University of Mississippi
eGrove

Statements of Position

American Institute of Certified Public Accountants (AICPA) Historical Collection

1995

Proposed audit and accounting guide : health care organizations ;Health care organizations; Exposure draft (American Institute of Certified Public Accountants), 1995, April 14

American Institute of Certified Public Accountants. Health Care Committee

American Institute of Certified Public Accountants. Health Care Audit Guide Task Force

Follow this and additional works at: https://egrove.olemiss.edu/aicpa_sop

Part of the Accounting Commons, and the Taxation Commons

Recommended Citation

American Institute of Certified Public Accountants. Health Care Committee and American Institute of Certified Public Accountants. Health Care Audit Guide Task Force, "Proposed audit and accounting guide : health care organizations ;Health care organizations; Exposure draft (American Institute of Certified Public Accountants), 1995, April 14" (1995). *Statements of Position*. 608.
https://egrove.olemiss.edu/aicpa_sop/608

This Book is brought to you for free and open access by the American Institute of Certified Public Accountants (AICPA) Historical Collection at eGrove. It has been accepted for inclusion in Statements of Position by an authorized administrator of eGrove. For more information, please contact egrove@olemiss.edu.

EXPOSURE DRAFT

PROPOSED AUDIT AND ACCOUNTING GUIDE

HEALTH CARE ORGANIZATIONS

(To supersede AICPA Audit and Accounting Guide *Audits of Providers of Health Care Services* and Statements of Position 89-5, *Financial Accounting and Reporting by Providers of Prepaid Health Care Services,* and 90-8, *Financial Accounting and Reporting by Continuing Care Retirement Communities*)

APRIL 14, 1995

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

Comments should be received by August 14, 1995, and addressed to
Annette J. Schumacher, Technical Manager, File H-1-500, Federal Government Division
AICPA, 1455 Pennsylvania Avenue, NW, Washington, DC 20004-1081

800086

EXPOSURE DRAFT

PROPOSED AUDIT AND ACCOUNTING GUIDE

HEALTH CARE ORGANIZATIONS

APRIL 14, 1995

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

This exposure draft has been sent to —

- State society and chapter presidents, directors, and committee chairpersons.
- Individuals, firms, and organizations identified as having an interest in accounting and auditing issues that affect health care organizations.
- Persons who have requested copies.

Copyright © 1995 by American Institute of Certified Public Accountants, Inc.

Permission is granted to make copies of this work provided that such copies are for personal, intraorganizational, or educational use only and are not sold or disseminated and provided further that each copy bears the following credit line: "Copyright © 1995 by American Institute of Certified Public Accountants, Inc. Used with permission."

Any individual or organization may obtain one copy of this document without charge until the end of the comment period by writing to the AICPA Order Department, Harborside Financial Center, 201 Plaza Three, Jersey City, NJ 07311-3881.

AICPA
American Institute of Certified Public Accountants

1211 Avenue of the Americas
New York, NY 10036-8775

(212) 596-6200
Fax (212) 596-6213

April 14, 1995

Accompanying this letter is an exposure draft of the proposed AICPA Audit and Accounting Guide *Health Care Organizations* that would supersede the AICPA Audit and Accounting Guide *Audits of Providers of Health Care Services*. It also would supersede the following AICPA Statements of Position (SOPs):

- SOP 89-5, *Financial Accounting and Reporting by Providers of Prepaid Health Care Services*
- SOP 90-8, *Financial Accounting and Reporting by Continuing Care Retirement Communities*

Summary information about the proposed Guide is provided in the preface of the exposure draft.

The proposed Guide discusses those aspects of accounting and auditing unique to health care organizations and was developed to assist health care organizations in preparing financial statements in conformity with generally accepted accounting principles and to assist independent auditors in auditing and reporting on those financial statements.

This exposure draft incorporates new accounting and financial reporting requirements issued by the Financial Accounting Standards Board (FASB), the Governmental Accounting Standards Board (GASB), and the AICPA Accounting Standards Executive Committee (AcSEC). Also incorporated in this exposure draft are new auditing standards issued by the AICPA Auditing Standards Board since the issuance of the pronouncements that this Guide would supersede. In particular, relevant provisions of FASB Statement No. 116, *Accounting for Contributions Received and Contributions Made,* and FASB Statement No. 117, *Financial Statements of Not-for-Profit Organizations,* have been incorporated into the proposed Guide.

The provisions of the proposed Guide would be effective for financial statements for periods beginning after June 15, 1995, except for organizations with less than $5 million in total assets and less than $1 million in annual expenses. For those organizations, the effective date would be fiscal years beginning after December 15, 1995. Earlier application would be permitted. The AICPA Health Care Committee recognizes that, for many organizations, the effective date of this Guide would be six months later than the effective dates of FASB Statements No. 116 and No. 117.

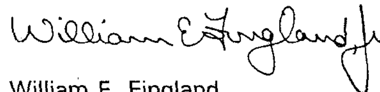
The Health Care Committee welcomes comments or suggestions on any aspect of the exposure draft. Matters about which specific comments are requested are listed in the exhibit following this letter. In order to facilitate the committee's consideration of comments, please include references to specific paragraph numbers, include reasons for any suggestions or comments, and provide alternative wording with supporting reasoning.

Responses should be addressed to Annette J. Schumacher, Technical Manager, File H-1-500, Federal Government Division, AICPA, 1455 Pennsylvania Avenue, NW, Washington, DC 20004-1081, in time to be received by August 14, 1995.

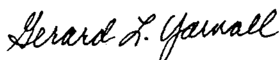
Written comments on the exposure draft will be available for public inspection at the AICPA library after September 14, 1995, for one year.

Sincerely,

William R. Titera
Chair
Health Care Committee



William E. Fingland
Chair
Health Care Audit Guide Task Force



Gerard L. Yarnall
Director
Audit and Accounting Guides

EXHIBIT — SPECIFIC ISSUES FOR COMMENT

Comments are specifically requested on the following issues addressed by this exposure draft:

ISSUE 1: EXPIRATIONS OF DONOR-IMPOSED RESTRICTIONS ON LONG-LIVED ASSETS

FASB Statement No. 116 permits preparers to recognize the expiration of donor-imposed restrictions on long-lived assets either (1) when the asset is placed into service or (2) over the useful life of the asset (see paragraph 10.9). The proposed Guide eliminates the latter option by requiring that the expiration of the restriction be recognized when the asset is placed in service. The purpose of this limitation is to achieve consistency of reporting for not-for-profit health care organizations, especially with respect to the operating measure.

Although the Guide is more restrictive than Statement No. 116, the restriction relates to the definition of an operating measure. FASB Statement No. 117 permits AICPA Audit and Accounting Guides to provide more specific reporting guidance for certain not-for-profit organizations, and reporting an operating measure was specifically considered in the deliberations relating to that permission.

Is this restriction appropriate for health care organizations?

ISSUE 2: ACCOUNTING FOR INVESTMENTS

The FASB is currently developing guidance on accounting for certain investments held by not-for-profit organizations. This project may result in a required fair value approach for certain securities held by not-for-profit organizations. Prior to the adoption of FASB Statement No. 117, changes in the valuation allowance of investments were often reported as a component of the statement of changes in fund balance. FASB Statement No. 117, in effect, replaced the statement of fund balance with the required statement of activities. However, in addition to the statement of activities, this Guide would require not-for-profit health care organizations to present a statement of operations that would include most changes in the valuation allowance. At present, the Guide would require most changes in valuation allowances for marketable equity securities portfolios to be included above the operating income caption in the statement of operations (see paragraph 4.13).

If the FASB adopts a fair value approach, should the changes in the valuation allowance related to debt and equity securities (referred to above) be included above the operating income caption in the statement of operations?

Health Care Committee
(1994–1995)

William R. Titera, Chair
A. Wayne Brown
Clarence Coleman, Jr.
Terry E. Duis
David P. Gaydosh
Woodrin Grossman
Barbara S. Gunn
James W. Karling
Craig L. McKnight
James E. Sweeten
G. Edward Tucker, Jr.
W. Mark Watson
Donald A. Westermann
Robert Allen Wright

Health Care Audit Guide Task Force
(1994–1995)

William E. Fingland, Chair
Kelly A. Barnes
Terry E. Duis
Martha Garner

AICPA Staff

Joseph F. Moraglio
Vice President
Federal Government Division

Gerard L. Yarnall
Director
Audit and Accounting Guides

Arleen Rodda Thomas
Director
Accounting Standards Division

Ian A. MacKay
Director
Federal Government Division

Annette J. Schumacher
Technical Manager
Federal Government Division

The committee and staff also gratefully acknowledge the contributions of Maribess L. Miller, former committee chair; Allen Merkley, former committee member; Phillip McCort; and Jonathan Weaver.

TABLE OF CONTENTS

	Page
PREFACE	xiii
PURPOSE	xiii
APPLICABILITY	xiii
LIMITATIONS	xiv
IMPACT ON OTHER LITERATURE	xiv
EFFECTIVE DATE AND TRANSITION	xiv
Chapter 1 — UNIQUE CONSIDERATIONS OF HEALTH CARE ORGANIZATIONS	1
OVERVIEW	1
CLASSIFICATION OF HEALTH CARE ORGANIZATIONS	1
FINANCIAL REPORTING OF HEALTH CARE ORGANIZATIONS	2
REVENUE FROM HEALTH CARE SERVICES	3
THIRD-PARTY PAYOR CONSIDERATIONS	4
CLASSIFICATION AND REPORTING OF NET ASSETS	4
HEALTH CARE CONTRACTING	6
Chapter 2 — GENERAL AUDITING CONSIDERATIONS	7
SCOPE OF THE ENGAGEMENT	7
PLANNING THE AUDIT	7
INHERENT RISK	8
INTERNAL CONTROL STRUCTURE	9
ANALYTICAL PROCEDURES	10
ACCOUNTING ESTIMATES	11
INDIVIDUAL PRACTICE ASSOCIATIONS	11
OTHER PLANNING CONSIDERATIONS	12
TRANSACTIONS PROCESSED BY SERVICE ORGANIZATIONS	14
OTHER AUDIT CONSIDERATIONS	15
Illegal Acts	15
Use of a Specialist	16
Going-Concern Considerations	16
COMMUNICATION	17
Communication of Matters Related to the Internal Control Structure	17
Communication With Audit Committees	17
CLIENT REPRESENTATIONS	17
SINGLE AUDIT ACT AND RELATED AUDIT CONSIDERATIONS	18

Page

Chapter 3 — CASH AND CASH EQUIVALENTS 20

ACCOUNTING AND FINANCIAL REPORTING 20

AGENCY FUNDS 20

DISCLOSURES 20

AUDITING 21

Chapter 4 — INVESTMENTS 22

INVESTMENTS OF NOT-FOR-PROFIT HEALTH CARE ORGANIZATIONS 22

FINANCIAL REPORTING 22

ACCOUNTING FOR CERTAIN MARKETABLE EQUITY SECURITIES BY NOT-FOR-PROFIT HEALTH CARE ORGANIZATIONS 23

AUDITING 25
- *Exhibit 4.1* Auditing Considerations 26

Chapter 5 — RECEIVABLES 27

ACCOUNTS RECEIVABLE FOR HEALTH CARE SERVICES 27

RATE SETTING 27

ESTIMATED FINAL SETTLEMENTS 28

STATE WAIVER CONTINGENCIES UNDER MEDICARE 28

PREMIUMS AND STOP-LOSS INSURANCE RECEIVABLES 29

PROMISES TO GIVE IN FUTURE PERIODS (PLEDGES) 29

FINANCIAL STATEMENT PRESENTATION 30
- Accounts Receivable 30
- Interfund Receivables 31
- Promises to Give in Future Periods (Pledges) 31

AUDITING 32
- Accounts Receivable Confirmations 32
- *Exhibit 5.1* Auditing Considerations 33

Chapter 6 — PROPERTY AND EQUIPMENT, SUPPLIES, AND OTHER ASSETS 37

OVERVIEW 37

ACCOUNTING 37

FINANCIAL STATEMENT PRESENTATION 38

AUDITING 38
- *Exhibit 6.1* Auditing Considerations 39

Chapter 7 — CURRENT LIABILITIES, TAX CONSIDERATIONS, AND LONG-TERM OBLIGATIONS 41

OVERVIEW 41

ACCOUNTING FOR CURRENT LIABILITIES 41

Page

TAX CONSIDERATIONS FOR NOT-FOR-PROFIT HEALTH CARE ORGANIZATIONS 41
TAX-EXEMPT ENTITIES 42
PRIVATE INUREMENT 42
UNRELATED BUSINESS INCOME TAX 42
ARBITRAGE RESTRICTIONS 43
FINANCIAL STATEMENT PRESENTATION 43
LONG-TERM DEBT 43
FINANCING AUTHORITIES 44
ASSETS WHOSE USE IS LIMITED 44
ADVANCE REFUNDINGS 44
ARBITRAGE REBATE LIABILITIES 45
AUDITING 45
Exhibit 7.1 Auditing Considerations 46

Chapter 8 — COMMITMENTS AND CONTINGENCIES 48
OVERVIEW 48
MEDICAL MALPRACTICE CLAIMS 48
ACCRUING MALPRACTICE LIABILITIES 48
ACCOUNTING FOR CLAIMS-MADE INSURANCE POLICIES AND TAIL COVERAGE 49
ACCOUNTING FOR RETROSPECTIVELY RATED PREMIUMS 50
ACCOUNTING FOR MEDICAL MALPRACTICE CLAIMS INSURED BY CAPTIVE INSURANCE COMPANIES 50
ACCOUNTING FOR TRUST FUNDS 51
AUDITING COMMITMENTS AND CONTINGENCIES 51
AUDITING MEDICAL MALPRACTICE LOSS CONTINGENCIES 52
AUDITING ACCOUNTING ESTIMATES 53
USE OF ACTUARIES AND ACTUARIAL METHODS 53
RISKS AND UNCERTAINTIES 55
EVALUATING LAWYERS' RESPONSES 55
AUDITING 56
Exhibit 8.1 Auditing Considerations 57

Chapter 9 — NET ASSETS (EQUITY) 59
INVESTOR-OWNED HEALTH CARE ORGANIZATIONS 59

Page

NOT-FOR-PROFIT AND GOVERNMENTAL HEALTH CARE ORGANIZATIONS 59
AUDITING 60
Exhibit 9.1 Auditing Considerations 61

Chapter 10 — REVENUE, EXPENSES, GAINS, AND LOSSES 62
CONCEPTUAL FRAMEWORK FOR REPORTING REVENUE, EXPENSES, GAINS, AND LOSSES 62
DISTINGUISHING CHARITY CARE FROM BAD-DEBT EXPENSE 62
REVENUE 62
EXPENSES 65
FINANCIAL STATEMENT PRESENTATION 65
AUDITING 66
Exhibit 10.1 Auditing Considerations 67

Chapter 11 — THE REPORTING ENTITY AND RELATED ORGANIZATIONS 69
OVERVIEW 69
FINANCIAL REPORTING 70
TRANSFERS 73
DISCLOSURE 74
BUSINESS COMBINATIONS 75
AUDITING 75
Exhibit 11.1 Auditing Considerations 76

Chapter 12 — INDEPENDENT AUDITOR'S REPORTS 78
OVERVIEW 78
UNQUALIFIED OPINION 78
UNQUALIFIED OPINION WITH EXPLANATORY PARAGRAPH 78
QUALIFIED OPINION 78
ADDITIONAL INFORMATION 79
SPECIAL REPORTS 79
Exhibit 12.1 Unqualified Opinion — Comparative Financial Statements 80
Exhibit 12.2 Unqualified Opinion With Explanatory Paragraph for Material Uncertainty Related to Medical Malpractice Liability 81
Exhibit 12.3 Unqualified Opinion With Explanatory Paragraph for Change in Accounting Principle That Has a Material Effect on the Comparability of Financial Statements 82
Exhibit 12.4 Qualified Opinion — Scope Limitation 83

Page

Exhibit 12.5 Qualified Opinion — Departure From Generally Accepted Accounting Principles That Have a Material Effect on the Financial Statements 84
Exhibit 12.6 Report on Financial Statements Prepared Pursuant to a Master Trust Indenture That Results in a Presentation Not in Conformity With Generally Accepted Accounting Principles or Other Comprehensive Basis of Accounting 85

Chapter 13 — FINANCIAL ACCOUNTING AND REPORTING BY PROVIDERS OF PREPAID HEALTH CARE SERVICES 86

OVERVIEW 86

ACCOUNTING FOR HEALTH CARE COSTS 86

ACCOUNTING FOR LOSS CONTRACTS 86

ACCOUNTING FOR STOP-LOSS INSURANCE 87

ACCOUNTING FOR CONTRACT ACQUISITION COSTS 87

Chapter 14 — FINANCIAL ACCOUNTING AND REPORTING BY CONTINUING CARE RETIREMENT COMMUNITIES 88

OVERVIEW 88

TYPES OF CONTRACTS 88
Type A Contracts 88
Type B Contracts 88
Type C Contracts 89

TYPES OF LIVING ACCOMMODATIONS 89

FEES AND PAYMENT METHODS 89
Advance Fee Only 89
Advance Fee With Periodic Fees 89
Periodic Fees Only 90

ACCOUNTING FOR REFUNDABLE ADVANCE FEES 90

ACCOUNTING FOR FEES REFUNDABLE TO RESIDENTS ONLY FROM REOCCUPANCY PROCEEDS OF A CONTRACT HOLDER'S UNIT 91

ACCOUNTING FOR NONREFUNDABLE ADVANCE FEES 91

ACCOUNTING FOR THE OBLIGATION TO PROVIDE FUTURE SERVICES AND THE USE OF FACILITIES TO CURRENT RESIDENTS 92

ACCOUNTING FOR THE COSTS OF ACQUIRING INITIAL CONTINUING-CARE CONTRACTS 93

FINANCIAL STATEMENTS 93

AUDITING 93
Exhibit 14.1 Accounting for Refundable and Nonrefundable Advance Fees 94

Page

Exhibit 14.2 Accounting for the Obligation to Provide Future Services and the Use of Facilities to Current Residents 96
Exhibit 14.3 Auditing Considerations 99

Appendix — ILLUSTRATIVE FINANCIAL STATEMENTS 101
Not-for-Profit Hospital 103
Governmental Hospital 119
Nursing Home 133
Continuing Care Retirement Community 142
Home Health Agency 151
Health Maintenance Organization 160
Ambulatory Care Organization 168

GLOSSARY 175

PREFACE

PURPOSE

This American Institute of Certified Public Accountants (AICPA) Audit and Accounting Guide has been prepared to assist health care organizations in preparing financial statements in conformity with generally accepted accounting principles (GAAP) and to assist independent auditors in auditing and reporting on those financial statements.

APPLICABILITY

This Guide applies to organizations whose principal operations consist of providing or agreeing to provide health care services and that derive all or almost all of their revenues from the sale of goods or services; it also applies to organizations whose primary activities are the planning, organization, and oversight of such organizations, such as parent or holding companies of health care providers. This Guide applies to health care organizations that are either (a) investor-owned businesses or (b) not-for-profit organizations that have no ownership interest and are essentially self-sustaining from fees charged for goods and services, as defined in Financial Accounting Standards Board (FASB) Statement of Financial Accounting Concepts No. 4, *Objectives of Financial Reporting by Nonbusiness Organizations*, paragraph 8,[1] or (c) governmental.

This Guide applies to the following types of health care organizations:

- Clinics, medical group practices, individual practice associations, individual practitioners, emergency care facilities, laboratories, surgery centers, and other ambulatory care organizations
- Continuing care retirement communities (CCRCs)
- Health maintenance organizations (HMOs) and similar prepaid health care plans
- Home health agencies
- Hospitals
- Nursing homes that provide skilled, intermediate, and less intensive levels of health care
- Drug and alcohol rehabilitation centers and other rehabilitation facilities

This Guide also applies to integrated delivery systems that include one or more of the above types of organizations.

This Guide does not apply to voluntary health and welfare organizations, as defined in FASB Statement No. 117, *Financial Statements of Not-for-Profit Organizations*. These organizations should follow the AICPA Audit and Accounting Guide *Not-for-Profit Organizations*.[2] Related fund-raising foundations that meet the definition of a *not-for-profit organization* given in FASB

---

[1] See paragraph 1.3 of this Guide.

[2] The AICPA released an exposure draft of the proposed Audit and Accounting Guide *Not-for-Profit Organizations* on April 14, 1995.

Statement No. 117 also should follow the AICPA Audit and Accounting Guide *Not-for-Profit Organizations*.

When separate financial statements are issued for a state or local governmental health care organization that uses enterprise fund accounting and reporting, the accounting, reporting, and disclosure requirements set forth in this Guide and by pronouncements of the Governmental Accounting Standards Board (GASB) apply. (See chapter 1 for a discussion of the application of GAAP.)

LIMITATIONS

This Guide does not discuss the application of all GAAP and all generally accepted auditing standards (GAAS) that are relevant to the preparation and audit of financial statements of health care organizations. The Guide is directed primarily to those aspects of the preparation and audit of health care organizations' financial statements that are unique to those organizations or are considered particularly significant to them.

IMPACT ON OTHER LITERATURE

This Guide incorporates certain provisions of FASB Statements No. 116, *Accounting for Contributions Received and Contributions Made,* and No. 117. Not all guidance that is included in those Statements, however, is incorporated, repeated, or summarized in this Guide. Accordingly, those Statements should be read in conjunction with this Guide.

This Guide supersedes the AICPA Audit and Accounting Guide *Audits of Providers of Health Care Services.* It also incorporates and supersedes the following AICPA Statements of Position (SOPs):

- SOP 89-5, *Financial Accounting and Reporting by Providers of Prepaid Health Care Services*
- SOP 90-8, *Financial Accounting and Reporting by Continuing Care Retirement Communities*

EFFECTIVE DATE AND TRANSITION

The provisions of this Guide are effective for financial statements for periods beginning after June 15, 1995, except for organizations with less than $5 million in total assets and less than $1 million in annual expenses. For those organizations, the effective date is fiscal years beginning after December 15, 1995. Earlier application is permitted.

