital has a defined benefit pension plan covering substantially all its employees. The 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 net periodic pension cost for 19X7 and 19X6 includes the following components:

	19X7	19X6
Service cost benefits earned during the period	$905,000	$770,000
Interest cost on projected benefit obligation	700,000	650,000
Actual return on assets	(950,000)	(800,000)
Net amortization and deferral	70,000	80,000
Net periodic pension costs	$725,000	$700,000

Assumptions used in the accounting for net periodic pension costs were:

	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

SAMPLE HOSPITAL

Notes to Financial Statements

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 obligations	$ 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
Funded status--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 costs	50,000	55,000
Unrecognized net asset at January 1, 19X6, being recognized over 15 years	(65,000)	(70,000)
Prepaid pension costs included in other current assets	$ 85,000	$ 35,000

SAMPLE HOSPITAL

Notes to Financial Statements

(12) 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
19X0	459,000
19X1	375,000
19X2	343,000
Total minimum lease payments	$2,200,000

Total rental expense in 19X7 and 19X6 for all operating leases was approximately $849,000 and $770,000, respectively.

(13) 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 adjacent to the Hospital facility.

SAMPLE CARE NURSING HOME, INC.
Balance Sheets*
December 31, 19X5 and 19X4

Assets	19X5	19X4
Current assets:		
Cash	$ 56,000	$ 57,000
Investments, at cost which approximates market	150,000	-
Assets whose use is limited and are required for current liabilities	50,000	50,000
Patient accounts receivable less allowance for doubtful accounts: 19X5--$6,700; 19X4--$5,300	162,000	152,000
Estimated third-party payor settlements	71,000	62,000
Interest receivable	7,000	-
Supplies	59,000	57,000
Prepaid expenses	3,000	2,000
Total current assets	558,000	380,000
Assets whose use is limited:		
Under indenture agreement--held by trustee	176,000	153,000
By board for capital improvements	47,000	47,000
Total assets whose use is limited	223,000	200,000
Less assets whose use is limited and that are required for current liabilities	50,000	50,000
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
Major movable equipment	129,000	97,000
Furniture and fixtures	88,000	81,000
Automotive equipment	11,000	11,000
	1,869,000	1,825,000
Less accumulated depreciation	210,000	141,000
	1,659,000	1,684,000
Other assets:		
Note receivable	81,000	72,000
Unamortized bond issuance cost	42,000	48,000
Other	19,000	-
Donor restricted investments	8,000	7,000
	150,000	127,000
Total assets	$2,540,000	$2,341,000

Liabilities and Fund Balance	19X5	19X4
Current liabilities:		
Current maturities of long-term debt	$ 50,000	$ 50,000
Accounts payable	78,000	52,000
Accrued expenses	225,000	233,000
Total current liabilities	353,000	335,000
Long-term debt, less current maturities	1,700,000	1,750,000
Fund balance:		
General	479,000	249,000
Donor-restricted	8,000	7,000
Total fund balance	487,000	256,000
Total liabilities and fund balance	$2,540,000	$2,341,000

See accompanying notes to financial statements.

*See note on page 85.

SAMPLE CARE NURSING HOME, INC.

Statements of Revenues and Expenses of General Funds*

Years Ended December 31, 19X5 and 19X4

	19X5	19X4
Patient service revenue (net of provision for uncollectible accounts of $92,000 in 19X5 and $83,000 in 19X4)	$2,071,000	$1,866,000
Other operating revenue	67,000	22,000
Total operating revenues	2,138,000	1,888,000
Operating 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
Depreciation	69,000	57,000
Total operating expenses	1,929,000	1,823,000
Income from operations	209,000	65,000
Nonoperating revenue	17,000	6,000
Excess of revenues over expenses	$ 226,000	$ 71,000

See accompanying notes to financial statements.

*See note on page 85.

SAMPLE CARE NURSING HOME, INC.

Statements of Changes in Fund Balances*

Years Ended December 31, 19X5 and 19X4

	19X5	19X4
General Funds		
Fund balance at beginning of year	$249,000	$172,000
Excess of revenues over expenses	226,000	71,000
Donations of equipment	4,000	6,000
Fund balance at end of year	$479,000	$249,000
Donor-Restricted Funds		
Fund balance at beginning of year	$ 7,000	$ 6,000
Donor-restricted gifts	1,000	1,000
Fund balance at end of year	$ 8,000	$ 7,000

See accompanying notes to financial statements.

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*See note on page 85.

SAMPLE CARE NURSING HOME, INC.

Statements of Changes in Financial Position of General Funds*

Years Ended December 31, 19X5 and 19X4

	19X5	19X4
Sources of funds:		
Income from operations	$209,000	$ 65,000
Add items included in operations not affecting cash:		
Depreciation	69,000	57,000
Amortization	6,000	6,000
Loss on disposal of property	-	11,000
(Increase) decrease in:		
Patient accounts receivable	(10,000)	(17,000)
Estimated third-party payor settlements	(9,000)	2,000
Interest receivable	(7,000)	-
Supplies	(2,000)	(4,000)
Prepaid expenses	(1,000)	1,000
Assets whose use is limited	-	(4,000)
Increase (decrease) in:		
Accounts payable	26,000	12,000
Accrued expenses	(8,000)	10,000
Total funds provided from operations	273,000	139,000
Nonoperating revenue	17,000	6,000
Donations of equipment	4,000	6,000
Proceeds from sale of property	-	2,000
Total sources of funds	294,000	153,000
Uses of funds:		
Additions to property and equipment	44,000	79,000
Increase in note receivable	9,000	-
Investments	150,000	-
Increase in assets whose use is limited	23,000	-
Addition of other asset	19,000	-
Reduction of long-term debt	50,000	50,000
Total uses of funds	295,000	129,000
Increase (decrease) in cash	(1,000)	24,000
Beginning cash balance	57,000	33,000
Ending cash balance	$ 56,000	$ 57,000

See accompanying notes to financial statements.

*See notes on pages 85 and 92.

SAMPLE CARE NURSING HOME, INC.
Notes to Financial Statements
December 31, 19X5 and 19X4

(1) Organization and Summary of Significant Accounting Policies

(a) Organization

Sample Care Nursing Home (Home) is a not-for-profit corporation that operates a nursing home consisting of 50 skilled and 130 intermediate care beds.

(b) General and Donor-Restricted Net Assets

Donor-restricted fund balance represents net assets whose use is restricted by a donor or grantor. General fund balance represents net assets on which the donor or grantor places no external restrictions or that arise as a result of the operations of the Home for its stated purposes.

Assets restricted by donors or grantors for specific operating purposes are reflected in other operating revenue to the extent used within the period.

(c) 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.

(d) Patient Service Revenue

Patient service revenue is recorded at established billing rates or at the amount realizable under agreements with third-party payors with the provision for uncollectible accounts deducted to arrive at net patient service revenue.

Revenues under third-party payor agreements are subject to examination and retroactive adjustment. Provisions for estimated third-party payor settlements are provided in the period the related services are rendered. Differences between the amounts accrued and subsequent settlements are recorded in operations in the year of settlement.

(e) Nonoperating Revenue

Unrestricted gifts, bequests and investment income are included as nonoperating revenue.

(f) Investments

Contributed investments are recorded at fair value at date of donation, which is then treated as cost. Marketable equity securities are stated at the lower of aggregate cost or market at the balance sheet date. Other marketable securities are stated at amortized cost, adjusted for other than temporary impairments in value.

SAMPLE CARE NURSING HOME, INC.
Notes to Financial Statements

(g) Property and Equipment

Property and equipment are recorded at cost or, if donated, at fair value at the date of donation. Depreciation is calculated on the straight-line method over the estimated useful lives of depreciable assets.

(h) Unamortized Bond Issuance Costs

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

(i) Income Taxes

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

(2) Assets Whose Use Is Limited

Assets held by the trustee for the Series 19X1 notes at December 31, 19X5 and 19X4 are summarized below:

	19X5	19X4
U.S. Treasury obligations, at cost which approximates market	$150,000	$130,000
Cash	23,000	21,000
Accrued interest income	3,000	2,000
	176,000	153,000
Less current portion	50,000	50,000
	$126,000	$103,000

Assets set aside by the Board of Directors for capital improvements consist of certificates of deposit, at cost which approximates market.

(3) Long-Term Debt

Long-term debt at December 31, 19X5 and 19X4, consisted of the following:

	19X5	19X4
9.5 percent notes payable to the City of Abacus, Indiana, maturing $50,000 annually through November 1, 19XX, with a final maturity of $1,000,000 on November 1, 19XX	$1,750,000	$1,800,000
Less current maturities	50,000	50,000
	$1,700,000	$1,750,000

SAMPLE CARE NURSING HOME, INC.