Unless this Guide is applied retroactively under the provisions of the following paragraph, the effect of initially applying this Guide should be reported as the effect of a change in accounting principle, in a manner similar to the cumulative effect of a change in accounting principle (Accounting Principles Board [APB] Opinion No. 20, *Accounting Changes*, paragraph 19). The amount of the cumulative effect should be based on a retroactive computation. A not-for-profit health care organization should report the cumulative effect of a change in accounting on each class of net assets. The cumulative effect of a change in accounting on unrestricted net assets should be reflected in the statement of operations after the captions "operating income" and "extraordinary items" (if any) but before the caption "change in unrestricted net assets." The cumulative effect on temporarily and permanently restricted net assets should be reflected in the statement of changes in net assets. An investor-owned business should report the amount of

the cumulative effect in the income statement between the captions "extraordinary items" and "net income."

A not-for-profit health care organization may apply this Guide retroactively by restating the opening net assets for the earliest year presented or for the year this Guide is first applied if no prior years are presented. In the period in which this Guide is first applied, that organization should disclose the nature of any restatement and its effect on the change in net assets for each period presented. An investor-owned business should account for any restatement as a change in accounting principle applied retroactively (APB Opinion 20, paragraphs 27 and 28).

Chapter 1

UNIQUE CONSIDERATIONS OF HEALTH CARE ORGANIZATIONS

OVERVIEW

1.1 Financial statements of health care organizations should be prepared in conformity with generally accepted accounting principles (GAAP). Statement on Auditing Standards (SAS) No. 69, *The Meaning of* Present Fairly in Conformity With Generally Accepted Accounting Principles *in the Independent Auditor's Report* (AICPA, *Professional Standards*, vol. 1, AU sec. 411), provides the GAAP hierarchy summary for both nongovernmental and governmental organizations.[1]

CLASSIFICATION OF HEALTH CARE ORGANIZATIONS

1.2 Health care enterprises usually can be classified into the following categories on the basis of their operating characteristics:

a. *Investor-Owned Health Care Enterprises*. These are owned by investors or others with a private equity interest and provide goods or services with the objective of making a profit.

b. *Not-for-Profit, Business-Oriented Organizations*. These are characterized by no ownership interests and essentially are self-sustaining from fees charged for goods and services. The fees charged by such organizations generally are intended to help the organization maintain its self-sustaining status rather than to maximize profits for the owner's benefit. Such organizations often are exempt from federal income taxes and may receive contributions of relatively small amounts from resource providers that do not expect commensurate or proportionate pecuniary return.

---

[1] Governmental Accounting Standards Board (GASB) Statement No. 20, *Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting*, paragraph 6, provides interim guidance for governmental proprietary activities, such as governmental health care enterprises, until the GASB completes its project on business-type activities. Governmental proprietary activities should apply all applicable GASB pronouncements as well as any Financial Accounting Standards Board (FASB) Statements and Interpretations, Accounting Principles Board (APB) Opinions, and Accounting Research Bulletins (ARBs) issued on or before November 30, 1989, that do not conflict with or contradict GASB pronouncements. Furthermore, paragraph 7 of GASB Statement No. 20 provides that governmental proprietary activities *may* apply all FASB Statements and Interpretations issued after November 30, 1989, that do not conflict with or contradict GASB pronouncements. Entities that choose to apply these "new" FASB pronouncements must apply them on an "all or none" basis (that is, they may not select which pronouncements to apply). The requirements set forth in this guide for governmental health care enterprises generally apply to such enterprises that apply paragraph 7 of GASB Statement No. 20. The GASB has issued an Exposure Draft (ED) of a proposed Statement, *The Use of Not-for-Profit Accounting and Financial Reporting Principles by Governmental Entities*. The proposed Statement would provide that proprietary activities that apply the provisions of paragraph 7 of GASB Statement No. 20 should apply only those "new" FASB Statements and Interpretations that are developed for business enterprises, rather than those whose provisions are limited to not-for-profit organizations or address issues primarily concerning such organizations (such as FASB Statement No. 116, *Accounting for Contributions Received and Contributions Made*, and No. 117, *Finanical Statements of Not-for-Profit Organizations*).

c. *Governmental Health Care Organizations*. These are legally created public corporations (or bodies corporate and politic) or organizations otherwise controlled by a state or local governmental unit. These organizations may be characterized by one or more of the following: the power to tax, the power to issue tax-exempt debt directly, popular election of officers, appointment or approval of a controlling majority of officers by state or local governmental officials, or the ability to be dissolved by the creating government without compensation for the net assets assumed by the government. These enterprises are referred to as *governmental health care organizations* throughout this guide.

d. *Not-for-Profit, Nonbusiness-Oriented Organizations*. These are voluntary health and welfare organizations (see the Glossary) as defined in Financial Accounting Standards Board (FASB) Statement No. 117, *Finanical Statements of Not-for-Profit Organizations*. Such organizations are within the scope of the AICPA Audit and Accounting Guide *Audits of Not-for-Profit Organizations* rather than this guide.

FINANCIAL REPORTING OF HEALTH CARE ORGANIZATIONS

1.3 The nature of the organization and its operating structure have a significant effect on the needs of financial statement users. According to FASB Statement of Financial Accounting Concepts (Concepts Statement) No. 4, *Objectives of Financial Reporting by Nonbusiness Organizations*, paragraph 8:

> Some organizations have no ownership interests but are essentially self-sustaining from fees they charge for goods and services. Examples are those private nonprofit hospitals . . . that may receive relatively small amounts of contributions and grants but finance their capital needs largely from the proceeds of debt issues and their operating needs largely from service charges rather than from private philanthropy or governmental grants. As a result, assessment of amounts, timing, and uncertainty of cash flows becomes the dominant interest of their creditors and other resource providers and profitability becomes an important indicator of performance. Consequently, the objectives of FASB Concepts Statement No. 1 [*Objectives of Financial Reporting by Business Enterprises*] may be more appropriate for those organizations. [Footnote reference omitted.]

1.4 The financial reporting for not-for-profit, business-oriented organizations and investor-owned health care enterprises generally is consistent except for transactions that clearly are not applicable. For example, not-for-profit, business organizations would have nothing to report for shareholders' equity. On the other hand, investor-owned health care enterprises typically would not have anything to report for contributions. Reporting for governmental health care organizations also is consistent except for unique matters peculiar to governmental entities.

1.5 The basic financial statements of health care organizations generally consist of a balance sheet, a statement of operations, a statement of changes in equity (or net assets), a statement of cash flows, and notes to the financial statements. The statement of operations for not-for-profit organizations reports all changes in unrestricted net assets for the period. Illustrative financial statements are included in the Appendix.

1.6 FASB Statement No. 117[2] requires not-for-profit organizations to provide information about the liquidity of assets and liabilities in the balance sheet. Health care organizations should classify assets and liabilities as current and noncurrent. However, rather than presenting a classified balance sheet, a continuing care retirement community (CCRC) instead may sequence assets according to their nearness of conversion to cash and may sequence liabilities according to the nearness of the maturity and resulting use of cash.

1.7 FASB Statement No. 95, *Statement of Cash Flows*, and Governmental Accounting Standards Board (GASB) Statement No. 9, *Reporting Cash Flows of Proprietary and Nonexpendable Trust Funds and Governmental Entities That Use Proprietary Fund Accounting*, established standards for cash flow reporting for investor-owned organizations and governmental entities, respectively. FASB Statement No. 95 was amended by FASB Statement No. 117 to include not-for-profit organizations. The statement of cash flows may be prepared using the direct or indirect method of reporting cash flows.

1.8 A health care organization may be a part of another organization, such as a general-purpose government, a medical school or a university, or a subsidiary of a corporation. The recommendations in this guide apply to the separate financial statements of these organizations as defined above. Therefore, when separate financial statements are prepared for a governmental health care organization that uses enterprise fund accounting and reporting, the accounting and disclosure requirements set forth by GASB pronouncements and this guide apply. The requirements in this guide generally apply to governmental health care organizations that apply paragraph 7 of GASB Statement No. 20, *Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting*. (See footnote 1.)

REVENUE FROM HEALTH CARE SERVICES

1.9 In general, gross service revenue is recorded in the accounting records on an accrual basis at the provider's established rates, regardless of whether the health care organization expects to collect that amount. Provisions recognizing contractual adjustments and other adjustments (see examples in paragraph 5.2) are recorded on an accrual basis and deducted from gross service revenue to determine net service revenue. For financial reporting purposes, gross revenue does not include charity care (see discussion in paragraph 10.2) and service revenue is reported net of contractual and other adjustments in the statement of operations. Accounting and auditing issues related to receivables and revenue from health care services are discussed in chapters 5 and 10.

1.10 In many cases, revenues are generated as a result of an agreement to provide health care rather than from the actual provision of services. For example, an integrated delivery system may agree to provide all health-related services for a specified group residing within its primary service area for an agreed-upon amount per member per month (PMPM). These revenues are premium revenues, not patient service revenues, since they are earned by agreeing to provide care, regardless of whether services actually are rendered.

---

[2] This pronouncement may not be applicable to governmental health care enterprises. (See footnote 1.)

THIRD-PARTY PAYOR CONSIDERATIONS

1.11 Some third-party payors retrospectively determine final amounts reimbursable for services rendered to their beneficiaries based on allowable costs. These payors reimburse the health care organization 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 affect materially the health care organization's financial position and results of operations. Consequently, a reasonable estimate of the amount receivable from or payable to these payors should be made in the same period that the related services are rendered. Accounting and auditing issues related to receivables from third parties are discussed in chapter 5.

CLASSIFICATION AND REPORTING OF NET ASSETS

1.12 Currently, many not-for-profit and governmental health care organizations use fund accounting for purposes of internal recordkeeping and managerial control. Many individual funds may be established by an organization to help in monitoring compliance with donor or grantor restrictions due to the fiduciary accountability associated with these resources. Each fund consists of a self-balancing group of accounts composed of assets, liabilities, and net assets. Consistent with FASB Concepts Statement No. 6, *Elements of Financial Statements*, FASB Statement No. 117 concluded that although some not-for-profit organizations may choose to classify assets and liabilities into fund groups, information about those groupings is not a necessary part of general-purpose external financial reporting. Although FASB Statement No. 117 does not preclude not-for-profit organizations from using fund accounting for internal recordkeeping and reporting, for purposes of external financial reporting each of the individual internal funds must be classified into one or more of the three broad classes of net assets: unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets. These classifications are related to the existence or absence of donor-imposed restrictions and are discussed in more detail in the following sections.

1.13 *Unrestricted Net Assets*. These represent the part of net assets that have not been externally restricted for identified purposes by donors and grantors. Unrestricted net assets also include assets whose use is contractually limited, such as—

- Proceeds of debt issues and funds of the health care organization deposited with a trustee and limited to use in accordance with the requirements of an indenture or a similar agreement.

- Other assets limited to use for identified purposes through an agreement between the health care organization and an outside party other than a donor or grantor. Examples include assets set aside under debt agreements, assets set aside under self-insurance (risk-retention) funding arrangements, and assets set aside to meet statutory reserve requirements (such as those required under state law for many health maintenance organizations [HMOs]).

1.14 Information about significant contractual limits (for example, debt covenants and self-insurance trusts) generally is disclosed in the notes to the financial statements. Similarly, information about self-imposed limits (such as board-designated assets) that is considered useful may be provided in the notes to the financial statements.

1.15 *Temporarily Restricted and Permanently Restricted Net Assets*. FASB Statement No. 117 defines two classes of donor-restricted net assets: temporarily restricted and permanently restricted. The distinction between these two types of restricted net assets is based on the nature of the donor's restriction. Temporarily restricted net assets are those donor-restricted net assets that can be used by the not-for-profit organization for their specified purpose once the donor's restriction is met. Generally, these restrictions are met either by the passage of time or by actions taken by the entity, such as use of the funds for the purpose intended. Permanently restricted net assets (for example, endowment funds) are those with donor restrictions that do not expire with the passage of time and cannot be removed by any actions taken by the entity. All donor-restricted net assets must be classified into one of these two broad categories for external reporting. Not-for-profit organizations may want to further classify temporarily and permanently restricted net assets into distinct groups that distinguish the nature or purpose of the donor's restriction.

1.16 It should be noted that donor restrictions generally relate to limitations on the use of net assets rather than the use of specific assets. According to FASB Concepts Statement No. 6, paragraphs 101 and 102:

> Restrictions impose responsibilities on management to ensure that the organization uses donated resources in the manner stipulated by resource providers. Sometimes donor-imposed restrictions limit an organization's ability to sell or exchange the particular asset received. For example, a donor may give a painting to a museum stipulating that it must be publicly displayed, properly maintained, and never sold.
>
> More commonly, donors' stipulations permit the organization to pool the donated assets with other assets and to sell or exchange the donated assets for other suitable assets as long as the economic benefits of the donated assets are not consumed or used for a purpose that does not comply with the stipulation. For example, a donor may contribute 100 shares of Security A to an organization's endowment, thereby requiring that the amount of the gift be retained permanently but not requiring that the specified shares be held indefinitely. Thus, permanently restricted net assets and temporarily restricted net assets generally refer to amounts of net assets that are restricted by donor-imposed limits, not to specific assets.

1.17 A not-for-profit organization can report separate line items within any of the three classes of net assets either on the face of the financial statements or in the notes to further distinguish the nature of donor restrictions within that category of net assets. For example, a health care organization may want to disclose the amount of temporarily restricted net assets restricted for a specific purpose such as indigent care. Further examples are provided in paragraph 15 of FASB Statement No. 117. An organization's internal fund accounting can be used to account for these different types of resources within a specific class of net assets.

HEALTH CARE CONTRACTING

1.18 Contracts between a health care provider and a payor based on anything other than full charges requires the provider to accept some financial risk. The nature and degree of risk for the provider varies depending on the contract terms (for example, the definition of the unit of service or the basis for payment). In planning the audit of the health care provider, the auditor considers the audit risk associated with the entity's health care contracts. For example, contracts with payments for services based on a discount from the provider's established rates may have different risks than contracts with payments for services based on a capitated arrangement.

1.19 Generally, capitation payments are made at the beginning of each month and obligate the provider to render covered services during the month. Revenue is earned as a result of agreeing to provide services to qualified beneficiaries and not as a result of actually providing the care. If the provider's accounting system records patient charges and establishes patient receivables as services are rendered, appropriate valuation allowances or adjustments should be recorded so only the amount of contract revenue is recorded.

1.20 A capitation contract may obligate the provider to assume the risk of physician referrals and other outside services. In this case, a liability for unpaid claims, including incurred but not reported claims, should be established. A lag analysis may be helpful in estimating the liability.

1.21 In addition to the capitation payments, the amount of contract revenue may be affected by factors such as reinsurance recoveries, deductibles, coinsurance, and risk pool adjustments. Risk pool adjustments may be based on factors such as utilization or cost targets.

1.22 Sometimes health care providers enter preferred provider arrangements with self-insured employers whereby the provider guarantees that the employer's health care cost will not increase over a specified amount or percentage. In substance, these providers may have provided aggregate stop-loss insurance to the self-insured employer, and a material liability to the provider may exist. FASB Statement No. 5, *Accounting for Contingencies*, provides guidance on accounting for these contingencies.

Chapter 2

GENERAL AUDITING CONSIDERATIONS

SCOPE OF THE ENGAGEMENT

2.1 For each audit engagement, the independent auditor and the health care organization should establish a clear understanding, preferably in writing, of the scope of audit services to be performed and the independent auditor's responsibilities regarding accompanying information. In addition to reporting on the entity's basic financial statements, the independent auditor may be asked to report on the following special reports: (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 auditing procedures to be performed and the type of reports to be issued are based on the scope of services required by the entity.

PLANNING THE AUDIT

2.2 The nature, timing, and extent of planning usually vary with the size and complexity of the entity, as well as with the independent auditor's experience with the entity and with the industry. SAS No. 22, *Planning and Supervision* (AICPA, *Professional Standards*, vol. 1, AU sec. 311), contains guidance on planning an audit in accordance with generally accepted auditing standards (GAAS).

2.3 The independent auditor's work in forming an opinion on financial statements consists of obtaining and evaluating evidential matter regarding management's assertions. Assertions are representations by management that are embodied in the financial statements. They can be either explicit or implicit and can be classified according to the following broad categories: existence and occurrence, completeness, rights and obligations, valuation and allocation, and presentation and disclosure.

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

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

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

INHERENT RISK

2.7 In determining the scope of audit procedures to be performed, the independent auditor should be aware of certain aspects of the health care organization's operations that are usually subject to higher or lower levels of inherent risk. SAS No. 47, *Audit Risk and Materiality in Conducting an Audit* (AICPA, *Professional Standards*, vol. 1, AU sec. 312), provides guidance on the consideration of audit risk and materiality when planning and performing an audit of financial statements.

2.8 In many health care organizations, certain accounts typically (1) will have a low volume of transactions, (2) will consist of transactions that are not complex, and (3) do not require the use of significant accounting estimates. Accounts such as inventories, marketable securities, assets whose use is externally limited, property and equipment, long-term debt, and equity frequently have these characteristics and may allow the auditor to assess inherent risk as being at a relatively low level. However, in certain circumstances, such as investments in complex derivative financial instruments that are marketable securities, inherent risk may be higher. The auditor should use professional judgment in evaluating the factors relevant to assessments of inherent risk.

2.9 Because of the large monetary amounts and the complexity of determining health care service revenue and receivables, there are risks associated with health care service revenue recognition and the valuation of the related receivables. A significant portion of services usually is paid for by third parties such as Medicare, Medicaid, and various health insurance carriers under statutory provisions or other arrangements in amounts that can be significantly different from, and frequently less than, the entity's established rates.

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

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

2.12 The risk of errors, irregularities, or illegal acts by clients is present in all audit engagements. SAS No. 53, *The Auditor's Responsibility to Detect and Report Errors and Irregularities* (AICPA, *Professional Standards*, vol. 1, AU sec. 316), and SAS No. 54, *Illegal Acts by Clients* (AICPA, *Professional Standards*, vol. 1, AU sec. 317), describe the auditor's responsibilities for detecting these matters in an audit of financial statements. They also describe the auditor's responsibilities for communicating detected errors, irregularities, and illegal acts to parties within and external to the entity.

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

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

b. Management places undue emphasis on meeting earnings projections.

c. Management's reputation in the business community is poor.

d. Management compensation is influenced by earnings.

e. Management lacks experience in dealing with complex matters such as third-party payment regulations or contracts and medical malpractice risks.

2.14 The following operating and industry characteristics also may be considered in assessing risk:

a. The profitability of the entity is significantly less than the industry average or inconsistent with the industry.

b. Operating results are significantly less than projected results.

c. Market share is decreasing.

d. Decision making is decentralized and lacks adequate monitoring.

e. Internal or external matters exist that raise substantial doubt about the entity's ability to continue as a going concern.

2.15 In assessing risk, the following engagement characteristics also may be considered:

a. Many contentious or difficult accounting issues are present.

b. The number and complexity of third-party payor contracts have increased.

c. Final settlements with third-party payors have resulted in substantial revisions to prior estimates.

d. The number or amount of adjustments in prior periods has been significant.

INTERNAL CONTROL STRUCTURE

2.16 SAS No. 55, *Consideration of the Internal Control Structure in a Financial Statement Audit* (AICPA, *Professional Standards*, vol. 1, AU sec. 319), describes the elements of an internal control structure and explains how an independent auditor should consider the internal control structure in planning and performing an audit. An entity's internal control structure consists of three elements: control environment, accounting system, and control procedures.

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

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

ANALYTICAL PROCEDURES

2.19 SAS No. 56, *Analytical Procedures* (AICPA, *Professional Standards*, vol. 1, AU sec. 329), provides guidance on the use of analytical procedures and requires their use in the planning and overall review stages of all audits. For planning purposes, these procedures should focus on (a) enhancing the independent auditor's understanding of the client's business and the transactions and events that have occurred since the last audit date and (b) identifying areas that may represent specific risks relevant to the audit. Thus, the objective of the procedures is to identify such things as the existence of unusual transactions and events, as well as amounts, ratios, and trends that might indicate matters that have financial statement and audit planning ramifications. For overall review purposes, these procedures should focus on considering the adequacy of the evidence gathered in response to unusual or unexpected balances or relationships. The objective of the procedures is to assist the auditor in assessing the conclusions reached and evaluating the overall financial statement presentation. Analytical procedures also may be used as substantive tests to identify potential misstatements. These procedures focus on comparing actual balances with expected balances and investigating and evaluating significant differences from the balances expected.

2.20 Examples of sources of information for developing expectations include prior-period financial information, budgets, and health care financial and statistical ratios. Additional information is available from the Center for Healthcare Industry Performance Studies' (CHIPS) Financial Analysis Service, which is published annually, as well as other health care industry associations.

2.21 Following are examples of analytical procedures the independent auditor may find useful:

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

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

ACCOUNTING ESTIMATES

2.22 In determining the scope of audit procedures to be performed, the independent auditor should recognize that certain areas of health care organization operations require accounting estimates that may be material in the preparation and presentation of financial statements. Statement of Position (SOP) 94-6, *Disclosure of Certain Significant Risks and Uncertainties*, requires entities to include in their financial statements information about the use of estimates in the preparation of financial statements. In addition, if certain specified disclosure criteria are met, the SOP requires entities to include disclosures about certain significant estimates in their financial statements. (SOP 94-6 is effective for financial statements issued for fiscal years ending after December 15, 1995.) SAS No. 57, *Auditing Accounting Estimates* (AICPA, *Professional Standards*, vol. 1, AU sec. 342), provides guidance on obtaining and evaluating sufficient competent evidential matter to support significant accounting estimates in an audit of financial statements in accordance with GAAS.

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

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

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

- The provision for third-party payor contractual adjustments and allowances and the provision for estimated receivables and payables for final settlements with those payors
- The provision for uncollectible accounts
- Accruals for uninsured medical malpractice claims
- Accruals for obligations under continuing care contracts
- Accruals by providers of prepaid health care services for IBNR costs

INDIVIDUAL PRACTICE ASSOCIATIONS

2.26 In planning the audit of an individual practice association (IPA), the auditor usually considers the following matters:

- The size of a typical IPA accounting department and business office often is not large enough to result in effective segregation of duties. However, most IPAs have an active office manager who can exercise a high degree of influence and control over the operations.