Notes to Financial Statements

The notes are collateralized by a first-mortgage lien on all property and equipment of the Home and a security interest in all receipts of the Home, except gifts, grants, bequests, donations, contributions, and any investment income thereon. The note indenture requires the maintenance of certain deposits with a trustee, which are included in assets whose use is limited.

The following is a schedule of maturities of long-term debt as of December 31, 19X5, for the next five years:

19X6	$ 50,000
19X7	50,000
19X8	50,000
19X9	50,000
19X0	50,000

(4) Pension Plan

The disclosures contained in this note would be similar to the disclosures contained in note 11 on pages 100 and 101 and, therefore, are not repeated here.

SAMPLE CONTINUING CARE RETIREMENT COMMUNITY (CCRC)

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	1,754,000
By Board for capital improvements--investments	100,000	64,000
	2,230,000	1,818,000
Property and equipment:		
Land	557,000	557,000
Land improvements	205,000	203,000
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)
Total 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

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
Fund balance (deficit)	(952,000)	(1,489,000)
Total liabilities and fund balance (deficit)	$17,823,000	$17,744,000

See accompanying notes to financial statements.

*See note on page 85.

SAMPLE CONTINUING CARE RETIREMENT COMMUNITY

Statements of Revenues and Expenses and Changes In Fund Balance (Deficit)*

Years Ended December 31, 19X5 and 19X4

	19X5	19X4
Revenues:		
Resident service revenue, including amortization of 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	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
Provision for uncollectible accounts	2,000	3,000
	3,963,000	3,708,000
	309,000	(210,000)
Gain (loss) on obligation to provide future services	12,000	(82,000)
Income (loss) from operations	321,000	(292,000)
Nonoperating revenues--contributions	216,000	151,000
Excess (deficiency) 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)

See accompanying notes to financial statements.

*See note on page 85.

SAMPLE CONTINUING CARE RETIREMENT COMMUNITY

Statements of Changes in Financial Position*

Years Ended December 31, 19X5 and 19X4

	19X5	19X4
Net cash flow from operating activities and nonoperating revenues:		
Income (loss) from operations	$321,000	$(292,000)
Noncash expenses, revenues, losses and gains included in operations:		
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
Net (increase) decrease in receivables, supplies, and payables	(45,000)	66,000
Net cash used for operations	(212,000)	(578,000)
Nonoperating revenues	216,000	151,000
Net cash flow from (used by) operating activities and nonoperating revenues	4,000	(427,000)
Cash flows from investing activities:		
Acquisition of property and equipment	(65,000)	(250,000)
Net (increase) decrease in assets whose use is limited	(412,000)	229,000
Net cash used by investing activities	(477,000)	(21,000)
Cash flows from financing activities:		
Net proceeds from advance fees and deposits	569,000	805,000
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
Increase in cash	45,000	50,000
Beginning cash balance	330,000	280,000
Ending cash balance	$375,000	$330,000

See accompanying notes to financial statements.

*See notes on pages 85 and 92.

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 78-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 which is refundable to the resident, are recorded as deferred revenue and are amortized into income using the straight-line method over the estimated remaining life expectancy of the resident.

Obligations to Provide Future Services. Annually, CCRC calculates the present value of the net cost of future services to be provided to current residents and compares that amount to the balance of deferred revenues from advance fees. If the present value of the net cost of future services exceeds the deferred revenues from advance fees, a liability is recorded (obligation to provide future services) 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 date of receipt, which then is treated as cost. Depreciation is computed on the straight-line method based on the following estimated useful lives:

Land improvements	20 years
Buildings	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.

SAMPLE CONTINUING CARE RETIREMENT COMMUNITY

Notes to Financial Statements

(3) Deferred Financing Costs

Deferred financing costs are being amortized using the straight-line method over the term of the related financing agreement.

(4) Tax Status

CCRC 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 3/4% 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

During 19X3, CCRC obtained the mortgage note financing which is repayable in consecutive monthly installments of principal and interest of $85,425 to May 20XX. The note contains a provision whereby the mortgagee may call the loan on its fifteenth anniversary. 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 revenues.

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. Commencing June 1, 19X4, CCRC is 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.

SAMPLE CONTINUING CARE RETIREMENT COMMUNITY

Notes to Financial Statements

The unsecured notes payable to bank requires monthly installments of $1,042, including interest, with various maturities through January 19X9.

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

SAMPLE HOME HEALTH AGENCY

Balance Sheets*

December 31, 19X5 and 19X4

Assets	19X5	19X4
Current assets:		
Cash	$ 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 certificate of deposit	100,000	100,000
	135,000	135,000
Equipment:		
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
Deferred finance charges	20,000	25,000
	$1,181,000	$853,000

Liabilities and Fund Balance	19X5	19X4
Current liabilities:		
Current maturities of long-term debt	$ 13,000	$ 13,000
Accounts payable	40,000	21,000
Accrued payroll and vacation	470,000	344,000
Accrued payroll taxes	26,000	8,000
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
Long-term debt, less current maturities (note 4)	105,000	118,000
Fund balance	429,000	252,000
	$1,181,000	$853,000

See accompanying notes to financial statements.

*See note on page 85.

SAMPLE HOME HEALTH AGENCY

Statements of Revenue and Expenses*

Years Ended December 31, 19X5 and 19X4

	19X5	19X4
Client service revenue:		
Home visits	$4,194,000	$2,806,000
Other	27,000	32,000
Less:		
Provision for uncollectible accounts	(98,000)	(50,000)
Contractual adjustments	(100,000)	(90,000)
Net client service revenue	4,023,000	2,698,000
Operating expenses:		
Professional care of clients	2,714,000	1,835,000
General and administrative	1,042,000	675,000
Dietary	57,000	52,000
Household and plant operation	33,000	31,000
Depreciation	21,000	15,000
Interest	16,000	19,000
Total operating expenses	3,883,000	2,627,000
Income from operations	140,000	71,000
Nonoperating revenue:		
Contributions	19,000	15,000
Investment income	18,000	12,000
Total nonoperating revenue	37,000	27,000
Excess of revenue over expenses	$ 177,000	$ 98,000

See accompanying notes to financial statements.

*See note on page 85.

SAMPLE HOME HEALTH AGENCY

Statement of Changes in Fund Balance*

Years Ended December 31, 19X5 and 19X4

	19X5	19X4
Balance at beginning of year	$252,000	$154,000
Excess of revenue over expenses	177,000	98,000
Balance at end of year	$429,000	$252,000

See accompanying notes to financial statements.

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*See note on page 85.

SAMPLE HOME HEALTH AGENCY

Statement of Changes in Financial Position*

Years Ended December 31, 19X5 and 19X4

	19X5	19X4
Sources of funds:		
Income from operations	$140,000	$71,000
Items in operations not affecting cash:		
Depreciation	21,000	15,000
Amortization of deferred finance charges	5,000	5,000
Net increase in receivables and payables	(117,000)	(71,000)
Funds provided from operations	49,000	20,000
Nonoperating revenue	37,000	27,000
Total sources of funds	86,000	47,000
Uses of funds:		
Purchase of equipment	30,000	19,000
Payment of long-term debt	13,000	-
Investments	10,000	15,000
Total uses of funds	53,000	34,000
Net increase in cash	33,000	13,000
Beginning cash balance	41,000	28,000
Ending cash balance	$ 74,000	$41,000

See accompanying notes to financial statements.

*See notes on pages 85 and 92.

SAMPLE HOME HEALTH AGENCY

Notes to Financial Statements

December 31, 19X5 and 19X4

(1) Summary of Significant Accounting Policies

(a) Assets Whose Use Is Limited. Assets set aside for board-designated purposes are classified as assets whose use is limited.

(b) Investments. Investments represent U.S. Treasury obligations at cost, which approximates market value.

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

(d) Deductions From Revenue. Client service revenue is recorded at established rates with contractual adjustments under third-party reimbursement agreements and the provision for uncollectible accounts deducted to arrive at net client service revenue.

(e) 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.

(2) Third-Party Rate Adjustments and Revenue

Approximately 38% in 19X5 and 37% in 19X4 of client service revenues were 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

Before January 1, 19X4, the board of directors decided that assets of $135,000 be designated for future major capital improvements. Those assets are classified in the balance sheets as assets whose use is limited.