- Physician compensation arrangements often use incentives or other features with complicated methodologies and formulas.

- Contracts with managed care plans, often with capitated payment and risk pool settlement terms, frequently represent a significant amount of revenue for the IPA.

2.27 IPAs with capitated contracts accrue costs when the services are rendered, including cost estimates of IBNR claims. The IBNR accrual includes an estimate of the costs of services for which the IPA is responsible, including referrals outside the IPA. Risk pool settlements should be accrued during the contract period based on relevant factors, such as experience to date.

OTHER PLANNING CONSIDERATIONS

2.28 In planning the audit, the independent auditor also should consider--

- Matters relating to the entity's business and the health care industry.

- Financial statement items likely to require adjustment.

- Conditions that might require extension or modification of audit tests (such as the existence of related party transactions) or the existence of uninsured malpractice risks.

- The entity's experience with payment denials and other matters subject to review by medical review organizations.

- The nature of reports expected to be rendered. Examples include reports 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, and other special reports.

2.29 Planning procedures usually include reviewing the independent auditor's files relating to the entity and holding discussions with audit personnel and the personnel of the entity. Examples of these procedures include the following:

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

- Review the minutes of meetings of the governing board of directors and board committees.

- Review the relationship of affiliated organizations to the health care organization and determine the extent to which their financial information should be included in the financial statements of the entity. (See the related discussion in chapter 11.)

- Review the status of unsettled cost (reimbursement) reports for prior periods filed with third-party payors.

- Discuss matters that may affect the audit with the firm's personnel responsible for any nonaudit services to the entity.

- Identify situations for which accounting estimates are required and relevant factors that may affect those estimates.

- Inquire about current business developments affecting the entity.

- Read the current year's interim financial statements and 10-Q forms.

- Review periodic reports to third-party payors or other regulatory bodies.

- Discuss the nature, scope, and timing of the engagement with the entity's management, board of directors, or audit committee.

- Consider the effects of all applicable accounting and auditing pronouncements, particularly recent pronouncements.

- 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.

2.30 The independent auditor may find it helpful to maintain a permanent file that includes copies of the following documents relating to the health care organization:

a. Articles of incorporation

b. Bylaws

c. Chart of accounts

d. Organization chart

e. Specific documents concerning restrictions on donor gifts and bequests

f. Contracts and agreements, including leases, agreements with physicians, agreements with third-party payors, and agreements with affiliated organizations

g. Description of the internal control structure (that is, the control environment, accounting system, and control procedures)

h. Loan agreements, bond indentures, and other debt instruments

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

2.32 The independent auditor intending to use audit-sampling procedures should refer to SAS No. 39, *Audit Sampling* (AICPA, *Professional Standards*, vol. 1, AU sec. 350), and to the Audit and Accounting Guide *Audit Sampling* when planning the work to be done.

2.33 If the health care organization has an internal audit function, the independent auditor should also refer to SAS No. 65, *The Auditor's Consideration of the Internal Audit Function in an Audit of Financial Statements* (AICPA, *Professional Standards*, vol. 1, AU sec. 322).

TRANSACTIONS PROCESSED BY SERVICE ORGANIZATIONS

2.34 Providers of health care services may use outside service organizations to perform tasks requiring specialized skills or equipment. Services provided by such organizations include either executing transactions and maintaining the related accountability or recording transactions and processing related data or both. Examples of service organizations used by health care organizations include the following:

- Bank trust departments that invest and hold assets whose use is limited
- Electronic data processing (EDP) service bureaus that process payroll
- Billing entities that prepare reimbursement claims to insurers and other third parties
- Administrators of employee benefit plans who process and pay benefit claims and maintain participant records

2.35 SAS No. 55 states that the auditor should obtain an understanding of each of the elements of the internal control structure sufficient to plan the audit and to assess control risk. SAS No. 70, *Reports on the Processing of Transactions by Service Organizations* (AICPA, *Professional Standards*, vol. 1, AU sec. 324), explains the considerations an auditor should make in fulfilling this responsibility when an entity uses a service organization to process transactions. The auditor of a health care organization should determine whether a service organization is used and obtain an understanding of the service organization's control structure regarding such transactions to the extent necessary to plan the audit. This understanding may be obtained by one or any combination of the following:

a. Considering information such as user manuals available at the health care organization

b. Considering information obtained directly from the service organization in response to a request from the health care organization

c. Obtaining and considering a service auditor's report

2.36 The auditor uses the understanding obtained to assess control risk. In some cases, the auditor may conclude that it would be efficient to perform procedures to obtain evidential matter about the operating effectiveness of certain control policies and procedures involving transactions processed by the service organization to provide a basis for assessing control risk below the maximum. Procedures to evaluate operating effectiveness include one or any combination of--

- Performing tests of controls at the health care organization.

- Performing tests of controls at the service organization.

- Obtaining a service auditor's report that describes the results of tests of operating effectiveness performed by the service auditor.

OTHER AUDIT CONSIDERATIONS

Illegal Acts

2.37 The Social Security Act provides for criminal penalties for individuals or entities that offer, pay, solicit, or receive remuneration to induce business that is reimbursed under Medicare or state health care programs. The types of remuneration covered by the Medicare Anti-Kickback Statute include, with certain exceptions, kickbacks, bribes, and rebates made directly or indirectly, overtly or covertly, and in cash or in kind. In addition, prohibited conduct includes not only remuneration intended to induce referrals or patients but also remuneration intended to induce the purchasing, leasing, ordering, or arranging for any good, facility, service, or item paid for by Medicare or state health care programs. In addition, fraudulent activities may exist that are unrelated to Medicare or state programs, such as fraudulent billing and admitting practices.

2.38 The auditor's procedures will vary based on his or her assessment of the risk of material misstatement resulting from such illegal acts. SAS No. 54 states that the auditor should plan and perform the audit to provide reasonable assurance of detecting illegal acts having a direct and material effect on the determination of financial statement amounts. SAS No. 54 also notes that an audit in accordance with GAAS does not include audit procedures specifically designed to detect illegal acts that have only an indirect effect on the financial statements (for example, illegal acts that have a material effect as the result of fines or penalties that may be imposed on the entity) and provides guidance on the auditor's responsibilities when specific information concerning the possible existence of this type of illegal act comes to the auditor's attention.

2.39 Examples of laws and regulations that are generally recognized by auditors to have a direct and material effect on the determination of amounts in financial statements of health care organizations include tax laws affecting tax accruals and tax expense as well as Medicare and Medicaid laws directly affecting the amount of revenue recognized during the accounting period (such as those concerning the submission of bills for fictitious patients).

2.40 HMOs also may be affected by many other laws and regulations such as those related to Medicare and Medicaid fraud and abuse, securities trading, occupational safety and health, food and drug administration, environmental protection, equal employment opportunities, and price-fixing or other antitrust violations. Generally, these laws and regulations relate more to an entity's operating aspects than to its financial and accounting aspects, and their financial statement effect is only indirect. An auditor ordinarily does not have sufficient basis for recognizing possible

violations of such laws and regulations. Their indirect effect is normally the result of the need to disclose a contingent liability because of the allegation or determination of illegality. For example, patients may be obtained based on illegal arrangements with physicians or other providers. While the direct effects of the services rendered may be recorded appropriately, their indirect effects, the possible contingent liability for violating Medicare and Medicaid fraud and abuse statutes, may not be appropriately disclosed. Even when violations of such laws and regulations can have consequences material to the financial statements, auditors may not become aware of the existence of the illegal act unless he or she is informed by the client, or there is evidence of a governmental agency investigation or enforcement proceeding in the records, documents, or other information normally inspected in an audit of financial statements.

2.41 Whether an act is, in fact, illegal is a determination that is normally beyond the auditor's professional competence. The auditor's training, experience, and understanding of the client and the industry may provide a basis for recognizing that some acts coming to the auditor's attention may be illegal. However, determining whether a particular client act is illegal generally would be based on the advice of an informed expert qualified to practice law or may have to await final determination by a court of law. For example, determining whether admitting a patient or providing a service is medically necessary or whether a particular procedure or device was properly approved is not within the auditor's professional competence.

Use of a Specialist

2.42 SAS No. 73, *Using the Work of a Specialist* (AICPA, *Professional Standards*, vol. 1, AU sec. 336), provides guidance to the auditor who uses the work of a specialist in performing the audit of a health care organization's financial statements. Guidance is provided on deciding when to use a specialist, the auditor's responsibilities for evaluating the qualifications and the work of the specialist, and using the findings of the specialist. The Statement requires the auditor to evaluate the relationship of the specialist to the client and states that the auditor should perform additional procedures if the auditor concludes that the objectivity of the specialist may be impaired by such a relationship.

Going-Concern Considerations

2.43 SAS No. 59, *The Auditor's Consideration of an Entity's Ability to Continue as a Going Concern* (AICPA, *Professional Standards*, vol. 1, AU sec. 341), provides guidance to the independent auditor conducting an audit on how to evaluate whether there is substantial doubt about the entity's ability to continue as a going concern. Continuation of an entity as a going concern is assumed in financial reporting in the absence of significant information to the contrary. Ordinarily, information that significantly contradicts the going-concern assumption relates to the entity's inability to continue to meet its obligations as they become due without substantial disposition of assets outside the ordinary course of business, restructuring of debt, externally forced revision of its operations, or similar actions. SAS No. 59 states that the independent auditor has a responsibility to evaluate whether there is substantial doubt about the entity's ability to continue as a going concern for a reasonable period of time, not to exceed one year beyond the date of the financial statements being audited.

2.44 Noncompliance with donor-imposed restrictions should be disclosed if there is a reasonable possibility that a material contingent liability has been incurred at the date of the financial statements or there is at least a reasonable possibility that the noncompliance could lead to a material loss of revenue or could cause an entity to be unable to continue as a going concern. If

the noncompliance results from an organization's failure to maintain an appropriate composition of assets in amounts needed to comply with all donor restrictions, the amounts and circumstances should be disclosed.

COMMUNICATION

Communication of Matters Related to the Internal Control Structure

2.45 SAS No. 60, *Communication of Internal Control Structure Related Matters Noted in an Audit* (AICPA, *Professional Standards*, vol. 1, AU sec. 325), provides guidance in identifying and reporting conditions related to an entity's internal control structure that are observed during an audit of the financial statements. It is contemplated that the communication generally would be to the audit committee or, in organizations that do not have an audit committee, to those with an equivalent level of authority and responsibility such as the board of directors, the owner in an owner-managed enterprise, or the individuals who engaged the independent auditor. Conditions noted by the independent auditor that are considered reportable under SAS No. 60 should be reported, preferably in writing. If information is communicated orally, the independent auditor should document the communication by appropriate memoranda or notations in the working papers.

Communication With Audit Committees

2.46 SAS No. 61, *Communication With Audit Committees* (AICPA, *Professional Standards*, vol. 1, AU sec. 380), establishes a requirement for the independent auditor to determine that certain matters related to the conduct of an audit are communicated to those with responsibility for oversight of the financial reporting process. The communications required by SAS No. 61 are applicable to (a) entities that either have an audit committee or otherwise have formally designated oversight of the financial reporting process to a group equivalent to an audit committee (such as a finance committee or a budget committee) and (b) all SEC engagements as defined in SAS No. 61. In addition, communication with the audit committee or its equivalent by the independent auditor on certain specified matters when they arise in the conduct of an audit is required by other standards, including SAS No. 53 and SAS No. 54.

CLIENT REPRESENTATIONS

2.47 SAS No. 19, *Client Representations* (AICPA, *Professional Standards*, vol. 1, AU sec. 333), provides guidance to the independent auditor about the representations to be obtained from management as part of an audit. The specific written representations to be obtained depend on the circumstances of the engagement and the nature and basis of presentation of the financial statements. Paragraph 4 of SAS No. 19 lists matters ordinarily included in management's representation letter. Independent auditors of health care organizations also might obtain representations, if applicable, of the following:

- The health care organization is in compliance with the provisions of Internal Revenue Code (IRC) sec. 501(c)(3) and is exempt from federal income tax under IRC sec. 501(a), as evidenced by a determination letter.

- Information returns have been filed on a timely basis.

- Provision has been made, when material, for estimated retroactive adjustments by third-party payors under reimbursement agreements.

- The health care organization is in compliance with bond indentures or other debt instruments.

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

- The health care organization is in compliance with contractual agreements, grants, and donor restrictions.

- The health care organization has maintained an appropriate composition of assets in amounts needed to comply with all donor restrictions.

- All assets and liabilities under the entity's control have been included in the financial statements.

- The internal controls over the receipt and recording of contributions received is adequate.

- Reclassifications between net asset classes is proper.

SINGLE AUDIT ACT AND RELATED AUDIT CONSIDERATIONS

2.48 An independent auditor may be engaged to audit the financial statements of a health care organization that receives financial assistance from a governmental agency in accordance with the Single Audit Act of 1984 and Office of Management and Budget (OMB) Circular A-128, *Audits of State and Local Governments*, OMB Circular A-133, *Audits of Institutions of Higher Education and Other Nonprofit Organizations*, or OMB Circular A-110, *Uniform Requirements for Grants to Universities, Hospitals, and Other Nonprofit Organizations*. Financial assistance may take the form of grants, contracts, loans, loan guarantees, property, cooperative agreements, interest subsidies, and insurance or direct appropriations.

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

2.50 OMB Circular A-133 establishes audit requirements for institutions of higher education and other nonprofit institutions that receive federal awards. Institutions covered by OMB Circular A-133 include colleges, universities, and their affiliated hospitals, as well as voluntary health and welfare organizations and other community-based organizations. The circular applies to institutions that receive $100,000 or more in federal awards. (The definition of *financial awards* given in this

circular is broader than the definition of *financial assistance* given both in the Single Audit Act of 1984 and OMB Circular A-128.) Institutions that receive at least $25,000 but less than $100,000 in federal financial assistance have the option of applying either the requirements of OMB Circular A-133 or separate program audit requirements. For institutions receiving less than $25,000, records must be kept and made available for review if requested, but the provisions of the circular do not apply. OMB Circular A-133 applies regardless of whether the institution receives awards directly from a federal agency or indirectly as a subrecipient. Recipients of federal awards that provide $25,000 or more annually to a subrecipient must determine whether the subrecipient has met the requirements of OMB Circular A-133.[1] OMB Circular A-133 does not apply automatically to all of the institutions it covers. Rather, its applicability depends on whether the federal agency granting the award to the institution has amended the regulations governing its programs to require audits performed in accordance with OMB Circular A-133. Until the requirements of OMB Circular A-133 are implemented by the federal agency or (in the case of a subrecipient) by the primary recipient, the audit requirements of Attachment F, *Grants and Agreements With Institutions of Higher Education, Hospitals, and Other Nonprofit Organizations*, to OMB Circular A-110 are still applicable.

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

2.52 SAS No. 74, *Compliance Auditing Considerations in Audits of Governmental Entities and Recipients of Governmental Financial Assistance* (AICPA, *Professional Standards*, vol. 1, AU sec. 801), provides general guidance on applying the requirements of SAS No. 53 and SAS No. 54 in audits of governmental entities and entities that receive governmental financial assistance. The Statement explains the requirements of the financial audit standards contained in *Government Auditing Standards* (the Yellow Book) issued by the Comptroller General of the United States and their relationship to GAAS. It also provides general guidance on testing compliance with requirements applicable to federal financial assistance programs. The Statement clarifies that the entity, rather than the independent auditor, is responsible for arranging for audits that meet all applicable requirements and provides guidance on communications the auditor should make upon becoming aware that the entity may be subject to an audit requirement that may not be satisfied by his or her engagement.

2.53 Specific guidance on audits in accordance with the Single Audit Act of 1984 and OMB Circular A-128 is provided in the AICPA Audit and Accounting Guide, *Audits of State and Local Governmental Units*. SOP 92-9, *Audits of Not-for-Profit Organizations Receiving Federal Awards*, provides specific guidance on audits in accordance with OMB Circular A-133.

---

[1] Medicare funds paid to a not-for-profit provider for health care services rendered to Medicare-eligible individuals are not considered federal financial assistance subject to OMB Circular A-133 audits.

Chapter 3

CASH AND CASH EQUIVALENTS

ACCOUNTING AND FINANCIAL REPORTING

3.1 Cash and cash equivalents should include all cash and highly liquid investments that are both (1) readily convertible to cash and (2) so near to maturity that they present insignificant risk of changes in value because of changes in interest rates, in accordance with FASB Statement No. 95, paragraph 8, and GASB Statement No. 9, paragraph 9. For fiduciary purposes, separate checking or savings accounts may be maintained for restricted donations. Such accounts, however, are not reported on a line separate from other cash and cash equivalents because donor restrictions generally relate to limitations on the use of net assets rather than on the use of specific assets.[1] However, cash and claims to cash that (a) are externally restricted as to withdrawal or use for other than current operations, (b) are externally designated for expenditure in the acquisition or construction of noncurrent assets, (c) are required to be segregated for the liquidation of long-term debts, or (d) are required by a donor-imposed restriction that limits their use to long-term purposes are reported separately and are excluded from cash and cash equivalents. If the form of the assets is not evident from the description on the balance sheet, the form of the assets should be disclosed in the notes to the financial statements. GASB Statement No. 9, paragraph 8, provides that a governmental health care enterprise's statement of cash flows should explain the change in all cash and cash equivalents, regardless of any restrictions on their use.

AGENCY FUNDS

3.2 Health care organizations may receive and hold assets owned by others under agency relationships; for example, they may perform billing and collection services for physicians. In accepting responsibility for those assets, an organization incurs a liability to the principal under the agency relationship to return the assets in the future or, if authorized, to disburse them to another party on behalf of the principal. Agency funds are included in unrestricted net assets. Transactions involving receipt and disbursement of agency funds are not included in the results of operations.

DISCLOSURES

3.3 If the provider has concentrations of credit risk related to financial instruments such as certificates of deposit or money market mutual funds, the disclosure requirements of FASB Statement No. 105, *Disclosure of Information about Financial Instruments with Off-Balance-Sheet*

---

[1] A columnar presentation that highlights the three classes of net assets (that is, permanently restricted, temporarily restricted, and unrestricted) is not precluded if the totals for the reporting entity as a whole are displayed.

Risk and Financial Instruments with Concentrations of Credit Risk,[2] should be followed. Examples of potential exposure to credit risk include funds deposited with a single financial institution in excess of Federal Deposit Insurance Corporation (FDIC) limits and investments in obligations that are not insured or guaranteed by the government. For governmental health care enterprises, GASB Statement No. 3, *Deposits with Financial Institutions, Investments (including Repurchase Agreements), and Reverse Repurchase Agreements*, requires certain disclosures about deposits, including credit risk classification of bank balances that are not entirely insured.

AUDITING

3.4 There are no unique auditing considerations with respect to cash and cash equivalents recorded by health care organizations.

---

[2] This pronouncement is not applicable to governmental health care enterprises that do not apply paragraph 7 of GASB Statement No. 20. (See footnote 1, chapter 1.)

Chapter 4

INVESTMENTS

For-profit health care enterprises are required to follow FASB Statement No. 115, *Accounting for Certain Investments in Debt and Equity Securities*. However, since not-for-profit organizations were excluded from the scope of FASB Statement No. 115 and since the existing audit guide for health care providers does not permit fair value accounting, not-for-profit health care organizations are not permitted to adopt FASB Statement No. 115. The FASB currently is developing guidance on accounting for investments for all not-for-profit organizations. This chapter of the guide will be revised upon issuance of a final FASB pronouncement and upon consultation with the GASB. Until that time, not-for-profit and certain governmental health care providers[1] should follow the guidance presented in this chapter.

INVESTMENTS OF NOT-FOR-PROFIT HEALTH CARE ORGANIZATIONS

4.1 Investments held by not-for-profit organizations are recorded initially at acquisition cost or, if received as a donation, at fair market value at the date of the gift, which thereafter is treated as cost. Investments are reported as current or noncurrent assets in conformity with GAAP.

FINANCIAL REPORTING

4.2 Investments are reported in the financial statements as follows:

a. Marketable securities include (1) equity securities, which are reported at the lower of aggregate cost or market value, and (2) debt securities, which are reported at amortized cost if there is the intent and ability to hold to maturity or at the lower of cost or market value otherwise.[2] If the market value is less than cost and the impairment in value is deemed to be other than temporary, the investments are reported at an amount not to exceed market value. Governmental health care organizations are required to account for and disclose certain information about their investments in accordance with GASB Statement No. 3 and GASB Technical Bulletin No. 94-1, *Disclosures about Derivatives and Similar Debt and Investment Transactions*.

b. Unconsolidated affiliates (for example, joint ventures) are accounted for in accordance with Accounting Principles Board (APB) Opinion No. 18, *The Equity Method of Accounting for Investments in Common Stock* (this also applies to for-profit health care organizations).

---

[1] Governmental health care providers that apply paragraph 7 of GASB Statement No. 20 are required to follow FASB Statement No. 115. All other governmental entities should follow the guidance for not-for-profit entities presented in this chapter.

[2] See AICPA, *Professional Standards*, AU sec. 9332, *Long-Term Investments: Auditing Interpretations of Section 332*.

c. Other securities (for example, real estate or oil and gas interests) are reported at amortized cost or at market value if an impairment in value is deemed to be other than temporary (this also applies to for-profit health care organizations).

4.3 Some noteworthy features related to accounting for investments of not-for-profit health care organizations are (a) accounting by net asset category to comply with and account for donor restrictions on investment practices and (b) valuation of marketable equity securities. In addition to imposing restrictions on the use of donations, donors may impose restrictions on investment practices and require separate accounting for principal and income transactions.

ACCOUNTING FOR CERTAIN MARKETABLE EQUITY SECURITIES BY NOT-FOR-PROFIT HEALTH CARE ORGANIZATIONS

4.4 Marketable equity security portfolios of not-for-profit health care organizations are reported at the lower of aggregate cost or market value, determined at the balance-sheet date. The amounts by which the aggregate cost of each portfolio exceeds market value are reported as valuation allowances unless the decline in market value is judged to be other than temporary (see paragraph 4.14).

4.5 Such marketable securities are grouped into separate portfolios for the purpose of comparing aggregate cost and market value to determine the amount to be reported in the financial statements. Marketable securities included in unrestricted net assets are grouped into separate portfolios according to the current or noncurrent classification of the securities. Marketable securities for which an external restriction exists are grouped into separate portfolios according to the type of restriction (that is, temporarily or permanently restricted).

4.6 The current portfolios of organizations that are consolidated or combined in financial statements are treated as a single combined portfolio. The noncurrent portfolios of those organizations also are treated as a single portfolio.

4.7 If there is a change between the portfolio classification of a marketable security, the security is transferred between the corresponding portfolios at the lower of its cost or market value at the date of the transfer. If market value is less than cost, the market value becomes the new cost basis, and the difference is accounted for as if it were a realized loss.

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

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

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

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

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

c. For each period for which a statement of operations is presented:

- Net realized gain or loss related to unrestricted net assets included in the statement of operations

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

- Market value of debt securities intended to be held to maturity and reported at amortized cost

4.9 All health care organizations with investments that meet the definition of financial instruments set forth in FASB Statement No. 105 are subject to the disclosure requirements of FASB Statement No. 105 and FASB Statement No. 107, *Disclosures about Fair Value of Financial Instruments*. Organizations with derivative financial investments are subject to the disclosure requirements in FASB Statement No. 119, *Disclosures about Derivative Financial Instruments and Fair Value of Financial Instruments*.[3]

4.10 FASB Statement No. 119 requires disclosures about derivative financial instruments--futures; forward, swap, and option contracts; and other financial instruments with similar characteristics. It also amends existing requirements of FASB Statement No. 105 and Statement No. 107.

4.11 FASB Statement No. 119 requires disclosures about amounts, nature, and terms of derivative financial instruments that are not subject to FASB Statement No. 105 because they do not result in off-balance-sheet risk of accounting loss. It requires that a distinction be made between financial instruments held or issued for trading purposes (including dealing and other trading activities measured at fair value with gains and losses recognized in earnings) and financial instruments held or issued for purposes other than trading. FASB Statement No. 119 requires additional disclosures about those derivative financial instruments held for trading purposes, those held for purposes other than trading, and those accounted for as hedges of anticipated transactions.

4.12 The financial statements are not adjusted for realized gains, losses, or changes in market prices with respect to marketable securities if such gains, losses, or changes occur after the date of the financial statements but before their issuance, except for the situation discussed in paragraph 4.13. However, significant net realized and net unrealized gains and losses arising after the balance sheet date but before the financial statements are issued, applicable to marketable securities owned at the date of the most recent balance sheet, should be disclosed.

4.13 Generally, the change in the valuation allowance for a marketable equity securities portfolio is disclosed and reported above the operating income caption in the statement of operations. However, if (1) the change in the valuation allowance relates to marketable equity securities for which the income is restricted to a specific purpose or future period, or (2) the governing board determines that relevant law requires the organization to permanently retain some portion of the income on investment in endowment funds, the change in valuation allowance should be reported in the statement of changes in net assets in the appropriate net asset category.

---

[3] These three pronouncements are not applicable to governmental health care enterprises that do not apply paragraph 7 of GASB Statement No. 20. (See footnote 1, chapter 1.)

4.14 For those marketable equity securities for which the effect of a change in carrying amount is included in the statement of changes in net assets (rather than in the statement of operations) as discussed in paragraph 4.13, the probable duration of an individual security's decline in market value below cost as of the balance sheet date should be determined. If the decline is judged to be other than temporary, the basis of the individual security is adjusted to the market value at the balance sheet date and the amount of the adjustment is reported as a realized loss. The new basis is not changed for subsequent recoveries in market value.

4.15 Realized gains and losses are recognized in the statement of operations as increases or decreases in unrestricted net assets unless their use is temporarily or permanently restricted by explicit donor stipulations or by law.

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

4.17 The accounting and the reporting of unrestricted investment income are discussed in chapter 10.

AUDITING

4.18 Auditing objectives and procedures for investments of health care organizations generally are similar to those of other organizations. In addition, the independent auditor may need to consider the specific auditing objectives, selected control procedures, and auditing procedures presented in exhibit 4.1.

Exhibit 4.1
Auditing Considerations

Financial Statement Assertions	*Specific Auditing Objectives*	*Selected Control Procedures*	*Auditing Procedures*
Existence and completeness, rights and obligations, and valuation	Marketable securities are fairly stated, properly classified, described, and disclosed.	An independent trustee manages the investments. The trustee's reports are reviewed by a responsible employee.	Verify existence through confirmation. Test the valuation of equity and debt securities not intended to be held to maturity by comparing the recorded values with the fair market values reported by the trustee or another independent source.
Presentation and disclosure	Securities are properly classified.	Classification is monitored periodically and is based on management's intent or ability to dispose of excess funds that are available for operations within an operating cycle.	Review the financial statements for propriety of reporting and disclosure.

Chapter 5

RECEIVABLES

ACCOUNTS RECEIVABLE FOR HEALTH CARE SERVICES

5.1 Receivables may include amounts due for (a) health care services from patients, residents, third-party payors, and employers, (b) premiums and stop-loss insurance recoveries, (c) intercompany transactions, (d) promises to give in future periods (pledges), and (e) amounts due from employees, physicians, or others. All loans, such as loans to physicians, should be evaluated periodically for impairment. Loans that are included in the scope of FASB Statement No. 114, *Accounting by Creditors for Impairments of a Loan,*[1] should be evaluated based on the provisions of that statement. A loan is impaired when, based on current information and events, it is probable that the provider will be unable to collect all amounts due, including principal and interest, according to the contractual terms of the loan agreement. If the provider measures an impaired loan using a present value amount, the creditor should calculate that present value based on an estimate of the expected future cash flows of the impaired loan, discounted at the loan's effective interest rate.

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

5.3 Revenue and the related receivables for health care services usually are recorded in the accounting records on an accrual basis at the provider's full established rates. The provision for contractual adjustments (that is, the difference between established rates and third-party payor payments) and discounts (that is, the difference between established rates and the amount collectible) are recognized on an accrual basis and deducted from gross service revenue to determine net service revenue. Contractual adjustments, discounts, and an allowance for uncollectibles are recorded to report the receivables for health care services at net realizable value. Estimates of contractual adjustments, other adjustments, and the allowance for uncollectibles are reported in the period during which the services are provided even though the actual amounts may become known at a later date. 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 or partial payment is received. As discussed in paragraph 10.2, the provision of charity care does not qualify for recognition as receivables or revenue in the financial statements.

RATE SETTING

5.4 The independent auditor should be familiar with the rate-setting environment in which the entity operates and the regulations and contractual agreements that determine payments to be

---

[1] This pronouncement is not applicable to governmental health care enterprises that do not apply paragraph 7 of GASB Statement No. 20. (See footnote 1, chapter 1.)

received for health care services. Payment rates established by regulations or contractual agreements may be determined either prospectively or retrospectively.

5.5 Prospective rate setting is a method used to set payment rates in advance of the delivery of health care services. Such payment rates determine what third parties will pay for health care services during the rate period (generally one year). Prospective rate setting may result from a contractual agreement with a third party, such as a Blue Cross plan, or it may be mandated through legislation. The intent of prospective rate setting is to establish payment rates before the period to which they will apply and that are not subject to change. The independent auditor should be aware, however, that some rate-setting methods described as prospective may include provision for retrospective adjustments and that some third parties pay prospective rates for certain services and retrospective rates for other services.

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

ESTIMATED FINAL SETTLEMENTS

5.7 Under a retrospective system, an entity may be entitled to receive additional payments or may be required to refund amounts received in excess of amounts earned under the system. Although final settlements are not made until a subsequent period, they usually are subject to reasonable estimations and are reported in the financial statements in the period in which services are rendered. Differences between original estimates and subsequent revisions (including final settlements) are included in the statement of operations in the period in which the revisions are made and disclosed, if material. Those differences are not treated as prior period adjustments unless they meet the criteria for prior period adjustments as set forth in FASB Statement No. 16, *Prior Period Adjustments*.

5.8 Rate-setting methods that are described as prospective but provide for retrospective adjustments are accounted for as retrospective rate-setting systems for the services to which they apply (see paragraph 5.7).

STATE WAIVER CONTINGENCIES UNDER MEDICARE

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

PREMIUMS AND STOP-LOSS INSURANCE RECEIVABLES

5.10 Some health care organizations contract to provide comprehensive health care services for a fixed period in return for fixed periodic premiums. Many of those organizations may transfer a portion of their financial risks under the contract to another organization by purchasing stop-loss insurance. Receivables of those organizations may include uncollected premiums and amounts recoverable from stop-loss insurers reduced by appropriate valuation allowances. Chapter 13 provides guidance on applying GAAP for stop-loss insurance costs of providers of prepaid health care services.

PROMISES TO GIVE IN FUTURE PERIODS (PLEDGES)

5.11 Providers involved in fund-raising campaigns frequently are the recipients of promises to give[2] with payments due in future periods; pledge drives are a common example. FASB Statement No. 116, *Accounting for Contributions Received and Contributions Made*, establishes the accounting and financial reporting guidance for pledges and similar promises to pay.[3] By specifying that they will adhere to future payment dates, donors implicitly indicate that their gift is to support activities in each period in which a payment is scheduled. Therefore, in any promise to give with payments due in future periods, a time restriction is implicit unless the donor explicitly states that the gift is to support current activities or other circumstances clearly point to that intent.

5.12 Promises to give fall into two broad categories: conditional and unconditional. Conditional promises to give depend on the occurrence of a specified future and uncertain event to bind the promisor. Conditional promises to give are not recognized in financial statements until the conditions on which they depend are substantially met (that is, until the period in which the conditional promise becomes an unconditional promise). A transfer of assets in partial fulfillment of a conditional promise shall be accounted for as a refundable advance (that is, as a liability) until such time as the conditional promise becomes unconditional.[4]

5.13 Unconditional promises to give with payments due in future periods should be reported as receivables and as restricted support in the period the promise is received (unless explicit donor

---

[2] To be recognized in financial statements there must be sufficient evidence in the form of verifiable documentation that a promise was made and received (FASB Statement No. 116, paragraph 6).

[3] This pronouncement may not be applicable to governmental health care enterprises. (See footnote 1, chapter 1.) Furthermore, FASB Statement No. 116 is not applicable to contributions and transfers from a governmental entity to a governmental health care enterprise. These contributions are to be accounted for in accordance with the National Council on Governmental Accounting (NCGA) Statement 2, *Grant, Entitlement, and Shared Revenue Accounting by State and Local Governments*, and GASB Statement No. 6, *Accounting and Financial Reporting for Special Assessments*. Furthermore, certain interfund transactions with other funds in the same financial reporting entity are to be accounted for as residual equity transfers or operating transfers, in accordance with NCGA Statement 1, *Governmental Accounting and Financial Reporting Principles*, paragraph 105.

[4] For accounting purposes, a conditional promise to give is considered unconditional if the possibility that the condition will not be met is remote. In the case of ambiguous donor stipulations, if a promise contains stipulations that are not clearly unconditional (that is, if the donor's stipulations are ambiguous), the promise is presumed to be a conditional promise. Additional guidance on distinguishing conditional promises from unconditional promises is provided in FASB Statement No. 116, paragraphs 22 and 23.

stipulations or circumstances surrounding the receipt of the promise make clear that the donor intended the promise to be used to support activities of the current period). The expiration of those restrictions (or the expiration of a portion of the restriction) is recognized as the donor makes the future payment or payments. If the promise is to be paid in one future payment, the related temporarily restricted net assets will be transferred to unrestricted net assets in the period in which the payment is received. If the donor sets forth a schedule of future payments, a transfer from temporarily restricted net assets to unrestricted net assets is made in each period a payment is received. If other explicit donor restrictions are attached to the promise, such as that the gift be used for a specific purpose, the expiration of the restriction is recognized in the time period(s) when the donor makes the future payment(s) and when the stipulated purpose for which the assets were restricted has been fulfilled. In the period (or periods) that the restrictions expire, the temporarily restricted net assets (or the portion of the temporarily restricted net assets that relate to the particular payment installment) are reclassified as unrestricted net assets and reported in the statement of activities as net assets released from restriction.

5.14 Pledges and other promises with payments due in the future are to be reported based on the present value of estimated future cash flows using a discount rate commensurate with the risks involved. Accretion of the discount element of the pledge is accounted for as contribution income, which increases unrestricted, temporarily, or permanently restricted net assets, as appropriate. Unconditional promises to give that are expected to be collected or paid in less than one year may be measured at net realizable value (net settlement value) because that amount, although not equivalent to the present value of estimated future cash flows, results in a reasonable estimate of fair value.

5.15 With regard to pledges and other promises to pay in future periods, if a provider routinely conducts fund drives, an estimate of the future cash flows of a portfolio of short-term promises resulting from a mass fund-raising appeal may be made based on experience gained from similar appeals in prior years.

FINANCIAL STATEMENT PRESENTATION

Accounts Receivable

5.16 Receivables are reported net of an allowance for doubtful accounts. 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 shall be reported separately in the financial statements.

5.17 Accounts receivable of health care organizations generally are subject to the same financial disclosure requirements as other business organizations. FASB Statement No. 107 sets forth disclosure requirements regarding the carrying amount of patient accounts receivable.

5.18 FASB Statement No. 105, *Disclosure of Information about Financial Instruments with Off-Balance-Sheet Risk and Financial Instruments with Concentrations of Credit Risk*,[5] requires disclosure of information about significant concentrations of credit risk from third parties and off-

---

[5] This pronouncement is not applicable to governmental health care enterprises that do not apply paragraph 7 of GASB Statement No. 20. (See footnote 1, chapter 1.)

balance-sheet risk of accounting losses for all financial instruments, including trade accounts receivable. Concentration of credit risk frequently is an issue because most health care organizations generally tend to treat patients from their local or surrounding communities. Accordingly, disclosure should be made of the primary geographic sources of patients. It should be noted that concentration of credit risk may be a significant issue in stand-alone financial statements issued for a member hospital of a large national multihospital system but may not be an issue for financial statements prepared for the hospital system. When the individual facilities' financial statements are consolidated into statements prepared for the entire system, the credit risk is dispersed over a much larger base of health plans, patients, and geographies and, therefore, is not as concentrated. Health care organizations with significant concentrations of credit risk should comply with the disclosure provisions of FASB Statement No. 105.

5.19 Off-balance-sheet risk exists when the possible accounting loss from a financial instrument is not reflected on the balance sheet. Health care organizations (most notably hospitals) may enter into arrangements where they will finance their patient accounts receivable as a cash flow management strategy. Organizations that enter into certain types of receivable financing arrangements should disclose their off-balance-sheet risk, in accordance with FASB Statement No. 105.

5.20 FASB Statement No. 119[6] requires disclosures about derivative financial instruments--futures; forward, swap, and option contracts; and other financial instruments with similar characteristics. It also amends existing requirements of FASB Statement No. 105 and Statement No. 107.[7]

5.21 FASB Statement No. 119 requires disclosures about amounts, nature, and terms of derivative financial instruments that are not subject to FASB Statement No. 105 because they do not result in off-balance-sheet risk of accounting loss. It requires that a distinction be made between financial instruments held or issued for trading purposes (including dealing and other trading activities measured at fair value with gains and losses recognized in earnings) and financial instruments held or issued for purposes other than trading. FASB Statement No. 119 requires additional disclosures about those derivative financial instruments held for trading purposes, those held for purposes other than trading, and those accounted for as hedges of anticipated transactions.

Interfund Receivables

5.22 Interfund receivables (or payables) may exist in internal records. However, since general-purpose financial statements do not classify assets and liabilities into fund groups, interfund receivables (or payables) are eliminated.[8]

Promises to Give in Future Periods (Pledges)

5.23 Recipients of unconditional pledges (promises to give in future periods) shall disclose—

---

[6] Ibid.

[7] Ibid.

[8] These interfund balances and transactions are different from interfund transactions between a governmental health care enterprise fund and another fund, such as the general fund or a special revenue fund of a primary government, when the two funds are included in the same financial reporting entity.

a. The amounts of promises receivable in less than one year, in one to five years, and in more than five years.

b. The amount of the allowance for uncollectible promises receivable.

5.24 Recipients of conditional pledges (promises to give in future periods) shall disclose—

a. The total of the amounts promised.

b. A description and amount for each group of promises having similar characteristics, such as amounts of promises conditioned on establishing new programs, completing a new building, or raising matching gifts by a specified date.

AUDITING

5.25 In general, receivables, particularly those arising from health care services, are material to the financial position of health care organizations. Specific auditing objectives, selected control procedures, and auditing procedures that should be considered by the independent auditor as they relate to the major components of receivables of health care organizations are presented in Exhibit 5.1 at the end of this chapter.

Accounts Receivable Confirmations

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

5.27 If confirmation of amounts due from patients and third-party payors is impracticable or determined not to be effective, the independent auditor should document this decision in accordance with SAS No. 67, *The Confirmation Process* (AICPA, *Professional Standards*, vol. 1, AU sec. 330), and should use alternate procedures such as the following:

- Performing an analytical procedure or testing the details of subsequent receipts
- Reviewing third-party contracts or payment agreements
- Comparing billings with documentation in medical records
- Reviewing the results of third-party payor audits and peer review organization (PRO) reports
- Examining or confirming interim payments with third-party payors

Exhibit 5.1
Auditing Considerations

Financial Statement Assertions	*Specific Auditing Objectives*	*Selected Control Procedures*	*Auditing Procedures*
Receivables for Health Care Services			
Existence	Amounts reported in the financial statements represent valid receivables, which do not include charity care balances.	Charges are generated automatically when services are performed.	Review and test subsequent receipts.
		A medical record is prepared.	Compare billing information to the documentation contained in the medical records.
		Procedures ensure that amounts due from third-party payors for individual accounts are supported properly.	Review the results of PRO and insurance company reviews for evidence that might indicate receivables may not be realized.
		Procedures ensure the proper recording of cash receipts.	Trace the receipts applicable to patient accounts to the accounts receivable records.
		Procedures ensure charity care balances are identified and excluded from gross receivables.	Review the management policy for determining charity care.
			Review policy and reasonableness of charity care measurement.

Completeness	Amounts reported in the financial statements are complete and are calculated and accumulated properly.	Procedures ensure that (a) detailed accounts receivable records are compared routinely with control accounts and third-party payor logs, (b) differences are investigated and reconciled, and (c) adjustments, if necessary, are made promptly.	Compare detailed accounts receivable records with control accounts and third-party payor logs, and investigate reconciling items.
Valuation	Receivables are reported in the financial statements at net realizable value.	Allowances for uncollectibles and contractual adjustments are reviewed periodically by management to ensure that receivables are reported at estimated net realizable value.	Review third-party contracts and recompute patient receivables. Examine contracts or confirm interim third-party payments with third-party payors.
		Write-offs and allowances for uncollectibles are identified and approved in accordance with the entity's established policy.	Review and test the method used to determine the allowances for uncollectible accounts. Determine that patient accounts are classified appropriately by payor (for example, Medicare or self-pay) to evaluate collectibility. Test Medicare logs for accuracy and completeness. Test and analyze aged accounts receivable trial balances, collection trends, delinquent

			accounts, subsequent period write-offs and economic or other factors used to determine allowance for uncollectible accounts. Review pledges and other receivables for collectibility.
Presentation and disclosure	Significant contractual arrangements with third parties are disclosed.		Determine that significant contractual arrangements with third parties are disclosed.
Estimated Third-Party Settlements			
Existence	Amounts reported in the financial statements represent valid receivables and/or payables.	Procedures ensure that estimated third-party settlements are determined in accordance with the reimbursement and rate-setting methodologies applicable to the entity.	Review correspondence from significant third-party payors related to (a) interim payment rates applicable to periods for which final settlements have not been made and (b) the amount of interim or final settlements made during the period.
Completeness and valuation	Amounts included in the financial statements are accurate and complete.	Procedures ensure that estimated third-party settlements are accurately calculated and reported.	Test the reasonableness of settlement amounts, including specific and unallocated reserves, in light of the payors involved, the nature of the payment mechanism, the risks associated with future audits, and other relevant factors.

			Review third-party payor audit reports and adjustments for prior years' cost reports or settlements to consider whether (a) the effect of such adjustments has been reported properly in the financial statements and (b) adjustments of a similar nature apply to the current period.
			Obtain a representation from management that provisions for estimated retroactive adjustments by third-party payors under reimbursement agreements for open years are adequate.
Presentation and disclosure	Amounts reported in the financial statements are presented properly and all required disclosures are made.		Determine that the tentative nature of third-party settlement amounts is disclosed properly.

Chapter 6

PROPERTY AND EQUIPMENT, SUPPLIES, AND OTHER ASSETS

OVERVIEW

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

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

6.3 Other assets may include prepaid expenses, deposits, and deferred expenses. Prepaid costs, such as amounts paid to physicians for future services (for example, administering a hospital department or providing community services that further the organization's mission) may be deferred and amortized over the period benefited. Such assets are classified as current or noncurrent as appropriate.

ACCOUNTING

6.4 Accounting for property and equipment, supplies, and other assets of health care organizations is similar to that used by other business organizations.

6.5 Depreciation and amortization of property and equipment are recorded in conformity with GAAP. Useful lives assigned to depreciable assets should be reasonable, based on the circumstances. The American Hospital Association publishes useful guidelines for classifications and estimated useful lives for property and equipment used by hospitals. Those guidelines also may be useful to other health care organizations. If there is a potential that an asset is impaired, health care organizations should consider the guidance in FASB Statement No. 121, *Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to Be Disposed Of*,[1] issued in March of 1995.

6.6 The recognition of contribution income related to donated long-lived assets (or assets recognized to be acquired with donated funds) is discussed in chapter 10 of this guide.

---

[1] This pronouncement is not applicable to governmental health care enterprises that do not apply paragraph 7 of GASB Statement No. 20. (See footnote 1, chapter 1.)

FINANCIAL STATEMENT PRESENTATION

6.7 Financial statement presentation of property and equipment of health care organizations is similar to that of other business organizations. Property held for investment purposes should be presented as part of investments. Donor or legal restrictions on the proceeds from the disposition of donated property and equipment (or of property and equipment purchased with cash restricted for acquisition of long-lived assets) are disclosed.