SAMPLE HOME HEALTH AGENCY

Notes to Financial Statements

(4) Long-Term Debt

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

	19X5	19X4
Note payable to Bank due in 6 remaining annual installments of $13,000 and a balloon payment of $40,000 due January 1, 19X3, interest payable quarterly 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
Later years	53,000

SAMPLE HEALTH MAINTENANCE ORGANIZATION (HMO)

Balance Sheets*

June 30, 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
Inventories of 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 (note 3)	(1,803,000)	(1,436,000)
	5,756,000	5,626,000
State guaranty fund deposit (note 5)	150,000	150,000
Unamortized debt issuance costs	18,000	21,000
Total assets	$9,869,000	$7,769,000

Liabilities and Fund Balance	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.

*See note on page 85.

SAMPLE HEALTH MAINTENANCE ORGANIZATION

Statements of Revenues and Expenses
and Changes in Fund Balance*

Years Ended June 30, 19X5 and 19X4

	19X5	19X4
Revenues:		
Premiums earned	$27,682,000	$22,500,000
Reinsurance recoveries	600,000	400,000
Coinsurance	689,000	500,000
Interest and other income	242,000	100,000
	29,213,000	23,500,000
Expenses:		
Administration	2,080,000	1,684,000
Membership services	527,000	440,000
Health centers--administration	1,923,000	1,866,000
Health centers--medical services	10,316,000	8,986,000
Outside physician services	2,430,000	1,844,000
Hospitalization and other outside services	10,719,000	8,090,000
	27,995,000	22,910,000
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.

*See note on page 85.

SAMPLE HEALTH MAINTENANCE ORGANIZATION

Statement of Changes in Financial Position*

Years Ended June 30, 19X5 and 19X4

	19X5	19X4
Sources of funds:		
Income from operations	$1,218,000	$ 590,000
Items in operations not affecting cash:		
Depreciation	370,000	339,000
Decrease in premiums receivable	49,000	84,000
Increase in accounts payable--medical services	774,000	335,000
Increase (decrease) in unearned premium revenue	(61,000)	115,000
Net increase (decrease) in other receivables, inventory, prepaid expenses, and other payables	150,000	(153,000)
Cash provided from operations	2,500,000	1,310,000
Increase in long-term debt	300,000	-
Total sources of funds	2,800,000	1,310,000
Uses of funds:		
Additions to property and equipment, net	497,000	121,000
Payment of long-term debt	387,000	1,000,000
Total uses of funds	884,000	1,121,000
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

See accompanying notes to financial statements.

*See notes on pages 85 and 92.

SAMPLE HEALTH MAINTENANCE ORGANIZATION

Notes to Financial Statements

June 30, 19X5 and 19X4

(1) Formation and Purpose of Sample HMO

Sample HMO (the Corporation) was incorporated in 1974 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

(a) Temporary Cash Investments. Temporary cash investments at June 30, 19X5 and 19X4 include a repurchase agreement with a bank and certificates of deposit carried at cost which is equivalent to market.

(b) 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.

(c) Health Care Service Cost Recognition. Sample HMO contracts with various health care providers for the provision of certain related medical care 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% of the capitation as a hospital risk-sharing fund. In the event of hospital utilization in excess of budget, those providers bear the risk to the extent of XX% 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 billed.

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

SAMPLE HEALTH MAINTENANCE ORGANIZATION

Notes to Financial Statements

(e) Property and Equipment. Property, leasehold interests, leasehold improvements, and equipment are recorded at cost, less accumulated depreciation and amortization. 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 1975-1976 from the Department of Health and Human Services (HHS). This property will be owned by the Corporation as long as the equipment and facilities are used for projects related to the objectives of the Public Health Service Act.

(f) Depreciation and Amortization of Property and Equipment. Depreciation and amortization are computed using the straight-line method over the estimated useful lives of the related assets as follows:

Health center	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

(g) Amortization of Debt Issuance Costs. Debt issuance costs are deferred and amortized using the straight-line method over the term of the related debt.

(h) Retirement Plan Expense. The Corporation has a retirement plan as more fully described in note 6. Charges to expense are recognized as the Corporation's contributions and are funded to the plan.

(i) Federal Income Tax. The Corporation is exempt from federal income taxes under Section 501(a) of the Internal Revenue Code; accordingly, no provision for federal income taxes has been made in the accompanying financial statements.

(j) Reinsurance. Reinsurance premiums are reported as health care costs, and reinsurance recoveries are reported as revenue.

SAMPLE HEALTH MAINTENANCE ORGANIZATION

Notes to Financial Statements

(3) Property and Equipment

At June 30, 19X5 and 19X4, property and equipment consists of the following:

	19X5	19X4
Land	$ 300,000	$ 300,000
Buildings and improvements (see note 4)	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

At June 30, 19X5 and 19X4, long-term debt consists of the following:

	19X5	19X4
HHS loan secured by health center, payable in annual installments of $78,000 to $231,000 beginning July 19XX through July 19XX, plus interest (payable semi-annually) at 7 1/2%	$2,020,000	$2,111,000
HHS loan secured by health center, payable in annual installments of $33,000 to $176,000 beginning July 19XX through July 20XX, plus interest (payable semiannually) at 9 1/4%	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

Interest expense on long-term debt for the year ended June 30, 19X5 was $385,000 ($375,000 in 19X4).

SAMPLE HEALTH MAINTENANCE ORGANIZATION

Notes to Financial Statements

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

Fiscal Year	
19X6	$ 241,000
19X7	259,000
19X8	280,000
19X9	300,000
19X0	320,000
Later years	3,136,000
	$4,536,000

(5) State Guaranty Fund Deposit

In August 19X5, the state enacted legislation specifically governing health maintenance organizations. The Corporation is classified as a medical group/staff model HMO under the new tax law.

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). This deposit requirement is similar to the state guaranty fund deposit requirement under prior legislation which was satisfied at June 30, 19X5 and 19X4, by placing $150,000 in a joint certificate of deposit with 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%-10% of eligible covered compensation) was $354,000 for the year ended June 30, 19X5 ($275,000 in 19X4).

(7) Reinsurance Activities

Sample HMO entered into a reinsurance agreement with a major insurance company to limit its losses on individual claims. Under the terms of this agreement:

- The insurance company will reimburse Sample HMO approximately XX% 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.

SAMPLE HEALTH MAINTENANCE ORGANIZATION

Notes to Financial Statements

- o In the event Sample HMO ceases operations--
  - Plan benefits will continue for members who are confined in an acute care hospital on the date of insolvency until their discharge.
  - Plan benefits will continue for any other member until the end of the contract period for which premiums have been paid.

Reinsurance 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 reinsurance recoveries are included in revenue in 19X5 and 19X4, respectively. Approximately $50,000 is recoverable from reinsurers related to health care costs, which is included in other receivables.

(8) Malpractice

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 is unable to estimate the ultimate cost, if any, of the resolution of such potential claims and, accordingly, no accrual has been made for them; however, management believes that these claims, if asserted, would be settled within the limits of insurance coverage.

SAMPLE AMBULATORY CARE, INC.

Balance Sheets*

December 31, 19X5 and 19X4

Assets	19X5	19X4
Current assets:		
Cash	$ 56,000	$ 76,000
Patient accounts receivable	305,000	283,000
Less allowance for uncollectible accounts	15,000	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
Inventories of supplies	21,000	18,000
Prepaid expenses and deposits	5,000	9,000
Total current assets	404,000	421,000
Property and equipment, at cost:		
Land	100,000	100,000
Land improvements	322,000	322,000
Buildings	683,000	682,000
Equipment	1,389,000	1,389,000
	2,494,000	2,493,000
Less accumulated depreciation and amortization	217,000	100,000
Net property and equipment	2,277,000	2,393,000
Other assets:		
Advances receivable (note 5)	166,000	205,000
Total assets	$2,847,000	$3,019,000

Liabilities and Fund Balance	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
Blue Cross current financing advance	-	1,000
Deferred revenue (note 3)	-	57,000
Total current liabilities	253,000	335,000
Commitment (note 5)		
Fund balance	2,594,000	2,684,000
Total liabilities and fund balance	$2,847,000	$3,019,000

See accompanying notes to financial statements.

*See note on page 85.

SAMPLE AMBULATORY CARE, INC.