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

AUDITING

6.9 Auditing objectives for property and equipment, supplies, and other assets of health care organizations are similar to those in audits of other business organizations. The auditor may be able to assess inherent risk for these accounts as being relatively low because the transactions therein are generally small in number, relatively simple in nature, and do not involve the use of complex estimates. The auditor should consider the characteristics of the entity and of the transactions occurring during the period when assessing inherent risk for these accounts.

6.10 A health care organization may have access to the use of property and equipment under a variety of arrangements. It may (a) own property and equipment, (b) rent property and equipment from an independent or related organization, (c) use property and equipment provided by a related organization (such as a religious order) or by an unrelated organization under an affiliation program, or (d) use property and equipment provided by a government agency or unit or a government-related hospital district. The independent auditor should inquire into (and the financial statements should disclose) the nature of any relationship between the health care organization and lessors, bailors, or other owners of property. With respect to leases, FASB Statement No. 13, *Accounting for Leases,* as amended and interpreted, provides accounting guidance.[2] GASB Statement No. 13, *Accounting for Operating Leases with Scheduled Rent Increases*, provides additional guidance for operating leases of governmental health care enterprises.

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

6.12 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 is revised periodically and sets forth plant asset classifications and the estimated useful lives of depreciable assets. The auditor also should 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.

6.13 The independent auditor may need to consider the specific auditing objectives, selected control procedure, and auditing procedures relating to property and equipment presented in exhibit 6.1.

---

[2] For governmental health care enterprises, NCGA Statement 5, *Accounting and Financial Reporting Principles for Lease Agreements of State and Local Governments*, requires the application of FASB Statement No. 13 for proprietary activities and provides additional guidance on specific matters unique to governmental entities.

Exhibit 6.1
Auditing Considerations

Financial Statement Assertions	*Specific Auditing Objectives*	*Selected Control Procedures*	*Auditing Procedures*
Donated Property Equipment			
Valuation	Donated property and equipment is reported at fair market value at the date of donation.	Procedures ensure that the donation of property and equipment is known and recorded and that documentation supports the determination of the fair market value.	Review the documentation supporting the determination of the fair market value.
Presentation and disclosure	The receipt of donated property and equipment is properly reported.		Review material donated property and equipment transactions to ensure the propriety of the reporting.
Property and Equipment Not Held for Use in Operations			
Presentation and disclosure	Property and equipment not used for operations is reported separately.	Property records segregate property and equipment not used for operating purposes.	Determine that property held for nonoperating purposes is reported separately.
Property and Equipment Additions			
Rights and obligations	The appropriate health care planning agency or other regulatory agency approvals, if required, have been obtained for property and equipment additions.	Management regularly monitors compliance with health care planning agency regulations related to additions of property and equipment. Additions are authorized in the capital budget.	For material new construction, determine compliance with health care planning agency or other regulatory agency requirements.

Existence and valuation	Recorded property and equipment are owned by the entity and are carried at the appropriate amounts.	Inventory of fixed assets is taken periodically. Detail property records periodically are reconciled to the recorded amounts.	Review a summary of property and equipment (cost and accumulated depreciation) including additions, deletions, and transfers.

Chapter 7

CURRENT LIABILITIES, TAX CONSIDERATIONS, AND LONG-TERM OBLIGATIONS

OVERVIEW

7.1 Current liabilities may include notes payable to banks; the current portion of long-term debt; accounts payable; advances from and amounts payable to third-party payors for estimated and final reimbursement settlements; refunds to and deposits from patients and others; deferred revenue; accrued salaries and payroll taxes; and other accruals such as pension or profit-sharing contributions, compensated absences, and income and other taxes. In addition, there may be a current portion of estimated malpractice costs and risk-contract recognized losses (see chapter 8).

7.2 Long-term obligations may include notes, mortgages, capital leases, bonds, and obligations under continuing care contracts. They also may include estimated malpractice cost and risk-contract recognized losses.

ACCOUNTING FOR CURRENT LIABILITIES

7.3 Accounting for current liabilities of health care organizations is similar to that of other business enterprises. Health care organizations are usually labor-intensive and 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*. Governmental health care entities should follow the guidance in GASB Statement No. 16, *Accounting for Compensated Absences*.

7.4 Liabilities related to postretirement benefits other than pensions should be accounted for in accordance with FASB Statement No. 106, *Employers' Accounting for Postretirement Benefits Other Than Pensions*, and postemployment benefits should be accounted for in accordance with FASB Statement No. 112, *Employers' Accounting for Postemployment Benefits.* These two pronouncements are not required to be applied by governmental health care enterprises. GASB Statement No. 12, *Disclosure of Information on Postemployment Benefits Other Than Pension Benefits by State and Local Governmental Employers*, however, does require certain disclosures about postemployment benefits.

TAX CONSIDERATIONS FOR NOT-FOR-PROFIT HEALTH CARE ORGANIZATIONS

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

an exemption is secured, the entity may become subject to federal income tax and the related filing requirements on the same basis as other tax-exempt entities.

TAX-EXEMPT ENTITIES

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

- No part of the entity's net earnings, either directly or indirectly, inures to any private shareholder or individual.

- No substantial part of the entity's activities consists of carrying on propaganda or otherwise attempting to influence legislation. (IRC sec. 501(h) provides a limited exception to the general rule that public charities may not incur expenditures to influence legislation.)

- The entity does not participate in, or intervene in, any political campaign on behalf of any candidate for public office.

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

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

PRIVATE INUREMENT

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

UNRELATED BUSINESS INCOME TAX

7.10 Although not-for-profit organizations may be exempt from federal income tax, they nevertheless may be subject to tax on unrelated business income. The objective of the tax on unrelated business is to place such activities on the same basis as that of taxable entities. Unrelated business income is the income from any regularly carried-on trade or business, the

conduct of which is not substantially related to the exercise or performance of the organization's tax-exempt purpose or function. The fact that proceeds from an activity are used exclusively for the entity's tax-exempt purpose does not make the activity substantially related to its tax-exempt purpose or function. As is the case with most tax-related definitions, there are qualifications and exceptions. Some of the more significant exclusions from this tax include——

- An annual specific deduction for certain limited activities.
- Income from activities of which substantially all the work is performed by unpaid volunteers.
- Income from activities carried on for the convenience of the entity's patients, officers, or employees.
- Dividends, interest, annuities, royalties, capital gains and losses, and rents from real property—with two major exceptions. The first exception is that income from investments that are debt-financed and otherwise not functionally related to the tax-exempt purpose is taxable. The second major exception makes taxable the interest, annuities, royalties, and rents received from a controlled (80-percent-owned) taxable corporation or partnership unless this entity is engaged in an activity that would have been exempt if it were carried on directly by the not-for-profit organization.

ARBITRAGE RESTRICTIONS

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

FINANCIAL STATEMENT PRESENTATION

7.12 Financial reporting and disclosure requirements for current liabilities and long-term obligations of health care organizations are the same as for other business organizations. In addition, with respect to CCRCs, the method of accounting for advance fees, the method of calculating the obligation to provide future services and use of facilities, and the refund policy for refundable fees are disclosed in the financial statements. Chapter 14 describes other disclosure requirements applicable to CCRCs. Taxable entities have the same financial reporting and disclosure requirements as other commercial enterprises. Tax-exempt entities should disclose their tax-exempt status.

LONG-TERM DEBT

7.13 Significant sums of money are required to replace and upgrade buildings and expand the facilities of health care organizations. As a result, health care organizations are dependent on external sources of funds to satisfy their capital needs. Most health care organizations finance acquisitions, additions, and renovations with long-term debt.

7.14 In addition to serving as a financing source for government operations, tax-exempt debt frequently is issued by state and local governments on behalf of nongovernmental organizations (for example, not-for-profit organizations) to foster private-sector participation in certain desirable community activities such as the provision of health care services. Tax-exempt bonds usually can be issued to obtain a higher ratio of project financing (up to 100 percent), a longer maturity period (up to thirty years), and a lower interest cost than taxable bonds. The majority of tax-exempt bonds issued by health care organizations are revenue bonds, which are bonds secured by a pledge of the entity's revenues. General obligation bonds are secured by the revenues of the issuing authority.

FINANCING AUTHORITIES

7.15 Because most providers legally cannot issue tax-exempt revenue bonds directly, a significant number of states have enacted legislation permitting health care organizations to borrow funds for capital projects by issuing bonds through financing authorities. Financing authorities are authorized to issue tax-exempt bonds or other obligations and use the proceeds for the benefit of the health care organization. To obtain project financing, a health care organization sometimes is required by a financing authority to enter into a lease arrangement, a sublease arrangement, or both. At other times, a lease or sublease arrangement is not required.

7.16 When a financing authority issues tax-exempt bonds or similar debt instruments and uses the proceeds for the benefit of a health care organization, the obligation is reported as a liability in the organization's balance sheet if the health care organization is responsible for repayment. If a health care organization has no obligation to make any payments of principal or interest, the organization should not reflect the liability on its balance sheet. In such circumstances, proceeds from the bond issue are reported as contributions from the sponsoring organization.

ASSETS WHOSE USE IS LIMITED

7.17 Among the many provisions normally included in the bond indentures of tax-exempt issues are the requirements to set aside funds annually from operations to ensure that bond principal, interest payments, and other requirements are met. The treatment of funds established under the terms of debt-financing instruments is discussed in paragraph 1.14.

ADVANCE REFUNDINGS

7.18 In an advance refunding, new debt is issued for the purpose of replacing an existing debt issue. Advance refundings enable providers to restructure their long-term liabilities, take advantage of reduced interest rates, or terminate restrictive bond covenants. The terms by which the debt may be satisfied legally and the related lien released without the debt necessarily being retired are spelled out in the debt instrument. Under the Tax Reform Act of 1986, bonds issued before January 1, 1986, may be advance refunded only twice. Bonds issued on or after that date may be advance refunded only once.

7.19 The accounting, financial reporting, and disclosure requirements for advance refundings entered into by health care organizations other than governmental entities are described in FASB Statement No. 4, *Reporting Gains and Losses from Extinguishment of Debt* (as amended), FASB

Statement No. 76, *Extinguishment of Debt*, and FASB Interpretation No. 39, *Offsetting of Amounts Related to Certain Contracts*. Generally speaking, these entities are required to report any gain or loss resulting from an advance refunding as an extraordinary item in the financial statements of the period in which the refunding occurred. The accounting, financial reporting, and disclosure requirements for advance refundings (and for current refundings) entered into by governmental health care entities are set forth in GASB Statement No. 23, *Accounting and Financial Reporting for Refundings of Debt Reported by Proprietary Activities*, and GASB Statement No. 7, *Advance Refundings Resulting in Defeasance of Debt*. Generally speaking, governmental entities are required to amortize any gain or loss resulting from an advance refunding to interest expense over the shorter of the life of the new bonds or the remaining life of the old bonds.

7.20 There are several types of advance refundings, including net advance refundings, full cash advance refundings, and crossover refundings (see the Glossary).

7.21 In a crossover refunding, because the old bonds are not defeased until the crossover date, no immediate gain or loss should be recognized. If the retirement dates of the old debt have been established, the call premium, unamortized premium or discount, and initial issue costs should be recognized systematically in the income statement over the remaining life of the old debt as an adjustment of the cost of borrowing related to the old debt. In addition, the income earned on the funds used to consummate the advance refunding and the interest expense on both the old and new debts should be recognized in the income statement. The funds used to consummate the advance refunding should be reported as an asset and both the old and new debts should be reported as liabilities. The assets and liabilities should not be offset.

ARBITRAGE REBATE LIABILITIES

7.22 Advance refundings involving tax-exempt debt are subject to arbitrage rules under the IRC sec. 103(c) and related regulations that, in general, prohibit the yield realized from the investment of the proceeds of the new debt from exceeding the yield on the debt itself. Compliance with those rules is necessary for the interest on the debt to be exempt from federal income tax and, possibly, from state and local tax.

7.23 Whenever a provider invests tax-exempt bond proceeds and the ultimate yield is higher than the interest rate on the bonds, the provider may be subject to an arbitrage rebate liability. The arbitrage determination is made as of the date of the issue; however, intentional acts undertaken after the date of the issue can disqualify the issue retroactively. The earnings in excess of interest expense represent a liability that must be paid to the U.S. Treasury in order for the bonds to maintain their tax-exempt status. The arbitrage rebate liability may be a substantial amount if the bond proceeds are not spent as quickly as planned. For example, this may occur if a provider encounters a delay in a major construction project.

AUDITING

7.24 Auditing objectives and procedures for long-term debt issued by health care organizations generally are similar to those of other organizations. In addition, the independent auditor may need to consider the specific auditing objectives, selected control procedures, and auditing procedures presented in exhibit 7.1.

Exhibit 7.1
Auditing Considerations

Financial Statement Assertions	*Specific Auditing Objectives*	*Selected Control Procedures*	*Auditing Procedures*
Tax-Exempt Debt			
Presentation and disclosure	Amounts related to tax-exempt debt are properly classified in the financial statements and related disclosures are adequate.	Procedures ensure that the providers monitor their compliance with restrictive debt covenants.	Review the debt instruments for the presence of any restrictive debt covenants. Test compliance with restrictive debt covenants.
Taxes			
Rights and obligations	The not-for-profit organization has obtained a qualifying income tax exemption from the governmental authority.	Management monitors compliance with applicable tax regulations. Transactions are reviewed for their effect on tax status and tax liabilities.	Determine that the not-for-profit organization has obtained a determination of its tax-exempt status. Inquire if tax returns have been filed on a timely basis. Determine the status of the tax returns under examination. Read the prior years' tax returns. Read the minutes and the accounting for evidence of significant unrelated business activities. Review for reasonableness the unrelated business income tax liability.

Presentation and disclosure	The entity's tax-exempt status and its tax contingencies are disclosed in the notes to the financial statements.		Determine that the entity's tax-exempt status is disclosed in the notes to the financial statements.

Chapter 8

COMMITMENTS AND CONTINGENCIES

OVERVIEW

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

8.2 FASB Statement No. 5, as amended and interpreted, and FASB Interpretation No. 14, *Reasonable Estimation of the Amount of a Loss*, provide guidance on accounting for contingencies. FASB Statement No. 60, *Accounting and Reporting by Insurance Enterprises*, discusses accounting for claims costs, including estimates of costs relating to IBNR claims. Governmental health care entities also should consider the accounting and disclosure requirements of GASB Statement No. 10, *Accounting and Financial Reporting for Risk Financing and Related Insurance Issues*.

MEDICAL MALPRACTICE CLAIMS

8.3 The extent of risk transfer is key in determining whether a liability should be recognized in a provider's financial statements pertaining to malpractice claims. The existence of an insurance policy, by itself, is no assurance that the risk of financial loss is transferred.

8.4 If the entity has purchased a claims-made insurance policy (see paragraph 8.13), there is no transfer of risk for claims not reported to the insurance carrier within the policy term. With regard to retrospectively rated insurance policies (see paragraph 8.14) and policies by captive insurance companies (see paragraphs 8.16 through 8.18), the economic substance of the terms of the insurance policy may more closely resemble a claims funding mechanism than an instrument that transfers risk of loss to an external third party. If the health care organization has not transferred risk to an external third party, it should evaluate its exposure to losses arising from malpractice claims and record a liability, if appropriate.

ACCRUING MALPRACTICE LIABILITIES

8.5 The ultimate costs of malpractice claims, which include costs associated with litigating or settling claims, are accrued when the incidents that give rise to the claims occur. Estimated losses from asserted and unasserted claims are accrued either individually or on a group basis, based on the best estimates of the ultimate costs of the claims and the relationship of past reported incidents to eventual claims payments. All relevant information--including industry experience, the entity's own historical experience, the entity's existing asserted claims, and reported incidents--is used in estimating the expected amount of claims. The accrual includes an estimate of the losses

that will result from unreported incidents, which are probable of having occurred before the end of the reporting period.

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

8.7 If it is probable that a loss has been incurred and the information available indicates the loss is within a range of amounts, the most likely amount of loss in the range is accrued. If no amount in the range is more likely than any other, the minimum amount in the range is accrued. The potential additional loss is disclosed if there is at least a reasonable possibility of a loss in excess of the amount accrued.

8.8 In estimating losses from malpractice claims, a health care organization may need to modify data drawn from industry experience so it is relevant to developing an estimate that is specific to the organization. Various factors (such as the nature of operations, size, and the provider's past experience) are considered in assessing comparability. Further, industry data that are not current may not be relevant.

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

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

8.11 A health care organization discloses its program of medical malpractice insurance coverages and the basis for any related loss accruals. If the organization cannot estimate losses relating to a particular category of malpractice claims (for example, asserted claims, reported incidents, or unreported incidents) in accordance with paragraphs 8.3 through 8.10, the potential losses related to that category of claims are not accrued. However, the contingency is disclosed in the notes to the financial statements, as required by FASB Statement No. 5.

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

ACCOUNTING FOR CLAIMS-MADE INSURANCE POLICIES AND TAIL COVERAGE

8.13 A claims-made insurance policy represents a transfer of risk within the policy limits to the insurance carrier for asserted claims and incidents reported to the insurance carrier. The policy, however, does not represent a transfer of risk for claims and incidents not reported to the insurance carrier during the policy period. Consequently, a health care organization that is insured

under a claims-made insurance policy recognizes the estimated cost of those claims and incidents not reported to the insurance carrier, in accordance with paragraphs 8.3 through 8.10. This is done *unless* the health care organization has bought tail coverage (see the Glossary) and included the cost of the premium as an expense in the financial statements for that period.

ACCOUNTING FOR RETROSPECTIVELY RATED PREMIUMS

8.14 A health care organization with a retrospectively rated insurance policy whose ultimate premium is based primarily on the health care organization's loss experience accounts for the minimum premium as an expense over the period of coverage under the policy and accrues estimated losses from asserted and unasserted claims in excess of the minimum premium, as indicated in paragraphs 8.3 through 8.10. Such estimated losses, however, are not accrued in excess of a stipulated maximum premium. If the health care organization cannot estimate losses from asserted or unasserted malpractice claims, as indicated in paragraphs 8.3 through 8.10, the health care organization should disclose the existing contingency in the notes to the financial statements, as required by FASB Statement No. 5.

8.15 A health care organization insured under a retrospectively rated policy whose ultimate premium is based primarily on the experience of a group of health care organizations amortizes the initial premium to expense on a pro rata basis over the policy term. The organization also accrues additional premiums or refunds on the basis of the group's experience to date, which includes a provision for the ultimate cost of asserted and unasserted claims before the financial statement date, whether reported or unreported. The health care organization discloses that (a) it is insured under a retrospectively rated policy and (b) premiums are accrued based on the ultimate cost of the experience to date of a group of organizations. If the health care organization cannot estimate losses from asserted or unasserted malpractice claims, as indicated in paragraphs 8.3 through 8.10, it should disclose the existing contingency in the notes to the financial statements, as required by FASB Statement No. 5.

ACCOUNTING FOR MEDICAL MALPRACTICE CLAIMS INSURED BY CAPTIVE INSURANCE COMPANIES

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

8.17 A health care organization insured by an unconsolidated multiprovider captive insurance company for medical malpractice claims under a retrospectively rated insurance policy whose ultimate premium is based primarily on the health care organization's experience up to a maximum premium, if any, accounts for such insurance as indicated in paragraph 8.14.

8.18 A health care organization insured by an unconsolidated multiprovider captive insurance company for medical malpractice claims under a retrospectively rated policy based primarily on the experience of a group of health care organizations accounts for such insurance as indicated in paragraph 8.15. However, the health care organization considers whether the economic substance of the multiprovider captive insurance company is sufficient to relieve the health care organization from further liability. The health care organization discloses that (a) it is insured under a

retrospectively rated policy of a multiprovider captive insurance company and (b) the premiums are accrued based on the captive insurance company's experience to date.

8.19 A health care organization that is insured by a multiprovider captive insurance company discloses in its financial statements that it is insured by such a company, and it discloses its ownership percentage, if significant, in the captive company as well as the method of accounting for its investment in, and the operations of, the captive company. In addition, if the health care organization cannot make the necessary estimates of losses from asserted or unasserted claims, as indicated in paragraphs 8.3 through 8.10, the health care organization discloses the existing contingency in the notes to the financial statements, as required by FASB Statement No. 5.

ACCOUNTING FOR TRUST FUNDS

8.20 In general, a trust fund, whether legally revocable or irrevocable, is included in the financial statements of the health care organization. A portion of the fund equal to the amount of assets expected to be liquidated to pay malpractice claims classified as current liabilities is classified as a current asset; the balance of the fund, if any, is classified as a noncurrent asset. Revenues and administrative expenses of the trust fund are included in the statement of revenue and expenses (see chapter 10). In some circumstances, the foregoing may not be possible (for example, if a common trust fund exists for a group of health care organizations; if the health care organization is part of a common municipality risk-financing internal service fund; or if the legal, regulatory, or indenture restrictions prevent the inclusion of a trust fund in a health care organization's financial statements). In those circumstances, the provisions of paragraphs 8.21 and 8.22 apply.

8.21 In general, estimated losses from asserted and unasserted claims are accrued and reported, as indicated in paragraphs 8.3 through 8.12. The estimated losses are not based on payments to the trust fund. However, accounting for a health care organization that participates in a pooled fund depends on the extent to which the associated risks and rewards have been transferred to another party. An organization that transfers its risk of loss to the common trust fund and forfeits its rights to any excess funding should expense its contributions and account for its participation in the trust fund based on the type of coverage obtained (for example, occurrence basis, claims-made, or retrospectively rated). Governmental health care entities that are component units of a state or local government reporting entity and that participate in that entity's risk-financing internal service fund should report claims expenses equal to the charges from the internal service fund if those charges meet the requirements of paragraphs 65 through 68 of GASB Statement No. 10.

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

AUDITING COMMITMENTS AND CONTINGENCIES

8.23 Auditing objectives and procedures for commitments and contingencies generally are similar to those of other organizations. The independent auditor may need to consider the specific auditing objectives, selected control procedures, and auditing procedures presented in exhibit 8.1 at the end of this chapter.

AUDITING MEDICAL MALPRACTICE LOSS CONTINGENCIES

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

- Determine the type (such as occurrence basis or claims-made) and level (per occurrence or in the aggregate) of insurance protection the provider has obtained.
- Determine if the coverage actually transfers the malpractice risks. Is the insurance with a related party (for example, a captive insurance company)? Does it provide for retrospective premiums or similar adjustments?

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

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

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

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

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

AUDITING ACCOUNTING ESTIMATES

8.29 Management is responsible for making the accounting estimates that are included in the financial statements. Management is also responsible for providing proper disclosure of 1) the use of estimates in the preparation of financial statements and 2) certain significant estimates (SOP 94-6).[1] The auditor is responsible for evaluating the reasonableness of management's estimates and the adequacy of the related disclosures. The auditor does this using one or more of the following approaches:

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

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

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

8.30 In evaluating management's estimates of asserted and unasserted claims, the auditor should consider factors such as management's description and evaluation of asserted claims and unasserted claims arising from reported incidents; the lawyer's (and, if appropriate, the outside risk manager's) assessment of asserted claims and reported incidents not covered by insurers; and the actuary's evaluations of the aggregate liability covering asserted claims and unasserted claims arising from reported and unreported incidents.

8.31 Written assurances should be obtained from management that it has disclosed all such matters required to be disclosed by FASB Statement No. 5.

8.32 In evaluating the information provided by legal counsel, it may be necessary to supplement the written representations with inquiries if the representations are not clear regarding the probability of the litigation outcome or the potential range of loss.[2]

8.33 The auditor should consider the frequency of losses due to unreported incidents and the magnitude of prior losses and underlying causes for the IBNR claims. If there is a basis for an accrual, the auditor should then determine whether the entity's prior history supports the estimation of the number of claims and the probable settlement value.

USE OF ACTUARIES AND ACTUARIAL METHODS

8.34 An actuary may be engaged to provide or review the estimate of the medical malpractice loss amount or range of amounts or to assist in developing certain factors and assumptions used in estimating the malpractice liability. The decision to use an actuary should be based on a

---

[1] See paragraph 8.39.

[2] According to SAS No. 12, *Inquiry of a Client's Lawyer Concerning Litigation, Claims, and Assessments* (AICPA, *Professional Standards*, vol. 1, AU sec. 337), a letter of audit inquiry to the lawyer handling the claims is the auditor's primary means of obtaining corroboration of the information furnished by management concerning claims made and known incidents for which claims have not been made that are either uninsured or in excess of the insurance coverage. Audit inquiry letters generally would not be required with respect to reported contingencies that were not considered to have a material potential loss. The inability or unwillingness of counsel to evaluate asserted claims and or reported incidents would give rise to a modification of the auditor's opinion.

consideration of whether (a) the estimated claim liability is potentially material to the fair presentation of financial statements in conformity with GAAP and (b) special knowledge is required to estimate the claim liability.

8.35 If an actuary is involved in a substantial way in determining the amount of a provider's malpractice self-insurance liability, the independent auditor should follow the requirements of SAS No. 73, *Using the Work of a Specialist* (AICPA, *Professional Standards*, vol. 1, AU sec. 336). The independent auditor should consider the actuary's professional qualifications, reputation, prior experience in estimating malpractice claim losses, and relationship to the client. There should be an understanding among the auditor, the client, and the actuary of the objectives and scope of the analysis and the methods and assumptions used. The independent auditor should be aware of (a) the limitations of assurances in actuarial calculations due to uncertainties and (b) restrictions as to the use of the actuarial reports. The independent auditor is responsible for determining the adequacy of the actuary's report for purposes of corroborating the representations in the financial statements. The independent auditor should perform an appropriate test of the accounting data provided by the client to the actuary. Such accounting data may include historical claim experience, policy terms (such as coverage, expiration, deductibles, presence of retrospectively determined premiums, and indemnity limitations), exposure data (such as the number of beds, high-risk medical specialties, outpatient visits, and emergency room visits), and information about risk management systems, personnel, and procedures.

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

- The risk of adverse deviation is an additional cost factor applied to bring a funding requirement to a selected confidence level. This factor does not meet the criteria for recognition as a liability in accordance with FASB Statement No. 5.

- An evaluation should be made of the extent and validity of industry data when the credibility factor actuarial technique is used. The lower the credibility factor, the greater the blending of industry data. This may create an unacceptable level of industry data at lower confidence levels. Further, a low credibility factor may indicate that provider-specific data is not sufficient to support the claims liability estimation process.

- A review of the discounting approach used is necessary to develop the required disclosure. The impact on the discounting calculation of any other adjustment made to the actuarially determined amounts (such as risk of adverse deviation or the credibility of the risk management system) has to be evaluated.

- A review of the expenses included in the loss estimation process should be made. Such expenses include the expense of settlement and litigation (that is, allocated loss adjustment expenses).

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

RISKS AND UNCERTAINTIES

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

8.39 SOP 94-6 requires entities to include in their financial statements information about--

- The nature of their operations.
- Use of estimates in the preparation of financial estimates.

In addition, if certain specified disclosure criteria are met, it requires entities to include in their financial statements disclosures about--

- Certain significant estimates.
- Current vulnerability due to certain concentrations.

EVALUATING LAWYERS' RESPONSES

8.40 Determining the outcome of pending or threatened litigation, claims and assessments (including unasserted claims and assessments) normally is beyond the auditor's professional competence. Accordingly, the auditor's evaluation of the need for disclosures or report modifications is based primarily on the opinion of the lawyer handling the matter. The American Bar Association (ABA) has adopted a *Statement of Policy Regarding Lawyers' Responses to Auditors' Requests for Information* under which lawyers accept certain responsibility for responses to auditors' inquiries. However, the ABA Statement of Policy is not enforceable by the ABA in the same way the AICPA is able to enforce its standards under the accounting profession's Code of Professional Conduct. As a result, lawyers' responses may vary widely.

8.41 Interpretation No. 7 of SAS No. 12, *Inquiry of a Client's Lawyer Concerning Litigation, Claims, and Assessments* (AICPA, *Professional Standards*, vol. 1, AU sec. 337), entitled "Assessment of a Lawyer's Evaluation of the Outcome of Litigation" (AICPA, *Professional Standards*, vol. 1, AU sec. 9337.18 -.23) includes the following examples of evaluations of litigation, which may be considered to communicate in a sufficiently clear manner a remote likelihood of an unfavorable outcome:

- "We are of the opinion that this action will not result in any liability to the company."

- "It is our opinion that the possible liability to the company in this proceeding is nominal in amount."

- "We believe the company will be able to defend this action successfully."

- "We believe that the plaintiff's case against the company is without merit."

- "Based on the facts known to us, after a full investigation, it is our opinion that no liability will be established against the company in these suits."

8.42 On the other hand, the lawyer may use terms, such as *meritorious defenses*, that have different meanings to different lawyers. The Interpretation includes the following examples of lawyers' evaluations that are unclear regarding the likelihood of an unfavorable outcome:

- "This action involves unique characteristics wherein authoritative legal precedents do not seem to exist. We believe that the plaintiff will have serious problems establishing the company's liability under the act; nevertheless, if the plaintiff is successful, the award may be substantial."

- "It is our opinion that the company will be able to assert meritorious defenses to this action." (The term "*meritorious defenses*" indicates that the company's defenses will not be summarily dismissed by the court; it does not necessarily indicate the lawyer's opinion that the company will prevail.)

- "We believe the action can be settled for less than the damages claimed."

- "We are unable to express an opinion as to the merits of the litigation at this time. The company believes there is absolutely no merit to the litigation." (If the company's lawyer, with the benefit of all relevant information, is unable to conclude that the likelihood of an unfavorable outcome is "remote," it is unlikely that management would be able to form a judgment to that effect.)

- "In our opinion, the company has a substantial chance of prevailing in this action." (A "substantial chance", a "reasonable opportunity", or similar terms indicate more uncertainty than an opinion that the company will prevail.)

8.43 When the lawyer's response is unclear, the auditor may request a conference to clarify the lawyer's opinion. If the response is still unclear or the materiality of the uncertainty cannot be determined, the auditor should qualify his or her opinion or disclaim an opinion for the uncertainty.

AUDITING

8.44 The independent auditor may need to consider the specific auditing objectives, selected control procedures, and auditing procedures for commitments and contingencies presented in exhibit 8.1.

Exhibit 8.1
Auditing Considerations

Financial Statement Assertions	*Specific Auditing Objectives*	*Selected Control Procedures*	*Auditing Procedures*
Malpractice Loss Contingencies			
Existence and occurrence, completeness, rights and obligations, and valuation	The liability for malpractice claims is reported properly in the balance sheet.	Insurance coverage is reviewed regularly, including the financial viability of the insurer. The risk management system identifies and monitors malpractice incidents and evaluates associated losses. Outside legal counsel and insurance carriers review and monitor all claims. The adequacy of malpractice accruals is reviewed regularly by management, including information obtained from qualified specialists. Information supplied to specialists is reviewed for accuracy and completeness. Actuarial assumptions are reviewed for compliance with GAAP. Changes in the risk management system are communicated on a timely basis.	Review the amount of insurance coverage, the type of coverage (claims-made or occurrence), the deductible provisions, and so forth, to determine the level of risk that is retained by the entity. Consider the financial viability of the insurance carrier. Send letters of inquiry to malpractice insurance carriers and legal counsel (in accordance with SAS No. 12). Review and test the method of estimating accruals (for example, review actuarial reports and prior historical loss experience). Determine that additional premiums charged by insurers for retrospectively related policies are reported as a liability. Review prior estimates and historical loss experience.

		Determine whether uncertainties related to medical malpractice claims need to be disclosed in the auditor's report.
Presentation and disclosure	The program of medical malpractice insurance coverage and the basis for any loss accruals are disclosed adequately in the financial statements.	Review disclosures related to medical malpractice insurance for propriety.

Chapter 9

NET ASSETS (EQUITY)

INVESTOR-OWNED HEALTH CARE ORGANIZATIONS

9.1 The equity accounts of investor-owned health care entities are similar to those of other investor-owned businesses.

NOT-FOR-PROFIT AND GOVERNMENTAL HEALTH CARE ORGANIZATIONS

9.2 The balance sheets of not-for-profit health care organizations should report separate amounts for each of three classes of net assets: (a) permanently restricted net assets, (b) temporarily restricted net assets, and (c) unrestricted net assets. This is based on the existence or absence of donor-imposed restrictions.

9.3 Unrestricted net assets generally result from revenues from providing or agreeing to provide health care services, receiving unrestricted contributions and grants, or receiving dividends or interest from investing in income-producing assets minus expenses incurred in providing or agreeing to provide health care services, providing other community benefits, and performing administrative functions. The only limits on the use of unrestricted net assets are the broad limits resulting from the nature of the provider's organization; the environment in which the organization operates; the purposes specified in its articles of incorporation or in its bylaws; or limits resulting from contractual agreements with suppliers, creditors, and others entered into in the course of business. Information about significant contractual limits, including the existence of restrictive debt covenants, generally is provided in the notes to the financial statements. Similarly, information about self-imposed limits may be provided in the notes to the financial statements. Such specifics include information about voluntary resolutions by the entity's governing board to designate a portion of its unrestricted net assets for identified purposes (for example, funded depreciation).

9.4 Information about the nature and amounts of different types of permanent restrictions or temporary restrictions should be provided either by reporting their amounts on the face of the financial statements or by including relevant details in the notes to the financial statements. Separate line items may be reported within permanently restricted net assets (or in the notes to the financial statements) to distinguish between permanent restrictions for holdings of (a) assets, such as land or works of art, donated with stipulations that they be used for a specified purpose, be preserved, and not be sold or (b) assets donated with stipulations that they be invested to provide a permanent source of income (that is, permanent endowment funds).

9.5 Similarly, separate line items may be reported within temporarily restricted net assets (or in the notes to the financial statements) to distinguish between temporary restrictions for (a) support of particular operating activities, (b) investment for a specified term, (c) use in a specified future period, or (d) acquisition of long-lived assets. Donors' temporary restrictions may require that resources be used in a later period or after a specified date (time restrictions) or that resources be used for a specified purpose (purpose restrictions) or both. For example, gifts of cash and other assets with stipulations that they be invested to provide a source of income for a specified term

and that the income be used for a specified purpose (that is, term endowments) are restricted both as to time and purpose.

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

9.7 Governmental health care entities either report (1) the three classes of net assets or (2) unrestricted (general) and restricted fund balances.

AUDITING

9.8 The independent auditor may need to consider the specific auditing objectives, selected control procedures, and auditing procedures relating to net assets (equity) presented in exhibit 9.1.

Exhibit 9.1
Auditing Considerations

Financial Statement Assertions	*Specific Auditing Objectives*	*Selected Control Procedures*	*Auditing Procedures*
Rights and obligations	Resources are used and accounted for in accordance with donor and grantor restrictions.	Management monitors compliance with these restrictions.	Review the minutes of board and board committee meetings for evidence of donor restrictions.
			Determine compliance with donor and grantor restrictions.
Presentation and disclosure	Net assets are presented and disclosed properly in the financial statements.	Procedures ensure proper authorization, recording, and presentation.	Test significant net asset transactions to determine that they are properly authorized and recorded.

Chapter 10

REVENUE, EXPENSES, GAINS, AND LOSSES

CONCEPTUAL FRAMEWORK FOR REPORTING REVENUE, EXPENSES, GAINS, AND LOSSES

10.1 FASB Concepts Statement No. 6 provides a useful conceptual framework for preparers of financial statements to distinguish among elements of financial statements for purposes of display. Additionally, not-for-profit organizations are subject to the requirements of FASB Statement No. 117. This chapter draws on the concepts contained in FASB Concepts Statement No. 6 and FASB Statement No. 117 in discussing revenue, expenses, gains, and losses with respect to health care organizations. Expenses are not generally netted against revenues, whereas gains and losses may be displayed as net amounts. The application of these concepts to the classification of revenue, expenses, gains, and losses in the statement of operations of health care organizations is discussed in paragraphs 10.2 through 10.10.

DISTINGUISHING CHARITY CARE FROM BAD-DEBT EXPENSE

10.2 Distinguishing charity care from bad-debt expense requires the exercise of judgment. Charity care results from an entity's policy to provide health care services free of charge to individuals who meet certain financial criteria. The establishment of a policy clearly defining charity care should result in a reasonable determination of who is eligible. Although it is not necessary for the entity to make this determination upon admission or registration of an individual, at some point the entity must determine that the individual meets the established criteria for charity care. Charity care represents health care services that are provided but are never expected to result in cash flows. As a result, charity care does not qualify for recognition as receivables or revenue in the financial statements. (See paragraph 10.16 for disclosure requirements relating to charity care.)

REVENUE

10.3 Revenue usually is recorded when coverage is provided to an enrollee or the service is provided to a patient or resident. Revenue is classified based on the type of service rendered or contracted to be rendered. Examples of revenue include--

- Patient service revenue, which is derived from fees charged for patient care. This may be based on diagnosis related group (DRG) payments, resource-based relative value scales (RBRVS) payments, per diems, discounts, or other fee-for-service arrangements.

- Premium revenue, which is derived from capitation arrangements.

- Resident service revenue, which may be related to maintenance fees, rental fees, or amortization of advance fees.

10.4 Some not-for-profit or governmental health care enterprises may receive relatively small amounts of contributions, grants, or tax support.[1] Such amounts, whether temporarily restricted, permanently restricted, or unrestricted, are recognized as revenue or gains when they are received. Guidance pertaining to noncash contributions is provided in paragraphs 10.7, 10.8, and 10.9.

10.5 Other operating revenue, gains, or losses are derived from services other than providing health care coverage to enrollees, patients, and residents. These typically include--

- Interest and dividends from all funds held by a trustee, malpractice funds, or other miscellaneous investment activities.
- Realized changes in market values of marketable securities.
- Fees from educational programs, which include tuition for schools (such as nursing) or laboratory and X-ray technology.
- Rental of health care facility space.
- Sales of medical and pharmaceutical supplies to employees, physicians, and others.
- Fees charged for transcripts for lawyers, insurance companies, and others.
- Proceeds from sale of cafeteria meals and guest trays to employees, medical staff, and visitors.
- Proceeds from sale of scrap, used X-ray film, etc.
- Proceeds from sales at gift shops, snack bars, newsstands, parking lots, vending machines, or other service facilities operated by the health care organization.

10.6 Interest earned and gains and losses recognized on investments and other assets (or liabilities) are reported by not-for-profit organizations as increases or decreases in unrestricted net assets, unless their use is temporarily or permanently restricted by explicit donor stipulation or by law. Occasionally, not-for-profit organizations may transfer funds to, or receive transfers from, other related not-for-profit organizations. Unless repayment is expected or the funds are restricted by an independent party, such transfers (referred to as *equity transfers*) are reported as separate items that increase or decrease unrestricted net assets. Net assets released from restriction, such as those related to the fulfillment of time or purpose restrictions, should be reported separately in the financial statements or in the notes.

10.7 Donations of noncash assets that are not long-lived assets are recognized as revenue or gains in the period received and as assets or a reduction of liabilities or expenses, depending on the form of the benefits received. (For example, a donation of supplies would be reflected as revenue or gains and as an increase in inventory or supply expense.) The donations are measured

[1] Providers that derive their revenue primarily from voluntary contributions from the general public are subject to the requirements of the AICPA Audit and Accounting Guide *Audits of Not-for-Profit Organizations*.

at fair value.[2] Donations received with no restrictions attached are reported as unrestricted support in the statement of activities. Donations with explicit donor restrictions attached are reported as temporarily restricted support. The expiration of these restrictions is recognized in the period when the time stipulated by the donor has elapsed, when the stipulated purpose for which the asset was restricted has been fulfilled, or both. When the restriction expires, the temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statement of activities as "net assets released from restriction." Donor-restricted contributions whose restrictions are met in the same reporting period may be reported as unrestricted support provided that an organization reports consistently from period to period and discloses its accounting policy.

10.8 Donations of long-lived assets, including the use of long-lived assets such as land, buildings, and equipment, are reported as revenue or gains in the period received. The donation is measured at its fair value. If the donor places no restrictions on the use of the asset, the donation is reported as unrestricted support. Donations of long-lived assets with explicit donor restrictions that stipulate how the assets are to be used are reported as temporarily restricted support. The provider reports expirations of donor restrictions when the stipulation is fulfilled. At that time, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statement of activities as "net assets released from restriction."

10.9 Donations of cash or other assets that must be used to acquire long-lived assets are reported as temporarily restricted support in the period received. Expirations of donor restrictions are reported when the acquired long-lived assets are placed in service. The temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statement of activities as "net assets released from restriction." For providers that prepare classified balance sheets, assets that are restricted by donors for acquisition of long-lived assets (such as cash or contributions receivable) are not included in "cash and cash equivalents" or with other "contributions receivable." Rather, those assets are reported in a separate section, such as "assets restricted to investment in property and equipment," and are sequenced near the "property and equipment" section of the balance sheet.

10.10 The nature and extent of donated services received by health care organizations varies and can range from the limited participation of many people in fund-raising activities to active participation in the entity's service programs. Because it is difficult to place a monetary value on such services, their values usually are not recorded. Guidance with regard to the accounting for and the reporting of donated services is provided in FASB Statement No. 116. For governmental health care enterprises, FASB Statement No. 116 is not applicable to contributions and transfers from another governmental entities. Contributions from one governmental entity to another governmental health care enterprise are accounted for in accordance with National Council on Governmental Accounting (NCGA) Statement 2, *Grant, Entitlement, and Shared Revenue Accounting by State and Local Governments*, and GASB Statement No. 6, *Accounting and Financial Reporting for Special Assessments.* Furthermore, certain interfund transactions with other funds in the same financial reporting entity are to be accounted for as residual equity transfers or operating transfers, in accordance with NCGA Statement 1, paragraph 105.

10.11 Some donors enter into trust or other arrangements under which not-for-profit organizations receive benefits that are shared with other beneficiaries. The accounting guidance on the recognition and measurement principles for these arrangements, commonly known as "split-interest

[2] Information necessary to estimate the fair value of a donated asset may be obtained from various sources as described in FASB Statement No. 116, paragraph 19.

agreements," is discussed in the exposure draft of the Audit and Accounting Guide *Not-for-Profit Organizations*.

EXPENSES

10.12 The basis and timing of the recognition of expenses for health care organizations generally are the same as for other business enterprises. Not-for-profit organizations report expenses as decreases in unrestricted net assets.

FINANCIAL STATEMENT PRESENTATION

10.13 Health care organizations should report the results of their operations in a statement of operations. Operating results should be reported separately from--

- Transactions with owners acting in that capacity.
- Equity transfers involving other entities that control the reporting entity, are controlled by the reporting entity, or are under common control with the reporting entity.
- Receipt of restricted contributions, including temporary restrictions (such as time or purpose) or permanent restrictions.
- Contributions of long-lived assets.
- Other items that are required by GAAP to be reported separately (such as extraordinary items, the effect of discontinued operations, or the cumulative effect of accounting changes).

10.14 Because of the importance of the operating indicator, it should be clearly labeled as operating income (or loss). Not-for-profit organizations should report their total income or loss from operations on a statement that, at a minimum, also presents the total changes in unrestricted net assets. If an organization's use of the term *operations* is not apparent from the details provided on the face of the statement, a note to financial statements should describe the nature of the reported measure of operations or the items excluded from operations.

10.15 For financial reporting purposes, patient service revenue is reported net of provisions for contractual and other adjustments in the operating statement. Significant revenue earned under capitation arrangements is reported separately. The notes to the financial statements disclose the methods of revenue recognition (for example, policies related to capitation revenue, patient service revenue, or contributions). In addition, with regard to contractual adjustments and third-party settlements, identification and explanation of the estimated amounts that are payable or receivable by the entity are disclosed.

10.16 As discussed in paragraph 10.2, patient service revenue does not include charity care. Management's policy for providing charity care, as well as the level of charity care provided, should be disclosed in the financial statements. Such disclosure generally is made in the notes to the financial statements and is measured based on the provider's rates, costs, units of service, or other statistical measure.