Statements of Revenues and Expenses*

Years Ended December 31, 19X5 and 19X4

	19X5	19X4
Patient service revenue:		
Emergency	$663,000	$ 310,000
Referred outpatients	137,000	26,000
	800,000	336,000
Deductions from (additions to) patient service revenue:		
Contractual adjustments (note 4)	(15,000)	(32,000)
Policy adjustments	(3,000)	6,000
Uncollectible accounts	38,000	5,000
	20,000	(21,000)
Net patient service revenue	780,000	357,000
Other operating revenue (note 3)	106,000	14,000
Total operating revenue	886,000	371,000
Operating expenses:		
Salaries and wages	425,000	184,000
Employee benefits	77,000	54,000
Supplies	107,000	52,000
Purchased services	132,000	79,000
Insurance	34,000	22,000
Professional fees	27,000	1,000
Depreciation and amortization	117,000	100,000
Other	60,000	47,000
Total operating expenses	979,000	539,000
Loss from operations	(93,000)	(168,000)
Nonoperating revenue--interest income	3,000	11,000
Excess of expenses over revenues	$(90,000)	$(157,000)

See accompanying notes to financial statements.

*See note on page 85.

SAMPLE AMBULATORY CARE, INC.

Statements of Changes in Fund Balance*

Years Ended December 31, 19X5 and 19X4

	19X5	19X4
Balance at beginning of period	$2,684,000	$2,841,000
Excess of expenses over revenues	(90,000)	(157,000)
Balance at end of period	$2,594,000	$2,684,000

See accompanying notes to financial statements.

*See note on page 85.

SAMPLE AMBULATORY CARE, INC.

Statements of Changes in Financial Position*

Years Ended December 31, 19X5 and 19X4

	19X5	19X4
Cash flow from operating activities and nonoperating revenue:		
Loss from operations	$(93,000)	$(168,000)
Noncash expenses, revenues, and losses included in operations:		
Depreciation	117,000	100,000
Write-down of receivable from Bancroft Affiliates, Inc.	48,000	-
Net increase in receivables, supplies, prepaids, and payables	(22,000)	(6,000)
Net cash flow from (used for) operating activities	50,000	(74,000)
Nonoperating revenue	3,000	11,000
Net cash flow from (used for) operating activities and nonoperating revenue	53,000	(63,000)
Cash flow used for investing activities:		
Acquisitions of property and equipment	(1,000)	(4,000)
Advance to Bancroft Affiliates, Inc.	(9,000)	(205,000)
	(10,000)	(209,000)
Cash flow from financing activities:		
Proceeds of notes payable	-	144,000
Payments to settle notes payable	(6,000)	-
Increase (decrease) in advance rentals payments	(57,000)	57,000
	(63,000)	201,000
Net increase (decrease) in cash	(20,000)	(71,000)
Beginning cash balance	76,000	147,000
Ending cash balance	$ 56,000	$ 76,000

See accompanying notes to financial statements.

*See notes on pages 85 and 92.

SAMPLE AMBULATORY CARE, INC.

Notes to Financial Statements

December 31, 19X5 and 19X4

(1) Summary of Significant Accounting Policies

(a) Patient Service Revenue. Patient service revenue is recorded at established rates with provisions for contractual adjustments, uncollectible accounts, and policy adjustments deducted or added to arrive at net patient service revenue.

(b) Third-Party Contractual Adjustments. Retroactively calculated third-party contractual adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted as required in subsequent periods based on final settlements.

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

(d) Depreciation and Amortization. Depreciation on plant and equipment and amortization of land improvements is computed on the straight-line method over the estimated lives of depreciable assets.

(e) Investment Income. Investment income and gains on investment transactions are recorded as nonoperating revenue.

(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.

SAMPLE AMBULATORY CARE, INC.

Notes to Financial Statements

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.

The members' agreement also provides for the rental of space to the member hospitals. Rental income from the member hospitals amounted to $86,000 in 19X5 and $14,000 in 19X4. As of December 31, 19X4, Sample Ambulatory Care, Inc. had received $57,000 in advance payments of rent from two of the member hospitals.

Additionally, during 19X4, each hospital loaned $48,000 to Sample Ambulatory Care, Inc. in the form of noninterest-bearing promissory notes. 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. returned $2,000 to each member hospital to reduce the notes payable to $138,000.

(4) Revenue From Contracting Agencies

Sample Ambulatory Care, Inc. participates as a provider of health care services to Blue Cross, Medicare, Department of Public Welfare (DPW), and County Indigent Plan patients.

The provisions of the Blue Cross agreement stipulate that services are reimbursed at a tentative reimbursement rate and that final reimbursement for these services is determined after submission of annual cost reports by Sample Ambulatory Care, Inc. and audits by Blue Cross.

SAMPLE AMBULATORY CARE, INC.

Notes to Financial Statements

For Medicare, DPW, and County Indigent Plan purposes, Sample Ambulatory Care, Inc. is considered a cost center of a member hospital. Reimbursement for covered services is based on tentative payment rates. The final reimbursement rates will be determined after submission of the hospitals' annual cost reports and an audit by the fiscal intermediaries. Provisions for estimated reimbursement adjustments have been made in the financial statements.

Summarized below is the percentage of gross patient service revenue by the major contract reimbursement programs:

	19X5	19X4
Blue Cross	28.7%	30.4%
Medicare	11.8	12.6
DPW and County Indigent Plan	2.9	2.3
	43.4%	45.3%

(5) Advances Receivable

During May, 19X4, Sample Ambulatory Care, Inc. entered into a five-year agreement with Bancroft Affiliates, Inc. (BA). Under this agreement, BA 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 BA will collect at least $18,000 per month during the term of this agreement. In any month in which BA does not collect the minimum guarantee, Sample Ambulatory Care, Inc. advances funds to BA to cover the deficiency. Such advances are to be repaid to the extent BA's net cash collections exceed the minimum guarantee amount.

Advances receivable include a $34,000 initial working capital advance made to BA in 19X4 and net additional advances under the terms of the agreement of $9,000 and $171,000 in 19X5 and 19X4, respectively. As of December 31, 19X5, advances receivable have been reduced by $48,000 to reflect the anticipated advances recoverable.

(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.

APPENDIX G

Statement of Position 87-1

Accounting for Asserted and Unasserted Medical Malpractice Claims of Health Care Providers and Related Issues

March 16, 1987

Issued by
Accounting Standards Division

American Institute of
Certified Public Accountants

AICPA

NOTE

This statement of position applies to all health care providers and provides guidance concerning medical malpractice insurance financial-reporting issues.

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 areas of financial accounting and reporting. Statements of position do not establish standards enforceable under rule 203 of the AICPA Code of Professional Ethics. However, 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*, identifies AICPA statements of position as another source of established accounting principles that the auditor should consider. Accordingly, members should be prepared to justify departures from the recommendations in this statement of position.

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Accounting for Asserted and Unasserted Medical Malpractice Claims of Health Care Providers and Related Issues

Introduction

1. Health care providers have traditionally purchased occurrence-basis insurance to protect themselves against losses from malpractice claims. Such losses include the costs of claims investigation and settlement resulting from allegedly improper professional health care services provided to patients. The cost of such insurance is fixed at the beginning of the policy term, and the premium has been charged to expense pro rata over the term of the policy.

2. The changing social and economic environment has both increased the cost and limited the availability of occurrence-basis medical malpractice insurance. Insurance companies have substantially raised premiums or restricted the degree of risk they were willing to assume. As a result, some health care providers have dropped their insurance coverage; others have kept their coverage but modified it to retain more of their malpractice risk by accepting higher deductibles, by purchasing retrospectively rated policies, by forming captive insurance companies, or by joining with others to form multiprovider captive insurance companies. Still other providers have purchased claims-made policies, which cover only claims reported to the insurance carrier during the policy term. Today, few health care providers have full insurance protection against losses from medical malpractice claims, and careful evaluation of ongoing insurance protection is required whenever one of the above modifications is made.

3. Many health care providers established trust funds as a means of funding the cost of uninsured (also referred to as self-insured) malpractice claims and related expenses. Others simply pay such costs out of general funds when they are incurred.

4. Accounting for asserted and unasserted medical malpractice claims has become diverse. The diversity is compounded by the use

of captive insurance companies, retrospectively rated policies, claims-made insurance programs, and trust funds because accounting pronouncements offer no specific guidance in those areas. Neither the AICPA's 1972 *Hospital Audit Guide* nor the AICPA's 1978 Statement of Position (SOP), *Clarification of Accounting, Auditing and Reporting Practices Relating to Hospital Malpractice Loss Contingencies*, provides specific guidance on those accounting issues. Accordingly, this statement has been prepared (*a*) as a basis for reducing the existing diversity of practice and (*b*) as a guide on accounting for uninsured asserted and unasserted medical malpractice claims and related issues.

Definitions

5. The following are definitions of terms used in this statement.

Asserted claim. A claim made against a health care provider by or on behalf of a patient alleging improper professional service.

Claims-made policy. A policy that covers only malpractice claims covered by the policy reported to the insurance carrier during the policy term.

Discounting. Measuring the cost of malpractice claims at the present value of the estimated future payments.

Health care provider. A person or other entity or group of entities under common control that delivers health care services, including, but not limited to, hospitals, nursing homes, and practices of physicians, dentists, or other health care specialists.

Multiprovider captive. An insurance company owned by two or more health care providers that underwrites malpractice insurance for its owners.

Occurrence-basis policy. A policy that covers claims resulting from incidents that occur during the policy terms, regardless of when the claims are reported to the insurance carrier.

Reported incident. An occurrence identified by a health care provider, usually under some form of claim-management-reporting system, as one in which improper professional service may be alleged, thereby resulting in a malpractice claim.

Retrospectively rated policy. An insurance policy with a premium that is adjustable based on the experience of the insured health care provider or group of health care providers during the policy term.

Self-insurance. Risk of loss assumed by a health care provider. No external insurance coverage.

Tail coverage. Insurance designed to cover malpractice claims incurred before, but reported after, cancellation or expiration of a claims-made policy.

Trust fund. A fund established by a health care provider to pay malpractice claims and related expenses as they arise. (In the case of a government, the trust fund often is established as an "internal service fund.")

Ultimate cost. Total claim payments, including costs associated with litigating or settling claims.

Unasserted claim. A medical malpractice claim that has not been, 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 provider that may result in a malpractice claim. The occurrence, however, has not yet been identified by the health care provider under a formal or informal claims-reporting system.

Wholly owned captive. An insurance company subsidiary of a health care provider that provides malpractice insurance primarily to its parent.

Scope

6. This statement applies to all health care providers and their wholly owned and multiprovider-owned captive insurance companies.

Relevant Accounting Pronouncements

7. Three accounting pronouncements provide guidance on accounting for medical malpractice claims: FASB Statement No. 5, *Accounting for Contingencies,* FASB Interpretation No. 14, *Reasonable Estimation of the Amount of a Loss,* and the 1978 AICPA Statement of Position, *Clarification of Accounting, Auditing, and Reporting Practices Relating to Malpractice Loss Contingencies.* The following discussion cites relevant passages from those pronouncements.

Accounting for Uninsured Asserted and Unasserted Malpractice Claims

8. An issue in accounting for uninsured asserted and unasserted malpractice claims is whether a health care provider should accrue for the ultimate cost of uninsured asserted and unasserted malpractice claims when incidents occur. Other accounting issues include how such losses should be accrued and how those accrued losses should be classified in the financial statements.

Discussion

9. Many health care providers that do not obtain insurance for their malpractice risks establish risk management systems to reduce their exposure to malpractice claims. Risk management systems are designed (*a*) to reduce the likelihood of incidents that may result in malpractice claims, (*b*) to identify such incidents that have occurred and to correct the underlying causes, (*c*) to minimize the amount of payments made on reported claims, and (*d*) to provide for the availability of financial resources to settle claims.

10. For accounting purposes, the two major categories of malpractice loss contingencies are asserted and unasserted claims. *Asserted claims* are claims made against a health care provider by or on behalf of a patient alleging improper professional service. *Unasserted claims* (that is, incurred but not reported claims) are claims that have not been asserted by or on behalf of a patient and may relate to either—

a. *Reported incidents,* which are occurrences that have been identified by the health care provider, usually under some form of claims management reporting system, as incidents in which improper care may be alleged, thereby resulting in malpractice claims, or—

b. *Unreported incidents,* which are occurrences that have not yet been identified by the health care provider under a formal or informal claims-reporting system as incidents in which improper professional service may be alleged, and can result in malpractice claims.

11. The 1978 SOP provides limited guidance on accounting for uninsured malpractice claims. That SOP requires estimated losses resulting from malpractice claims to be accounted for in accordance with FASB Statement No. 5 and FASB Interpretation No. 14.

Accordingly, an expense should be accrued if an incident has occurred that will probably result in an uninsured loss and if the amount can be reasonably estimated. In making the estimate, prior claim experience should be considered, including an analysis of the frequency of past claims. The SOP indicates that a qualified actuary may be helpful in deriving an estimate of claims incurred but not reported and also in quantifying the uncertainties inherent in such estimates.

12. FASB Interpretation No. 14 states that if it is probable a loss has been incurred but that only a range of loss can be reasonably estimated, the loss should still be accrued. However, in such circumstances, the most likely amount in the range should be accrued. If no amount is more likely than any other amount, the minimum amount should be accrued, and the amount of any potential additional loss should be disclosed in the notes to the financial statements.

Present Practices

13. Some health care providers accrue estimated losses from malpractice claims based on information developed from their risk management systems. Losses from asserted claims are based on the best estimate of the cost of settling or litigating the claims, including the expense of settlement and litigation (ultimate cost). Many of those estimates are made by claims managers or attorneys.

14. Losses from unasserted claims arising from reported incidents are estimated and accrued either individually or in groups. Individual accrual is based on an analysis of each incident; group accrual is based on the historical relationship between unasserted claims arising from reported incidents and eventual loss.

15. Some health care providers also estimate and accrue losses from unreported incidents. Those estimates are generally based on the provider's experience of the relationship between unreported incidents and eventual losses or on industry experience. Losses from reported and unreported incidents are often estimated with the help of actuaries.

16. Other health care providers accrue amounts for estimated losses from malpractice claims based on actuarially determined payments to a trust fund or captive insurance company. Many of those payments represent the present value of expected future payments for malpractice claims less amounts previously funded and

amounts to be funded in future years. Those amounts generally result in leveling the reported expense of malpractice claims over a period of years and are not usually based on incidents occurring in the current year.

Views on the Issues

17. Some believe that the ultimate costs of malpractice claims should be accrued when the incidents that cause them occurred, if it can be determined that it is probable that losses have been incurred and if the amounts can be reasonably estimated. However, they maintain that the ability to make reasonable estimates varies for asserted and unasserted claims. They believe that accrual of estimated losses from asserted claims and the related settlement and litigation expenses should be based on the best estimate of the costs of settling or litigating the claims.

18. These individuals also believe that estimated losses from reported incidents should be accrued if sufficient information is available from the health care provider's own experience to determine—either individually or on a group basis—that it is probable that losses have been incurred and that they can be reasonably estimated. In addition, they maintain that estimated losses from unreported incidents should also be accrued if the health care provider has sufficient statistics on its paid claims that resulted from unreported incidents to provide a basis on which to estimate the amount of such losses. However, if a health care provider does *not* have sufficient historical experience on which to estimate losses from reported or unreported incidents, they believe the cost of such claims should not be accrued. The existing contingency should be disclosed in the notes to the financial statements.

19. Others maintain that the actuarially determined payment to a trust fund or captive insurance company should be accrued as an expense in the health care provider's financial statements because the amount was determined by an actuary, who is a specialist in the field. They believe that Statement on Auditing Standards No. 11, *Using the Work of a Specialist*, supports their position. SAS No. 11 states in paragraph 9 that "if the auditor determines that the specialist's findings support the related representations in the financial statements, he may reasonably conclude that he has obtained sufficient evidential matter." Those who support accruing actuarially

determined payments contend that accountants do not have the level of expertise to challenge an actuary's recommendations.

20. Others believe that actuarially determined payments frequently include amounts that do not meet the criteria for accrual under FASB Statement No. 5 for the following reasons:

a. Actuarially determined payments generally result in leveling the cost of malpractice claims over a period of years. For example, if it is probable that a $1 million loss will occur some time in the next five years, $200,000 may be funded in each of the next five years. For accounting purposes, $1 million should be accrued in the year the incident occurred if the amount of loss can be reasonably estimated at that time.

b. Many actuarially determined payments are computed at the request of the health care provider at the beginning of a year or earlier, and, therefore, the health care provider's claim experience for that year is not considered.

c. The actuarial computations may be based on industry experience rather than on the health care provider's claim experience. If the health care provider's claim experience differs materially from the experience of others, the actuarial determinations would not conform with FASB Statement No. 5.

d. Actuarially determined payments may contain provisions for adverse deviation that do not conform with FASB Statement No. 5, which requires an accounting accrual based on reasonable estimates of incurred losses.

Conclusions

21. The ultimate costs of malpractice claims, which include costs associated with litigating or settling claims, should be accrued when the incidents occur that give rise to the claims, if it can be determined that it is probable that liabilities have been incurred and if the amounts of the losses can be reasonably estimated.