10.17 Expenses may be reported on the face of the financial statements using either a natural classification or a functional presentation. Public companies (that is, registrants with the SEC) are required to disclose segment information.[3] Not-for-profit organizations that report using a natural classification of expenses are required to disclose expenses by functional classification.

10.18 The extent of classification and subclassification of expenses depends on many factors, such as the nature and complexity of the health care organization. For example, some entities may present only two categories: (a) health services (including inpatient services, outpatient procedures, home health services, etc.) and (b) general and administrative. Others may present additional distinctions such as physician services, research, and teaching. Functional allocations should be based on full cost allocations.

AUDITING

10.19 The independent auditor may need to consider the specific auditing objectives, selected control procedures, and auditing procedures to audit revenue, expenses, gains, and losses presented in exhibit 10.1.

---

[3] The segment reporting requirements of NCGA Interpretation 2, *Segment Information for Enterprise Funds*, applies to governmental health care enterprises.

Exhibit 10.1
Auditing Considerations

Financial Statement Assertions	*Specific Auditing Objectives*	*Selected Control Procedures*	*Auditing Procedures*
Revenue and Gains for Health Care Services			
Existence and occurrence, completeness, and presentation and disclosure	Revenue and gains are reported in the proper period using the accrual basis of accounting and are classified properly by the type of service rendered.	Procedures help ensure that revenue is accrued as services are performed or as contractual obligations are satisfied.	Perform a walk-through of the revenue system. Compare the current period's revenue with prior periods' revenue and/or budgets and obtain explanations for large or unusual variances.
		Management monitors the accuracy and completeness of medical records for DRG assignments.	Challenge the accuracy of revenue recorded based upon DRG assignments by reviewing the results of the peer review organization's (PRO) DRG validation audits, appropriateness of admissions and related denials.
	In the statement of operations, revenue from health care services is reported, net of contractual adjustments and other adjustments, in the proper period and is classified properly.	Controls ensure that deductions from revenue are recorded in the proper period and are classified properly. Contractual and other adjustments are authorized, controlled, and recorded properly. Charity care, bad-debt writeoffs, and courtesy and policy discounts are authorized, controlled, and recorded properly.	Review the financial statements to determine that revenue is reported net of contractual adjustments and other adjustments. Test contractual adjustments, other adjustments, and bad debts to determine that they are accounted for both in accordance with the respective contracts and the entity's policy. Determine that specific and unallocated reserves

			appear reasonable and comparable to prior year. Review third-party payor contracts and methods of payment and test the entity's computation of estimated adjustments to revenue as required under such contracts.
Expenses			
Existence and occurrence, completeness, valuation and allocation, and presentation and disclosure	Expenses are reported in the proper period and are classified properly.	Controls ensure that expenses are reported properly in the current period and are classified properly.	Compare current period expenses with prior-period expenses and/or budget and obtain explanations for large or unusual variances.

Chapter 11

THE REPORTING ENTITY AND RELATED ORGANIZATIONS

OVERVIEW

11.1 The FASB is presently studying the concept of the reporting entity and issues related to consolidations, application of the equity method of accounting, and accounting for various types of joint ventures. On August 26, 1994, the FASB released a document entitled *Preliminary Views on Major Issues Related to Consolidation Policy* as part of its project on consolidations and related matters. The conclusions in this chapter will be reconsidered when the FASB completes this project, which may affect the definition of *control* and other related matters. The GASB has issued Statement No. 14, *The Financial Reporting Entity*, which addresses these issues for governmental entities. GASB Statement No. 14 establishes standards for defining and reporting for the financial reporting entity and for reporting its participation in joint ventures. The GASB also has on its agenda a project on the reporting of affiliated organizations, such as foundations, and has issued an exposure draft of a proposed Statement entitled *The Financial Reporting Entity—Affiliated Organizations*. Accordingly, these matters may require reconsideration pending resolution by the FASB and the GASB.

11.2 Networks among health care organizations, both vertical and horizontal, are being formed continually and new organizational structures are being developed. The dynamics of change in the health care industry and their impact on evolving organizational structures must be considered in defining the reporting entity.

11.3 An integrated health care system typically consists of multiple related entities, operating both for-profit and not-for-profit organizations. A not-for-profit parent corporation may be the sole corporate member or, through other means, it may control other entities such as a not-for-profit hospital, a not-for-profit medical foundation that contracts with a for-profit physician group, or other not-for-profit providers such as a long-term care center, a substance abuse center, a surgery center, or an outpatient clinic. The system also may own stock in various for-profit ventures such as HMOs or insurance companies that may or may not provide patient care. Fund-raising typically is accomplished through a separate foundation. Foundations, auxiliaries, guilds, and similar organizations frequently assist and, in many instances, are related to the health care organization.

11.4 The guidance in this chapter relates to for-profit and not-for-profit consolidations of parent-subsidiary relationships, whether through stock ownership or other means of control. Other circumstances may exist in the health care industry where combined financial statements involving commonly controlled entities are more meaningful than their separate financial statements. More specific guidance related to combined financial statements can be found in Accounting Research Bulletin (ARB) No. 51, *Consolidated Financial Statements*, paragraphs 22 and 23.[1]

---

[1] In some situations, debt agreements may require combined financial statements of affiliated entities, the assets or revenues of which serve as collateral for the related debt (sometimes called an "obligated group"). ARB No. 51 applies to those situations. However, if debt or other agreements prescribe a financial presentation that varies from GAAP (for example, exclusion of entities otherwise required to be consolidated), the auditor should consider SAS No. 62, *Special Reports* (AICPA, *Professional Standards*, vol. 1, AU sec. 623), for reporting guidance.

FINANCIAL REPORTING

11.5 Whether the financial statements of a reporting health care organization and those of one or more other for-profit or not-for-profit entities should be consolidated, whether those other entities should be reported using the equity method, and the extent of disclosure that should be required (if any) if consolidated financial statements are not presented, should be based on the nature of the relationship between the entities.

11.6 Health care organizations may be related to one or more other entities in numerous ways, including ownership, control, and/or economic interest.

11.7 As discussed in paragraphs 11.10 through 11.16, the existence of various forms of control and economic interests result in various financial reporting. Certain kinds of control result in consolidation (see paragraph 11.10). Other kinds of control result in consolidation only if coupled with an economic interest (see paragraph 11.11). Still other kinds of control result in consolidation being permitted but not required, if coupled with an economic interest (see paragraph 11.12). The existence of either control or an economic interest, but not both, is discussed in paragraph 11.13; disclosures concerning restrictions on distributions are discussed in paragraph 11.14; and reporting under the equity method of accounting is discussed in paragraph 11.16.

11.8 Control is the direct or indirect ability to determine the direction of management and policies through ownership, contract, or otherwise. However, the rights and powers of the controlling entity may vary depending on the legal structure of the controlled entity and the nature of control. The majority owner of a for-profit entity's voting stock or the sole corporate member of a not-for-profit entity may not only have the ability to determine the direction of the controlled entity but also have the proportionate right to (or the responsibility for) operating results and a residual interest in the net assets upon dissolution. However, in other situations, the rights of the controlling party may be more limited. For example, in the case of a sole general partner in a limited partnership, the limited partners--and not the general partner--may be entitled to the net assets upon dissolution. As a result, whether the financial statements of a controlled entity should be consolidated with the reporting entity depends on the nature of control and whether an economic interest exists.

11.9 An economic interest in another entity exists if (a) the other entity holds or utilizes significant resources that must be used for the unrestricted or restricted purposes of the reporting entity--either directly or indirectly--for producing income or providing services or (b) the reporting entity is responsible for the liabilities of the other entity. The following are examples of economic interests:

- Other entities solicit funds in the name of, and with the expressed or implied approval of, the reporting entity. In addition, substantially all of the funds solicited are intended by the contributor or are otherwise required to be transferred to the reporting entity or used at its discretion or direction.

- The reporting entity transfers significant resources to another entity whose resources are held for the benefit of the reporting entity.

- The reporting entity assigns certain significant functions to another entity.

- The reporting entity provides or is committed to provide funds for another entity or the reporting entity guarantees significant debt of another entity.

- The reporting entity has a right to, or the responsibility for, the operating results of another entity. Or, upon dissolution, the reporting entity is entitled to the net assets, or is responsible for any deficit, of another entity.

11.10 Health care organizations with a controlling financial interest in other entities through direct or indirect ownership of a majority voting interest[2] in those other entities should consolidate those other entities, unless control is likely to be temporary or does not rest directly or indirectly with the majority owner (for example, if the subsidiary is in legal reorganization or in bankruptcy). In such situations consolidation is prohibited, as discussed in paragraph 13 of FASB Statement No. 94.

11.11 In the case of (a) control through a majority voting interest in the board of another entity by means other than ownership or sole corporate membership[3] and (b) an economic interest in such entities, consolidation is required, unless control is likely to be temporary or does not rest with the majority owner. In this situation consolidation is prohibited, as discussed in paragraph 13 of FASB Statement No. 94, *Consolidation of All Majority-Owned Subsidiaries*.

11.12 Control of a separate not-for-profit organization in which the reporting entity has an economic interest may take forms other than majority ownership or voting interest; for example, control may be through contract or affiliation agreement.[4] In circumstances such as these, consolidation is permitted but not required, unless control is likely to be temporary. In this situation consolidation is prohibited, as discussed in paragraph 13 of FASB Statement No. 94. If the reporting entity controls a separate not-for-profit entity through a form other than majority ownership (paragraph 11.10) or voting interest (paragraph 11.11), has an economic interest in that other entity, and consolidated financial statements are not presented, the notes to the financial statements should include the following disclosures:

- Identification of the other entity and the nature of its relationship with the reporting entity that results in control

---

[2] Because not-for-profit organizations may exist in various legal forms, ownership of not-for-profit organizations may be evidenced in various ways. Examples include corporations issuing stock, corporations issuing ownership certificates, membership corporations issuing membership certificates, joint ventures, and partnerships. A parent corporation typically owns stock in a for-profit entity, whereas a sole corporate member holds membership rights in a not-for-profit entity. As it relates to health care consolidations, sole corporate membership in a not-for-profit entity is considered to be equivalent to ownership of a majority voting interest in a for-profit entity, unless the sole corporate member's interest in the controlled entity is restricted by state law.

[3] For purposes of this guide, a majority voting interest in the board of another entity by means other than ownership or sole corporate membership is illustrated by the following example. Entity B has a five-member board, and a simple voting majority is required to approve board actions. Entity A will have a majority voting interest in the board of entity B if three or more of its board members, officers, or employees serve on (or may be appointed at entity A's discretion to) the board of entity B. However, if three of entity A's board members serve on the board of entity B but entity A does not have the ability to require that those members serve on entity B's board, entity A does not have a majority voting interest in the board of entity B.

[4] Evidence of control may include authority to amend articles of incorporation and bylaws or authority to approve operating, capital, and construction budgets; capital acquisitions; strategic plans, goals, and objectives; and mergers or dissolutions.

- Summarized financial data of the other entity, including total assets, liabilities, net assets, revenue, and expenses; and resources that are held for the benefit of the reporting entity or that are under its control

- The disclosures set forth in FASB Statement No. 57, *Related Party Disclosures*

11.13 In some cases, one entity may have an economic interest in another entity without controlling it (for example, a noncontrolled entity may solicit funds in the name of, and with the expressed or implied approval of, the reporting entity and substantially all of the funds solicited are intended by the contributor to benefit the reporting entity). The existence of control or an economic interest, but not both, precludes consolidation but requires the disclosures set forth in FASB Statement No. 57.[5]

11.14 If consolidated financial statements are presented and they include a controlled not-for-profit organization, they should disclose any restrictions made by entities outside of the reporting entity on distributions from the controlled not-for-profit organization to the reporting entity and any resulting unavailability of the net assets of the controlled not-for-profit organization for use by the reporting entity.

11.15 When consolidated financial statements are required or permitted, a minority interest should be provided only if such interest is represented by an economic interest whereby the minority interest would share in the operating results or residual interest upon dissolution.

11.16 Investments in common stock of for-profit entities in which the reporting entity has 50 percent or less of the voting stock in the investee should be reported under the equity method in conformity with APB Opinion No. 18, if the guidance in that opinion requires use of the equity method. The equity method should be followed by an investor whose investment in voting stock gives it the ability to exercise significant influence over operating and financial policies of an investee. Determining the ability of an investor to exercise significant influence is not always clear, and applying judgment is necessary to assess the status of each investment. However, to achieve a reasonable degree of uniformity, the ownership of 20 percent or more of the voting stock leads to a presumption that the investor can exercise significant influence and, therefore, the investment should be accounted for under the equity method in accordance with APB Opinion No. 18. However, this presumption can be overcome in certain instances. FASB Interpretation No. 35, *Criteria for Applying the Equity Method of Accounting for Investments in Common Stock*, paragraph 4, provides examples of indications that an investor may be unable to exercise significant influence. Health care organizations that report investments on the equity method should make the financial statement disclosures required by APB Opinion No. 18.

11.17 This guide provides guidance concerning consolidated financial statements. Consolidation of a parent or subsidiary organization requires the presentation of a single set of amounts for the entire reporting entity. Combination, as discussed in paragraphs 22 and 23 of ARB No. 51, refers to financial statements prepared for organizations between which common control exists but for which the parent-subsidiary relationship does not exist. Both consolidation and combination require elimination of interorganization transactions and balances. Paragraph 22 of ARB No. 51 states that "there are circumstances, however, where combined financial statements (as

---

[5] The existence of an economic interest does not necessarily cause the entities to be related parties, as defined in FASB Statement No. 57. However, the disclosures required by that statement are required under this guide if an economic interest exists.

distinguished from consolidated statements) of commonly controlled companies are likely to be more meaningful than their separate statements." This guide prohibits consolidated financial statements in certain circumstances. However, it provides no guidance concerning combined financial statements of commonly controlled entities, which may be presented in certain circumstances in conformity with the guidance in ARB No. 51.

11.18 This guide provides no guidance concerning the financial statements of only the parent entity or only the subsidiary entity. Paragraph 15 of FASB Statement No. 94 precludes the use of the parent company's financial statements as the general-purpose financial statements of the primary reporting entity. However, that statement does not discuss the use of the parent company's financial statements as other than the general-purpose financial statements for the primary reporting entity.[6] GAAP do not preclude the issuance of financial statements for the subsidiary only. However, care should be taken to include all disclosures required by FASB Statement No. 57 and other relevant pronouncements.

TRANSFERS

11.19 Equity transfers are similar to ownership transactions between a for-profit parent and its owned subsidiary (for example, additional paid-in capital or dividends). However, equity transfers can occur only between related not-for-profit entities when one controls the other or both are under common control. An equity transfer embodies no expectation of repayment, nor does the transferor receive anything of immediate economic value (such as a financial interest or ownership). Equity transfers are reported separately as changes in net assets, are excluded from operating income, and do not result in any step-up in basis of the underlying assets transferred.

11.20 Other transfers may occur among related entities. If the entities are consolidated or combined, such transfers are eliminated in consolidation and/or combination. If the entities are not consolidated or combined (for example, in separate subsidiaries, parent only, or obligated group financial statements), the method of accounting for such transfers is dictated by the substance of the transaction as well as the legal form. For example, transfers by a foundation to a hospital under common control, when the foundation is acting other than as an owner, should be accounted for as contributions received by the hospital, consistent with FASB Statement No. 116 and chapter 10 of this guide.

11.21 A health care organization may loan or advance resources to a related entity. If repayment is expected, a receivable or payable should be recorded by the entities. Subsequent to the time the loan is made, the ability of the receiving entity to repay the loan should be considered. If the transfer is not to be repaid, or if the receiving entity is perceived as unable to repay the loan, it should be accounted for as an equity transfer with the transferor reducing net assets and the transferee increasing net assets (see paragraph 10.19).

11.22 Transfers that result in changes in ownership interest are accounted for as investments in accordance with APB Opinion No. 18 and FASB Statement No. 94.

---

[6] Contractual agreements or regulatory provisions may require parent company only financial statements. SAS No. 62 provides guidance for reporting on financial presentations to comply with contractual agreements or regulatory provisions.

11.23 A related entity may act as an agent for the reporting entity. Resources transferred by a related fund-raising organization to an affiliated health care entity that were solicited in the name of the health care entity may represent transfers under an agency arrangement. The reporting entity (and not the agent) records the contribution received in accordance with FASB Statement No. 116. If a contribution is transferable to the ultimate recipient through an agent acting as an intermediary, the ultimate recipient should report the contribution when adequate evidence that the agent has received the promise to give or the contribution becomes available.

11.24 Assets transferred from one commonly controlled entity to another should be recorded by the transferee at the carrying value of the transferring entity. This treatment is consistent with the guidance prescribed by AICPA Accounting Interpretation No. 39, *Transfers and Exchanges Between Companies Under Common Control*, of APB Opinion No. 16, *Business Combinations*.

DISCLOSURE

11.25 Significant relationships and transactions not in the ordinary course of business with directors, management, medical staff, or other related parties (including unconsolidated related organizations) should be disclosed in accordance with FASB Statement No. 57. SAS No. 45, *Omnibus Statement on Auditing Standards--1983*, "Related Parties" (AICPA, *Professional Standards*, vol. 1, AU sec. 334), sets forth procedures for the auditor to consider in determining the existence of transactions with related parties and identifying them.

11.26 Hospital boards may contract with management companies to operate their facilities. Frequently, the management company will employ the administrator as well as other key personnel. Further, services may be acquired from entities related to the management company. The auditor should evaluate the impact of these arrangements on the hospital's internal controls and disclose related party transactions as required by FASB Statement No. 57.

11.27 The reporting and disclosure requirements of the nongovernmental health care organization under the circumstances noted in paragraphs 11.10 through 11.18 are summarized as follows:

Circumstances	*Requirements*
The entity owns a majority of a for-profit entity's voting stock.	Consolidate.
The entity is the sole corporate member of a not-for-profit entity.	Consolidate.
The entity controls another through a majority voting interest in the board and an economic interest exists.	Consolidate.
The reporting entity owns 50 percent or less of the common voting stock of an investee and can exercise significant influence over operating and financial policies.	The investment should be accounted for under the equity method in accordance with APB Opinion No. 18.

There have been material transactions between the health care entity and the related organization. (This could be present in any of the foregoing circumstances.)	In the notes to the financial statements (a) disclose the existence and nature of the relationship and (b) describe and quantify the transactions.
An entity has control over another not-for-profit organization or has an economic interest in the other, but not both.	In the notes to the financial statements (a) disclose the existence and nature of the relationship and (b) describe and quantify the transactions.
The reporting entity controls a separate not-for-profit entity through a form other than majority ownership or voting interest and has an economic interest in that other entity.	Consolidation permitted but not required. If consolidated statements are not presented, the notes to the financial statements should disclose (a) the identification of the other entity and the nature of its relationship with the reporting entity, (b) summarized financial data of the other entity, and (c) the disclosures set forth in FASB Statement No. 57.

BUSINESS COMBINATIONS

11.28 As discussed in paragraph 11.2, the dynamics of change in the health care industry have resulted in increased business combinations as new organizational structures are being formed. APB Opinion No. 16 provides guidance regarding business combinations concerning for-profit business enterprises and may provide a useful framework when evaluating similar transactions entered into by not-for-profit health care business organizations. A list of possible factors to be considered when evaluating these transactions in relation to APB Opinion No. 16 is summarized as follows:

Circumstances	*Accounting and Disclosure Guidance*
Monetary consideration received or paid, change in legal title to assets, and/or assumption of liabilities	This is similar to a purchase under APB Opinion No. 16.[7]
Change in control (for example, change in sole corporate member)	This is similar to a pooling of interests transaction under APB Opinion 16. No step-up in basis.

AUDITING

11.29 The independent auditor may need to consider the specific auditing objectives, control procedures, and auditing procedures for related party organizations, balances, and transactions presented in exhibit 11.1.

[7] See AICPA Accounting Interpretation No. 39 of APB Opinion No. 16 for treatment of transfers and exchanges between companies under common control.

Exhibit 11.1
Auditing Considerations

Financial Statement Assertions	*Specific Auditing Objectives*	*Selected Control Procedures*	*Auditing Procedures*
Existence and occurrence, completeness, and presentation and disclosure	The reporting entity is appropriate.	Procedures ensure that investees, affiliates, and other related entities are accounted for appropriately.	Review the articles of incorporation, bylaws, and minutes of directors' meetings, shareholder lists, and filings with regulatory authorities to determine the existence of related parties. Obtain representations from management as to whether all investees, affiliates, and related entities have been accounted for properly or disclosed. Review transactions with investees, affiliates, and other related entities to determine that they are reported properly.
	Relationships and transactions with related organizations are identified and disclosed, if appropriate, because of economic dependence of the entity.	Procedures ensure that conflict-of-interest policies, procedures, and disclosure requirements are met.	Test significant related party transactions as follows: • Determine substance. • Examine documents (invoices, contracts, and agreements). • Determine the basis of pricing.

		• Determine the collectibility of receivables and advances.
		Review related party transactions for completeness by-- • Considering previously identified transactions or relationships. • Reviewing the minutes of directors' and other meetings. • Discussing related party transactions with entity personnel. • Reviewing unusual transactions. • Reviewing the responses to related party (conflict-of-interest questionnaires.
Presentation and disclosure	Related party transactions and organizations are reported properly.	Review the presentation and disclosure of related party information for completeness.

Chapter 12

INDEPENDENT AUDITOR'S REPORTS

OVERVIEW

12.1 The guidance in SAS No. 58, *Reports on Audited Financial Statements* (AICPA, *Professional Standards*, vol. 1, AU sec. 508), applies to audit reports on the financial statements of health care organizations. Such a report may contain an unqualified opinion, an unqualified opinion with an explanatory paragraph, a qualified opinion, a disclaimer of opinion, or an adverse opinion. The facts and circumstances of each particular audit govern the appropriate form of the report. Report examples appearing in this chapter illustrate the form of certain auditor's reports issued by the independent auditor in auditing the financial statements of a health care organization.

UNQUALIFIED OPINION

12.2 The independent auditor's standard report states that the financial statements present fairly, in all material respects, an entity's financial position, results of operations, and cash flows in conformity with GAAP. This conclusion may be expressed only when the independent auditor has formed such an opinion on the basis of an audit performed in accordance with GAAS. An example of the independent auditor's standard report is presented in exhibit 12.1 at the end of this chapter.