22. *Estimating the Amount of Loss.* 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 should be accrued. If no amount in the range is more likely than any other, the minimum amount in the range should be accrued, and the

potential additional loss should be disclosed if there is at least a reasonable possibility of loss in excess of the amount accrued. (See FASB Interpretation No. 14.) If the range of loss cannot be reasonably estimated, no loss should be accrued.

23. Estimated losses should be reviewed and changed if necessary at each reporting date; the amounts of the changes would be recognized currently as additional expense or reductions of expense.

24. *Asserted Claims and Unasserted Claims Arising From Reported Incidents.* Estimated losses from asserted claims should be 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 should be accrued individually or on a group basis, using the relationship of past reported incidents to eventual claim payments. All relevant information, including industry experience, should be used in estimating the expected amount of asserted claims and unasserted claims arising from reported incidents.

25. *Unreported Incidents.* A health care provider should accrue estimated losses from unreported incidents based on its best estimate of the ultimate costs. Those estimates should be 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 provider's own historical experience, and the provider's existing asserted claims and reported incidents. The accrual should be 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.

26. In estimating the extent to which unreported incidents are probable of having occurred, some health care providers may develop a range of possible estimates of the number of unreported incidents, including zero. However, the greater the volume of a health care provider's operations, the greater the likelihood that the provider's minimum estimate of the number of probable unreported incidents will be greater than zero.

27. *Use of Industry Experience.* In estimating losses from malpractice claims, a health care provider should use data on industry experience only to the extent that such data is relevant to developing an estimate specific to the entity. The relevance of industry data depends principally on the comparability of the health care provider with the entities whose experiences are used in developing that data. Various factors, such as the nature of operations, size, and geographic location, should be considered in assessing comparability. Further, industry data that is not current may not be relevant. How the health care provider plans to use the data affects which factors are more important in a given circumstance, as indicated in the following examples:

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 a provider's business activity and risk management system to that of the other providers included in the industry data would be critical in determining whether and how industry experience can be used. (Not being able to make such comparisons of the risk management systems would indicate that industry data should not be used in estimating the extent of a provider's probable unreported incidents.)

28. 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) should be classified as current liabilities; all other accrued unpaid claims and expenses should be classified as noncurrent liabilities.

29. *Disclosure.* A health care provider should disclose its program of medical malpractice insurance coverages and the basis for any related loss accruals. If the health care provider cannot estimate losses relating to a particular category of malpractice claims (for example, asserted claims, reported incidents, or unreported incidents) in accordance with paragraphs 22 through 27, the potential losses related to that category of claims should not be accrued. However, the contingency should be disclosed in the notes to the financial statements, as required by FASB Statement No. 5.

Disclosure of Discounting Accrued Unpaid Malpractice Claims

30. An issue in accounting for medical malpractice claims is what should be disclosed by health care providers that discount accrued unpaid medical malpractice claims.

Discussion

31. The relevant accounting pronouncements are not specific about whether unpaid malpractice claims should be recorded at the estimated ultimate cost of settlement or at the present value of anticipated future cash payments. Because of the substantial delay between the date an incident occurs and the date the claim is paid, the difference between recording the amount of accrued asserted and unasserted claims at their estimated ultimate cost of settlement and at their present value is significant.

Conclusions

32. A task force of the Accounting Standards Division is considering the accounting implications of certain discounting applications, including discounting insurance claims. Until the discounting issue is resolved, health care providers that discount accrued malpractice claims should disclose in the notes to their financial statements the carrying amount of accrued malpractice claims that are discounted in the financial statements and the interest rate(s) used to discount those claims (see FASB Statement No. 60, *Accounting and Reporting by Insurance Enterprises*, paragraph 60(d)).

Accounting for Claims-Made Policies and Tail Coverage

33. An issue in accounting for a claims-made policy is whether a health care provider should accrue for the ultimate costs of malpractice claims and incidents not reported to the insurance carrier during the term of the policy. Other issues include (*a*) how that accrual should be made and (*b*) whether buying tail coverage satisfies the requirement to provide for the costs of malpractice claims and incidents not reported to the insurance carrier.

Discussion

34. Many health care providers now buy claims-made malpractice insurance. A claims-made policy differs from an occurrence-

basis policy in that it covers only claims reported to the insurance carrier during the policy term. If a claims-made policy is not continually renewed or if tail coverage is not obtained when the policy is discontinued, a health care provider is uninsured for malpractice claims reported to the insurance carrier after the termination of the policy, regardless of when the incidents occurred.

35. An accounting issue to be addressed is whether a health care provider with a claims-made policy should accrue a liability for estimated losses relating to unasserted claims and incidents not reported to the insurance carrier, although they may be covered by future claims-made policies.

36. A health care provider may terminate a claims-made policy and buy tail coverage. If so, another accounting issue to be addressed is whether the cost of tail coverage should be charged to expense when the decision is made to terminate the claims-made policy or whether the cost should be deferred and amortized to expense over the period that claims are expected to be reported.

Present Practices

37. Few health care providers now accrue for estimated losses from unasserted claims and incidents not reported to the insurance carrier that are expected to be covered under future claims-made policies.

38. Most health care providers charge the cost of tail coverage to expense in the periods in which they obtain the coverage.

Views on the Issues

39. Some believe that a claims-made policy represents a transfer of risk within the policy limits to the insurance carrier and that it is unnecessary to accrue for estimated losses from unasserted claims and unreported incidents to be covered under future claims-made policies. They maintain that such accrual would be necessary only if the health care provider decided not to renew a claims-made policy or the insurance carrier indicated it would not renew the policy and tail coverage was not going to be or could not be obtained.

40. Others believe that a claims-made policy does not transfer risk to the insurance carrier for unasserted claims and incidents not

reported to the insurance carrier; they maintain that the health care provider should accrue for such claims. The accrual should be reversed when the claims are subsequently reported and covered by a claims-made or tail coverage policy.

41. Some believe the premium for tail coverage should be charged to expense when the coverage is obtained because the premium relates to past occurrences.

42. Others believe recognition in expense of the cost of tail coverage should be deferred. They maintain that it should be charged to expense over the estimated period in which the claims will be reported because the tail coverage is a continuation of the claims-made policy.

Conclusions

43. A claims-made policy represents a transfer of risk within the policy limits to the insurance carrier for asserted claims and incidents reported to the insurance carrier; however, this policy does not represent a transfer of risk for claims and incidents not reported to the insurance carrier. Consequently, a health care provider that is insured under a claims-made policy should account for the estimated cost of those claims and incidents not reported to the insurance carrier in accordance with paragraphs 22 through 27. This should be done unless the health care provider has bought tail coverage and included the cost of the premium as expense in the financial statements for that period.

Accounting for Retrospectively Rated Premiums

44. The issues to be addressed in accounting for retrospectively rated premium policies are (*a*) how health care providers should account for premiums and (*b*) what disclosures of estimated losses should be made under such policies if the ultimate premiums are based primarily on each health care provider's loss experience or on the experience of a group of health care providers.

Discussion

45. The premium for a nonretrospectively rated policy is fixed for the period of the contract and is usually charged to expense pro rata over the contract period. However, for a retrospectively rated

policy, an estimated or deposit premium is generally paid to the insurance company at the inception of the contract period. The deposit premium usually consists of a minimum premium, representing the insurance company's expenses and profits, plus an amount for estimated claims experience. During the term of the policy, the deposit premium is adjusted, subject to any minimum and maximum premium limitations of the contract, based on the experience of the health care provider.

46. Some retrospectively rated policies are primarily based on the experience of the individual health care provider and some are primarily based on the experience of a group of health care providers. Other policies may be based on some combination of both individual and group experience.

Present Practices

47. Some health care providers account for minimum premiums paid to insurance companies on retrospectively rated policies as expense over the period of coverage and recognize estimated losses in excess of the minimum premium from asserted and unasserted claims as additional insurance expense for the period.

48. Others amortize premiums on retrospectively rated policies over the period of coverage and recognize adjustments resulting from favorable or unfavorable claim experience in the financial statements when the insurance company reports them.

Views on the Issues

49. A retrospectively rated policy may provide that the insurer will not return the minimum premium regardless of the degree of favorable experience and, if experience is unfavorable, that the insured will only be required to pay a maximum amount. Some believe an estimate of the total premium ultimately to be paid should be charged to expense over the term of the contract.

50. Those who support that view maintain that health care providers retain risk of loss up to the maximum premium under those contracts. Estimated losses from asserted and unasserted claims should be accrued as indicated in paragraphs 22 through 27 up to that maximum amount.

51. Others believe that minimum premiums on retrospectively rated policies should be amortized pro rata over the period of coverage. Retrospective premium adjustments should be recorded as adjustments of insurance expense when the insured is notified of such adjustments. Those who support this view maintain that the premium is the best estimate of losses from asserted and unasserted claims and, therefore, should be the insurance expense for the period.

Conclusions

52. A health care provider with a retrospectively rated medical malpractice insurance policy whose ultimate premium is based primarily on the health care provider's loss experience should account for the minimum premium as expense over the period of coverage under the policy and accrue estimated losses from asserted and unasserted claims in excess of the minimum premium as indicated in paragraphs 22 through 27. However, such estimated losses should not be accrued in excess of a stipulated maximum premium. If the health care provider cannot estimate losses from asserted or unasserted malpractice claims as indicated in paragraphs 22 through 27, the health care provider should disclose the existing contingency in the notes to the financial statements (see paragraph 29).

53. A health care provider insured under a retrospectively rated policy with premiums based primarily on the experience of a group of health care providers should amortize the initial premium to expense pro rata over the policy term. The provider should also accrue additional premiums or refunds on the basis of the group's experience to date, which should include provision for the ultimate cost of asserted and unasserted claims before the financial statement date, whether reported or unreported. The health care provider should disclose (*a*) that it is insured under a retrospectively rated policy and (*b*) that premiums are accrued based on the ultimate cost of the experience to date of a group of providers. If the health care provider cannot estimate losses from asserted or unasserted malpractice claims as indicated in paragraphs 22 through 27, it should disclose the existing contingency in the notes to the financial statements (see paragraph 29).

Accounting for Medical Malpractice Claims Insured With Captive Insurance Companies

54. In accounting for medical malpractice claims insured with wholly owned and multiprovider owned captive insurance companies, an accounting issue to be considered is how health care providers should account for estimated losses from asserted and unasserted claims.

Discussion

55. Some health care providers have formed wholly owned subsidiaries to insure the parent entity and possibly other health care providers. Those entities are captive insurance companies for which FASB Statement No. 60 specifies the accounting.

56. Other health care providers have formed multiprovider captive insurance companies to insure their medical malpractice claims. Those entities are also captive insurance companies for which FASB Statement No. 60 specifies the accounting. A multiprovider captive insurance company is commonly formed by a group of health care providers that are related geographically, that are affiliated or under common control, such as by members of a religious community, or that have similar malpractice claims experience. A multiprovider captive insurance company may be formed to (*a*) spread the risk of malpractice claims among a number of similar institutions, (*b*) obtain excess coverage at a lower cost, or (*c*) provide for advance funding of the cost of malpractice claims within the provisions of reimbursement regulations. The captive may retain the entire risk assumed from its insureds or it may obtain excess coverage from a commercial insurance company.

57. Premiums on some policies issued by multiprovider captives are fixed for the period of the contract. However, premiums on many policies issued by such insurers are retrospectively rated. Such premiums may be based on the experience of the individual health care provider or on the experience of the group. The arrangements between providers and their captive may be complex; a careful analysis is generally required to determine the extent of coverage that in fact is provided by the captive. If, for instance, the insurance contract requires a premium essentially equal to claims incurred by the provider plus a fee for expenses and profit, the captive is, in effect, only a claims-paying agent.

Present Practices

58. Financial statements of health care providers generally do not disclose the method of accounting for captive insurance companies.

Views on the Issues

59. Some believe that a health care provider that is insured by its wholly owned captive is, in substance, uninsured. They believe, therefore, that the same considerations apply in accounting for estimated losses from uninsured asserted and unasserted malpractice claims of the parent as described in paragraphs 21 through 29. FASB Statement No. 5, paragraph 27, states that "uninsured risks may arise in a number of ways, including . . . insurance through a subsidiary or investee to the extent not reinsured with an independent insurer." A footnote to that paragraph states that "the effects of transactions between a parent or investor and a subsidiary or investee insurance company shall be eliminated from an enterprise's financial statements."

60. Similarly, some believe that policies issued by multiprovider captives in which the premiums are based on the experience of the individual health care providers are, in substance, not insurance. Thus, the premiums should be accounted for as expense over the periods of coverage; estimated losses from asserted and unasserted claims should be accrued and reported as indicated in paragraphs 21 through 29. However, if the premiums are based on the experience of the group, they should be amortized to expense pro rata over the terms of the policies.

61. Others believe that for retrospectively rated policies issued by multiprovider captives, with the premiums based only on the health care provider's individual experience, the initial premiums should be amortized to expense pro rata over the terms of the policies. Premium adjustments should be recorded only when the health care providers are notified by the multiprovider captives.

Conclusions

62. The financial statements of a health care provider insuring medical malpractice claims through a wholly owned captive insurance subsidiary must include provision for estimated losses from asserted and unasserted claims as indicated in paragraphs 21 through

29. That may be done directly in the financial statements of the health care provider or in consolidation of the financial statements of the wholly owned captive.

63. A health care provider insured by a multiprovider captive insurance company for medical malpractice claims under a retrospectively rated insurance policy whose ultimate premium is primarily based on the health care provider's experience up to a maximum premium, if any, should account for such insurance as indicated in paragraph 52.

64. A health care provider insured by a multiprovider captive insurance company for medical malpractice claims under a retrospectively rated policy based primarily on the experience of a group of health care providers should account for such insurance as indicated in paragraph 53. However, the health care provider should consider whether the economic substance of the multiprovider captive is sufficient to relieve the health care provider from further liability. The health care provider should disclose (*a*) that it is insured under a retrospectively rated policy of a multiprovider captive and (*b*) that premiums are accrued based on the captive's experience to date.

65. A health care provider that is insured by a multiprovider captive should disclose in its financial statements that it is insured by a multiprovider captive, and it should disclose its ownership percentage 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 provider cannot make the necessary estimates of losses from asserted or unasserted claims as indicated in paragraphs 22 through 27, the health care provider should disclose the existing contingency in the notes to the financial statements (see paragraph 29).

Accounting for Trust Funds

66. Another issue is how a health care provider should account for a trust fund established to make resources available to settle malpractice claims.

Discussion

67. One of the objectives of a risk management system is to make sure that sufficient resources are available to settle malpractice claims as they come due. Some health care providers establish trust funds in an attempt to make sure that financial resources are available to pay claims. In most circumstances, a trustee controls the trust fund assets and the trust agreement provides that the assets can be used only to investigate, litigate, and settle malpractice claims and to pay administrative expenses of the trust fund.

68. Diverse practices have developed for reporting medical malpractice trust funds and their revenues and administrative expenses in the financial statements of the health care provider.

Present Practices

69. Some health care providers treat a payment to a trust fund as a transfer of funds from one case account to another. Others exclude the trust fund from their financial statements and charge the payment to an expense account. They recognize a liability for unpaid claims only to the extent that claims exceed the amount in the trust fund. Revenues, generally interest income, and administrative expenses of the trust fund are recorded in the financial statements of the health care provider only if the trust fund is included in the statements.

Views on the Issues

70. Some believe that a trust fund, whether legally revocable or irrevocable, should be included in the health care provider's financial statements because establishing a trust fund does not relieve the health care provider of the financial responsibility for malpractice claims. A health care provider cannot limit its legal obligation for malpractice claims to the amount in the trust fund; a malpractice claimant can look to all the assets of the health care provider as well as to the trust fund to satisfy a malpractice claim. A medical malpractice trust fund cannot be compared to a pension fund because, under certain circumstances, a company's pension obligations can be limited to the amount in the pension fund.

71. Others maintain that a medical malpractice trust fund is comparable to a pension fund and should not be reported in the health care provider's financial statements. They believe that because

future malpractice claims will be paid from the trust fund, establishing a fund provides a transfer of risk and that only malpractice claims exceeding the amount in the trust fund should be reported in the health care provider's financial statements. They also maintain that there is no significant distinction for accounting purposes between assets held in revocable and irrevocable trusts because the assets of the trust are used solely to discharge obligations for unpaid claims.

72. Some believe that a trust fund included in the financial statements of the health care provider should be classified as a current asset, and others maintain that it should be classified as a noncurrent asset. Still others believe that classification should depend on the classification of estimated unpaid malpractice claims.

Conclusions

73. A trust fund, whether legally revocable or irrevocable, should be included in the financial statements of the health care provider. A portion of the fund equal to the amount of assets expected to be liquidated to pay malpractice claims classified as current liabilities should be classified as a current asset; the balance of the fund, if any, should be classified as a noncurrent asset. In the financial statements of the health care provider, revenues of the trust fund should be included with other operating revenues; the administrative expenses of the trust fund should be included with other administrative expenses. In some circumstances the foregoing may not be possible: for example, if a common trust fund exists for a group of health care providers; if the health care provider is part of a common municipality trust fund; and if legal, regulatory, or indenture restrictions prevent the inclusion of a trust fund in a health care provider's financial statements. In those circumstances, the provisions of paragraphs 74 and 75 still apply.

74. Estimated losses from asserted and unasserted claims should be accrued and reported as indicated in paragraphs 21 through 29 and should not be based on payments to the trust fund.

75. A health care provider's financial statements should disclose the existence of the trust fund, and, if the trust is irrevocable, that should also be disclosed.

Effective Date and Transition

76. This statement is effective for fiscal years beginning after June 30, 1987, with earlier application encouraged. 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 amounts per share for each year restated.

77. 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.

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GLOSSARY

This glossary defines the terms as used in this guide.

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.

advance fee. A payment required to be made by a resident before or at the time of admission to a continuing care retirement community for future accommodations and services specified in a contract, which remains in effect as long as the resident resides in the community.

allowance. The difference between gross revenue from services rendered and amounts received (or to be received) from patients, residents, clients, or third-party payors. Allowances are to be distinguished from uncollectible accounts resulting from credit losses. (See **uncompensated services.**)

ambulatory care. Health services rendered to persons who are not confined overnight in a health care institution. Ambulatory care services are often referred to as outpatient services.

ambulatory services. The essential characteristic of ambulatory services is that the patients 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 generally are those special services for which charges are customarily made, in addition to routine charges, that include laboratory, radiology, surgical, and other services.

annuity funds. Funds given to an entity as consideration for an agreement to pay periodically to the donor (or specified designated individuals) stipulated amounts, for the period set forth in the agreement.

asserted claim. A claim made against a health care entity by or on behalf of a patient alleging improper professional service.

assets (or funds) whose use is limited. Assets whose use is limited appear in the general funds section of the balance sheet and include the following:

- Assets set aside by the governing board for identified purposes and over which the board retains control and at its discretion, subsequently may use for other purposes (sometimes referred to as board-designated funds).
- 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 similar document.

- 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.

bad debts. (See uncompensated services.)

board-designated funds. (See assets whose use is limited.)

capitation fee. A fixed amount per member 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 the HMO or a prepaid health care plan and the provider. These contracts are generally with a medical group or IPA, but may also be with hospitals and other providers. The capitation fee is actuarially determined based on expected costs to be incurred.

charity allowances. Differences between revenue recorded at established rates for services provided to patients, residents, and clients, and amounts realizable from patients and residents meeting the entity's criteria for medical indigency. (See uncompensated services.)

claims-made 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 entity used for diagnosis and treatment of outpatients.

continuing care contract. An agreement between a resident and a continuing care retirement community 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 (CCRC). A legal entity sponsoring and/or guaranteeing residential 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 residential care facility.)

contractual adjustments (allowances). Differences between revenue at established rates and amounts realizable from third-party payors under contractual agreements.

contributed services. (See donated services.)

cost finding. The segregation of direct costs by cost centers, the allocation of overhead costs to revenue-producing and other centers among inpatients, outpatients, and additional classifications.

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.

customary charge. The amount that a physician normally charges the majority of patients. Under Medicare, it is the median charge used by a particular physician for a specified type of service during the calendar year preceding the fiscal year in which a claim is processed.

daily inpatient census. The number of inpatients present at the census-taking time each day. Generally, the inpatient census is taken each midnight. 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, uncompensated services, courtesy and policy discounts, and other adjustments and deductions.

diagnosis-related group (DRG). A patient classification scheme that categorizes patients who are medically related with respect to diagnoses and treatment and are statistically similar in their length of stay.

donated services. The estimated monetary value of service of personnel who receive no monetary compensation or partial compensation for their services. The term is usually applied to services rendered by members of religious orders, societies, or similar groups to institutions operated by or affiliated with such groups.

donor-restricted funds. Funds restricted for specific purposes by donors or grantors--for example, endowment funds or funds restricted to plant replacement and expansion.

endowment funds. Funds for which a donor has stipulated, as a condition of a gift, that the principal of the fund is to be maintained inviolate and in perpetuity and that only income may be expended. (See also **term endowment funds.**)

enrollee. An individual who is a subscriber or an eligible dependent of a subscriber in an HMO or a prepaid health care plan.

functional classification. The grouping of expenses according to the operating purposes (for example, patient care, education, 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.

general funds. Funds not restricted for identified purposes by donors or grantors, including resources that the governing board may use for any designated purpose and resources whose use is limited by agreement between the health care entity and an outside party other than a donor or grantor.

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).

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 an HMO or a prepaid health care plan. In return, the IPA receives either a capitation fee (fixed amount per member) or a fee for service 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.

living trust funds. Funds acquired by an entity subject to agreement whereby resources are made available to the entity on condition that the entity pay periodically to a designated person or persons the income earned on the resources acquired for the lifetime of the designated person or persons or for a specified period.

maintenance costs. Costs associated with maintaining enrollment records and processing premium collections and payments.

multiprovider captive. An insurance company owned by two or more health care entities that underwrites malpractice insurance for its owners.

nonoperating revenue (expense). Revenue (expense) not directly related to the entity's ongoing or principal operations is classified as nonoperating revenue and may include unrestricted gifts, unrestricted income from endowment funds, and income and gains from investments of general funds. (See chapter 12.)

object classification. A method of classifying expenditures according to their natural classification such as salaries and wages, employee benefits, supplies, purchased services, and so on.

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.

operating revenue. Revenue resulting from the entity's ongoing or central operations (for example, revenue for the care of patients or residents of a hospital or nursing home; premiums from subscribers or a prepaid health care plan.

other operating revenue. A separate classification of operating revenue not resulting directly from those operations (for example, cafeteria sales, personal telephone calls, sale of medical and pharmacy supplies to employees, and grants and specific purpose gifts to the extent of related expenses).

outliers. In referring to the PPS, outliers or atypical cases are those that, although classifiable into a specific DRG, have an extremely short or extremely long length of stay relative to most cases in the same DRG. Generally, health care entities receive additional payment, under specified conditions, for outlier cases.

outpatient. (See ambulatory care.)

peer review organization (PRO). Under federal statutory provisions, peer review organizations are required in each state to monitor hospital activity under PPS. Each hospital must contract with a PRO, which will review (1) the validity of diagnostic information, which establishes the DRG; (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.

pooled investment. Assets of two or more funds consolidated for investment purposes.

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 HMOs, PPOs, eye plans, dental 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.

reinsurance (or stop-loss insurance). A contract in which an insurance company agrees to indemnify the insured in accordance with the terms of the policy. (The term reinsurance is used extensively in the HMO industry, but generally refers to insurance.)

replacement and expansion funds. Donor or grantor funds restricted for renewal or replacement of plant.

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.

retirement of indebtedness funds. (See **assets whose use is limited.**)

retrospectively rated 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.

revenue bonds. Bonds generally issued by a financing authority for the benefit of a health care entity and secured by a pledge of the entity's revenues.

self-insurance. That portion of risk or loss assumed by a health care entity; no external insurance coverage.

share of pooled investments. The proportion of pooled investments, including accumulated gains or losses, owned by a particular fund, usually expressed by a number (units) indicating the fractional ownership of total shares in the pool or by a percentage expressing the portion of the total pool owned by the particular fund.

specific purpose funds. Funds restricted for a specific purpose or project. Board-designated funds do not constitute specific purpose funds.

subscriber. The person who is responsible for payment of premiums or whose employment is the basis for eligibility for membership in an HMO or 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.

term endowment funds. Donated funds that by the terms of the agreement become available either for any legitimate purpose designated by the board or for a specific purpose designated by the donor on an event's occurrence or on the passage of a stated period of time.

third-party payor. Any agency (such as Blue Cross plans or the Medicare program) that contracts with health care entities and patients to pay for the care of covered patients.

trust fund. A fund established by a health care entity with an outside entity to be used for a specific purpose, such as to pay malpractice claims and related expenses as they arise.

ultimate cost. Total claim payments, including costs associated with litigating or settling claims.

unasserted claim. A medical malpractice claim that has not been but may in the future be asserted by or on behalf of a patient related to a reported or unreported incident.

uncompensated services. Charity care and services that result in bad debts. Charity care or free care reflects an inability to pay for all or part of services rendered. Bad debts reflect an unwillingness to pay for services, although the ability to pay may exist.

unreported incident. An occurrence in which improper professional service may have been administered by the health care entity and which may result in a malpractice claim and the incident 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.