UNQUALIFIED OPINION WITH EXPLANATORY PARAGRAPH

12.3 SAS No. 58 indicates instances when an explanatory paragraph should be added following the standard opinion paragraph for (a) material uncertainties (see exhibit 12.2) or (b) a change in accounting principles or in their method of application that has a material effect on the comparability of financial statements (see exhibit 12.3).

QUALIFIED OPINION

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

a. There is a lack of sufficient competent evidential matter or there are restrictions on the scope of the audit that have led the independent auditor to conclude that an unqualified opinion cannot be expressed and the independent auditor has concluded not to disclaim an opinion (see exhibit 12.4).

b. The independent auditor believes, on the basis of the audit, that the financial statements contain a departure from GAAP, the effect of which is material, and has concluded not to express an adverse opinion (see exhibit 12.5).

ADDITIONAL INFORMATION

12.5 SAS No. 29, *Reporting on Information Accompanying the Basic Financial Statements in Auditor-Submitted Documents* (AICPA, *Professional Standards*, vol. 1, AU sec. 551), contains useful guidance on reporting on additional information. The information covered by SAS No. 29 is presented to accompany the basic financial statements in an independent auditor-submitted document and is not considered necessary for a fair presentation of financial position, results of operations, changes in net assets, and cash flows in conformity with GAAP. Such information includes additional details or explanations of items in, or related to, the basic financial statements, consolidating information, historical summaries of items extracted from the basic financial statements, statistical data, and other material, some of which may be from sources outside the accounting system or outside the health care organization.

12.6 With respect to supplementary and other information, guidance is contained in SAS No. 8, *Other Information in Documents Containing Audited Financial Statements* (AICPA, *Professional Standards*, vol. 1, AU sec. 550), and SAS No. 52, *Omnibus Statement on Auditing Standards--1987*, "Required Supplementary Information" (AICPA, *Professional Standards*, vol. 1, AU sec. 558). Among other changes, SAS No. 52 amends SAS No. 29 regarding required supplementary information. In addition, SAS No. 42, *Reporting on Condensed Financial Statements and Selected Financial Data* (AICPA, *Professional Standards*, vol. 1, AU sec. 552), contains guidance on reporting in a client-prepared document when condensed financial statements or selected financial data are presented by a public entity.

SPECIAL REPORTS

12.7 If a health care organization is required to follow reporting requirements of a regulatory agency, to report under a cash receipts and disbursements basis of accounting, or to report on another comprehensive basis of accounting other than GAAP, the auditor should follow the guidance in SAS No. 62, *Special Reports* (AICPA, *Professional Standards*, vol. 1, AU sec. 623). SAS No. 62 also provides reporting guidance when reporting on specified elements, accounts, or items of a financial statement; compliance with aspects of contractual agreements or regulatory requirements related to audited financial statements; financial presentations to comply with contractual agreements or regulatory provisions; and financial information presented in prescribed forms (see exhibit 12.6). 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* (AICPA, *Professional Standards*, vol. 1, AU sec. 622).

Exhibit 12.1
Unqualified Opinion--Comparative Financial Statements

Independent Auditor's Report

To the Board of Trustees
XYZ Health Care Organization

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

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

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

[Signature]
[Date]

Exhibit 12.2
Unqualified Opinion With Explanatory Paragraph for Material Uncertainty Related to Medical Malpractice Liability

Independent Auditor's Report

To the Board of Trustees
XYZ Health Care Organization

[Include standard wording for first three paragraphs--see exhibit 12.1]

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

[Signature]
[Date]

Exhibit 12.3
Unqualified Opinion With Explanatory Paragraph for Change in Accounting Principle That Has a Material Effect on the Comparability of Financial Statements

Independent Auditor's Report

To the Board of Trustees
XYZ Health Care Organization

[Include standard wording for first three paragraphs--see exhibit 12.1]

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

[Signature]
[Date]

Exhibit 12.4
Qualified Opinion--Scope Limitation

Independent Auditor's Report

To the Board of Trustees
XYZ Health Care Organization

[Include same first paragraph as the standard report--see exhibit 12.1]

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

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

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

[Signature]
[Date]

Exhibit 12.5
Qualified Opinion--Departure From Generally Accepted Accounting Principles That Have a Material Effect on the Financial Statements

Independent Auditor's Report

To the Board of Trustees
XYZ Health Care Organization

[Include same first and second paragraphs as the standard report--see exhibit 12.1]

XYZ Health Care Organization has excluded, from property and debt in the accompanying balance sheets, certain lease obligations that, in our opinion, should be capitalized to conform with generally accepted accounting principles. If these lease obligations were capitalized, property would be increased by $XXX,XXX and $XXX,XXX, long-term debt would be increased by $XXX,XXX and $XXX,XXX, and unrestricted net assets would be increased by $XXX,XXX and $XXX,XXX as of September 31, 19X2, and 19X1, respectively. In addition, operating income would be increased by $XXX,XXX and $XXX,XXX, respectively, for the years then ended.

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

[Signature]
[Date]

Exhibit 12.6

Report on Financial Statements Prepared Pursuant to a Master Trust Indenture That Results in a Presentation Not in Conformity With Generally Accepted Accounting Principles or Other Comprehensive Basis of Accounting

Independent Auditor's Report

To the Board of Directors
Sample Health Care Corporation

We have audited the accompanying special-purpose combined balance sheets of the Obligated Group (as defined in the Master Trust Indenture dated December X, 19X0, between Sample Health Care Corporation and Any Bank as Trustee) of Sample Health Care Corporation and Affiliates as of December 31, 19X2, and 19X1, and the related special-purpose combined statements of operations, changes in net assets, and cash flows for the years then ended. These financial statements are the responsibility of management. Our responsibility is to express an opinion on these financial statements based on our audits.

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

As described in Note 1, these special-purpose financial statements were prepared in accordance with the accounting requirements set forth in the Master Trust Indenture and are not intended to be a presentation in conformity with generally accepted accounting principles.

In our opinion, the special-purpose financial statements of the Obligated Group as of and for the years ended December 31, 19X2, and 19X1, are fairly presented, in all material respects, on the basis of accounting described in Note 1.

This report is intended solely for the information and use of the board of directors and management of Sample Health Care Corporation, the Trustee under the Master Trust Indenture, and bondholders, and should not be used for any other purpose.

[Signature]
[Date]

Chapter 13

FINANCIAL ACCOUNTING AND REPORTING BY PROVIDERS OF PREPAID HEALTH CARE SERVICES

OVERVIEW

13.1 This chapter provides guidance on applying GAAP to providers of prepaid health care services for the accounting and reporting of health care costs, contract losses (premium deficiencies), stop-loss insurance (reinsurance), and contract acquisition costs.

ACCOUNTING FOR HEALTH CARE COSTS

13.2 Health care costs should be accrued as services are rendered, including estimates of the costs of services rendered but not yet reported. Furthermore, if a provider of prepaid health care services is obligated to render services to specific members beyond the premium period due to provisions in the contract or regulatory requirements, the costs to be incurred of such services, net of any related anticipated revenues, also should be accrued currently. Costs that will be incurred after a contract is terminated, such as guaranteed salaries, rent, and depreciation, net of any anticipated revenues, should be accrued when it is determined that a contract with a sponsoring employer or other group will be terminated.

13.3 Amounts payable to hospitals, physicians, or other health care providers under risk-retention, bonus, or similar programs should be accrued during the contract period based on relevant factors, such as experience to date.

13.4 The basis for accruing health care costs and significant business and contractual arrangements with hospitals, physicians, or other associated entities should be disclosed in the notes to the financial statements.

ACCOUNTING FOR LOSS CONTRACTS

13.5 A prepaid health care provider enters into contracts to provide members with specified health care services for specified periods in return for fixed periodic premiums. The premium revenue is expected to cover health care costs and other costs over the terms of the contracts. Only in unusual circumstances would a provider be able to increase premiums on contracts in force to cover expected losses. A provider may be able to control or reduce future health care delivery costs to avoid anticipated losses, but the ability to avoid losses under existing contracts may be difficult to measure or to demonstrate. Associated entities such as hospitals, medical groups, and IPAs may enter into similar contracts with prepaid health care providers in which they agree to deliver identified health care services to the providers' members for specified periods in return for fixed fees.

13.6 FASB Statement No. 5 states that a loss should be accrued in financial statements when it is probable that a loss has been incurred and the amount of the loss can be reasonably estimated. Accordingly, losses should be recognized when it is probable that expected future health care

costs and maintenance costs under a group of existing contracts will exceed anticipated future premiums and stop-loss insurance recoveries on those contracts. The estimated future health care costs and maintenance costs to be considered in determining whether a loss has been incurred should include fixed and variable, direct, and allocable indirect costs. Contracts should be grouped in a manner consistent with the provider's method of establishing premium rates, for example, by community rating practices, geographical area, or statutory requirements, to determine whether a loss has been incurred.

ACCOUNTING FOR STOP-LOSS INSURANCE

13.7 In stop-loss insurance, prepaid health care providers or associated entities transfer portions of their financial risks to other companies. A provider typically contracts to recover health care costs in excess of stated amounts during the contract periods.

13.8 Stop-loss insurance premiums should be included in reported health care costs. Stop-loss insurance recoveries should be reported as reductions of related health care costs. Receivables representing amounts recoverable from insurers should be reported as assets, reduced by appropriate valuation allowances. In addition, the nature, amounts, and effects of significant stop-loss insurance contracts should be disclosed.

ACCOUNTING FOR CONTRACT ACQUISITION COSTS

13.9 Many prepaid health care providers incur costs that vary with, and are primarily related to, the marketing of subscriber contracts and member enrollment. These costs, sometimes referred to as acquisition costs, consist mainly of commissions paid to agents or brokers and incentive compensation based on new enrollments. Commissions and incentive compensation may be paid when the contracts are written, at later dates, or over the terms of the contracts as premiums are received. Some providers incur additional costs directly related to the acquisition of specific contracts, such as the costs of specialized brochures, marketing, and advertising. Providers also incur costs that are related to the acquisition of new members but that do not relate to specific contracts and are not considered acquisition costs. These costs include salaries of the marketing director and staff, general marketing brochures, and general advertising and promotion expenses.

13.10 Although there is theoretical support for deferring certain acquisition costs, acquisition costs of providers of prepaid health care services--other than costs of advertising--should be expensed as incurred.[1] Advertising costs should be accounted for in conformity with the guidance in SOP 93-7, *Reporting on Advertising Costs*.[2]

---

[1] In accordance with existing practice, as mandated by SOP 89-5, *Financial Accounting and Reporting by Providers of Prepaid Health Care Services*. Although SOP 89-5 has been superseded with the issuance of this Audit and Accounting Guide, its provisions have been adopted in this chapter.

[2] This pronouncement is not applicable to governmental health care enterprises that do not apply paragraph 7 of GASB Statement 20. (See footnote 1, chapter 1.)

Chapter 14

FINANCIAL ACCOUNTING AND REPORTING BY CONTINUING CARE RETIREMENT COMMUNITIES

OVERVIEW

14.1 This chapter provides guidance on applying GAAP to continuing care retirement communities (CCRCs) for refundable and nonrefundable advance fees, for obligations to provide future services and the use of facilities to current residents, and for the costs of acquiring initial care contracts.

14.2 There are over one thousand CCRCs in the United States. Most CCRCs are operated by not-for-profit organizations, and many are affiliated with religious organizations.

14.3 CCRC facilities may be independent or they may be affiliated with other health care facilities. They usually provide less intensive care than do hospitals. They generally supply required continuous nursing service or appropriate assistance to residents who have a wide range of medical conditions and needs.

14.4 Some states regulate CCRCs, although most states currently do not. There is, however, a growing trend toward regulation in this rapidly developing industry. States that do require some form of regulation specify that the CCRCs be certified by a state authority, such as a department of insurance or a department of social services. In addition, some states mandate that escrow or reserve funds be maintained for the protection of residents.

TYPES OF CONTRACTS

14.5 There are three basic types of contracts used by CCRCs. They include all-inclusive (type A), modified (type B), and fee-for-service (type C) contracts.

Type A Contracts

14.6 An all-inclusive continuing-care contract includes residential facilities, meals, and other amenities. It also provides long-term nursing care for little or no increase in periodic fees, except to cover normal operating costs and inflation.

Type B Contracts

14.7 A modified continuing-care contract also includes residential facilities, meals, and other amenities. However, only a specified amount of long-term nursing care is provided for little or no increase in periodic fees, except to cover normal operating costs and inflation. After the specified amount of nursing care is used, residents pay either a discounted rate or the full per diem rates for required nursing care.

Type C Contracts

14.8 A fee-for-service continuing-care contract includes residential facilities, meals, and other amenities as well as emergency and infirmary nursing care. Access to long-term nursing care is guaranteed, but it may be required at full per diem rates.

TYPES OF LIVING ACCOMMODATIONS

14.9 CCRCs offer different types of living accommodations to residents, such as single or shared apartment units or individual homes. They also provide a variety of amenities, including social, recreational, dining, and laundry services.

14.10 CCRCs may provide long-term nursing-care services, either at the same location or, by agreement, with another facility. Residents are transferred to or from a nursing center as medical care is required. As the health of a resident declines, he or she may be transferred permanently to a nursing center.

FEES AND PAYMENT METHODS

14.11 Continuing-care contracts contain a number of different approaches to providing delivery of services. Contract provisions, for example, may stipulate the amount of the advance fee, whether periodic fees will be required, and, if so, whether they can be adjusted. In addition, contracts generally do the following: detail the future services that will be provided to residents; explain how a resident will be charged for services; describe the CCRC's refund policies and the formula for calculating the amount of the refund, which may be simple or complex; and describe the obligations of the CCRC and the resident if a contract is terminated or a residential unit is reoccupied.

14.12 A CCRC may require several different payment methods for services and the use of facilities. Paragraphs 14.13 through 14.15 discuss three of the most prevalent methods.

Advance Fee Only

14.13 Under this method, a resident pays an advance fee in return for future services and the use of facilities. Such services generally include CCRC housing-related services (for example, meals, laundry, housekeeping, and social services) and health care. These usually are 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.

Advance Fee With Periodic Fees

14.14 Under this method, a resident pays an advance fee and periodic fees for services and the use of facilities. Such periodic fees may be fixed, or they may be subject to adjustment for increases in operating costs or inflation or for other economic reasons.

Periodic Fees Only

14.15 Under this method, a resident pays a fee at periodic intervals for services and the use of the facilities provided by the CCRC. Such fees may be either fixed or adjustable.

14.16 An advance fee may be met by transferring a resident's personal assets (which may include rights to future income) or by paying a lump sum of cash to the CCRC.

14.17 Advance fees received for future services may be refunded at the occurrence of some future event, such as death, withdrawal from the CCRC, termination of the contract, or reoccupancy of a residential unit. The amount of the refund generally is based on contractual provisions or statutory requirements.

14.18 Many continuing-care contracts are similar to annuity contracts. Under those contracts, the CCRC assumes the risks associated with (a) estimating the amount of the advance fee and other fees to be paid by a resident and (b) determining whether such fees will be sufficient to cover the cost of providing a resident's required services and the use of facilities. For some contracts, residents may share the future costs without limit.

14.19 The CCRC has an obligation to provide future services for the length of the contract or the life of the resident. In certain circumstances, this obligation continues regardless of whether advance fees or periodic fees are sufficient to meet the costs of providing services to a resident.

ACCOUNTING FOR REFUNDABLE ADVANCE FEES

14.20 Payment of an advance fee generally is required before a resident acquires a right to reside in an apartment or residential unit for life. A portion of advance fees may be refundable by rescission within a legally set time period or if a certain future event occurs, such as the death or withdrawal of a resident or termination of the contract. Some refunds are paid only if a residential unit is reoccupied.

14.21 CCRC refund policies vary either by region or according to statutory requirements, but generally the amount of the refund is based on provisions specified in a contract. For example, some contracts require a refund of the advance fee, less a reasonable processing fee. Amounts refunded may be based on a fixed amount or percentage, an amount that declines to a fixed amount over time, an amount that declines to zero, or an amount based on the resale amount. Refunds may be contingent on vacating the unit, resale of the unit, or passage of a fixed period of time if the unit is not resold.

14.22 The estimated amount of advance fees that is expected to be refunded to current residents under the terms of the contracts should be accounted for and reported as a liability. The estimated amount should be based on the individual facility's own experience or, if records are not available, on the experience of comparable facilities. The remaining amount of advance fees should be accounted for as deferred revenue within the liability section of the balance sheet. Adjustments to the estimated liability should be accounted for as deferred revenue and amortized together with nonrefundable advance fees as discussed in paragraph 14.23. The gross amount of contractual refund obligations under existing contracts and the CCRC's refund policy should be disclosed in the notes to the financial statements. Amounts refunded should be disclosed in the statement of cash flows as a financing transaction.

14.23 The deferred revenue should be amortized to income over future periods based on the estimated life of the resident or on the contract term, if shorter. The period of amortization should be adjusted annually based on the actuarially determined, estimated, remaining life expectancy of each individual or on the joint and last survivor life expectancy of each pair of residents occupying the same unit. The straight-line method should be used to amortize deferred revenue except in certain circumstances when costs are expected to increase at a significantly higher rate than future revenues in the later years of residence. In those situations, deferred revenue may be amortized to income using a method that reflects the disproportionate ratio between the costs of the expected services and the expected revenues. The amortized amount should not exceed the amount available to the CCRC under state regulations, contract provisions, or management policy. Unamortized deferred revenue from nonrefundable advance fees should be recorded as revenue upon a resident's death or the termination of the contract. The method of amortization should be disclosed in the notes to the financial statements.

ACCOUNTING FOR FEES REFUNDABLE TO RESIDENTS ONLY FROM REOCCUPANCY PROCEEDS OF A CONTRACT HOLDER'S UNIT

14.24 Some contracts between a CCRC and a resident stipulate that all or a portion of the advance fee may be refundable if the contract holder's unit is reoccupied by another person. The source of money for the payment is from the proceeds of the advance fees collected by the CCRC from the next resident of the reoccupied unit. The terms governing how the proceeds from the next resident are to be paid to the previous resident vary from contract to contract. In effect, the CCRC acts as if it were an agent for present and future residents.

14.25 The portion of the fees that will be paid to current residents or their designees, only to the extent of the proceeds of reoccupancy of a contract holder's unit, should be accounted for as deferred revenue, provided that legal and management policy and practice support the withholding of refunds under this condition. Similar amounts received from new residents in excess of the amount to be paid to previous residents or their designees also should be deferred. The deferred revenue should be amortized to income over future periods based on the remaining useful life of the facility. The basis and method of amortization should be consistent with the method for calculating depreciation and should be disclosed in the notes to the financial statements.

ACCOUNTING FOR NONREFUNDABLE ADVANCE FEES

14.26 Under provisions of continuing-care contracts entered into by a CCRC and residents, nonrefundable advance fees represent payment for future services and should be accounted for as deferred revenue. If a CCRC has sufficient historical experience and relevant statistical data about life expectancies, it should consider that information when determining the remaining life of residents. A CCRC with insufficient historical experience or reliable actuarial data may use relevant data of similar communities within that area, relevant national industry statistics, or other appropriate data. Nonrefundable advance fees should be amortized in the manner discussed in paragraph 14.23.

14.27 The application of the conclusions in paragraphs 14.25 and 14.26 is presented in exhibit 14.1 at the end of this chapter.

ACCOUNTING FOR THE OBLIGATION TO PROVIDE FUTURE SERVICES AND THE USE OF FACILITIES TO CURRENT RESIDENTS

14.28 A CCRC expects to provide services and the use of facilities to individuals over their remaining lives under continuing-care contract agreements. The nature and extent of such services depend on such variables as the individual's age, health, sex, and economic status upon entering the CCRC. Thus, the CCRC assumes a risk in estimating the cost of future services and the use of facilities. Although many CCRCs are allowed contractually to increase periodic fees, some contracts may restrict increases in periodic fees and require continuing services without additional compensation. If the advance fees and periodic fees charged are insufficient to meet the costs of providing future services and the use of facilities, the CCRC has a liability to provide future services and the use of facilities that is equal to the estimated cost of providing future services and the use of facilities in excess of the related anticipated revenues. The liability is based on actuarial assumptions (such as mortality and morbidity rates), on estimates of future costs and revenues, and on the specific CCRC's historical experience and statistical data.

14.29 The obligation to provide future services and the use of facilities to current residents should be calculated annually in order to determine whether a liability should be reported in the financial statements. The liability related to continuing-care contracts is the present value of future net cash flows, minus the balance of unamortized deferred revenue, plus depreciation of facilities to be charged related to the contracts, plus unamortized costs of acquiring the related initial continuing-care contracts, if applicable. The calculation should be made by grouping contracts by type, such as all contracts with a limit on annual increases in fees, contracts with unlimited fee increases, and so forth.

14.30 Cash inflows include revenue contractually committed to support the residents and inflows resulting from monthly fees including anticipated increases in accordance with contract terms. Cash outflows are composed of operating expenses (including interest expense and excluding selling expense) and general and administrative expenses. Anticipated cost increases affecting these operating expenses should be considered in determining cash outflows. The expected inflation rate as well as other factors should be considered in determining the discount rate. In calculating the liability, the specific CCRC's historical experience or statistical data relating to the residents' life spans should be used. The life spans used should be the same as those used to amortize deferred revenue (see paragraph 14.23). For a new CCRC, either relevant data of similar communities in the area or relevant national industry statistics may be used if they are deemed to be representative.

14.31 In October 1988, the FASB added the issue of discounting to its agenda. Until the discounting issue is resolved, a CCRC should disclose in its notes to the financial statements 1) the carrying amount of the liability to provide future services and the use of facilities related to continuing-care contracts that is presented at present value in the financial statements (if not separately disclosed in the balance sheet) and 2) the interest rate used to discount that liability.

14.32 The application of the conclusions in paragraph 14.30 is presented in exhibit 14.2 at the end of this chapter.

ACCOUNTING FOR THE COSTS OF ACQUIRING INITIAL CONTINUING-CARE CONTRACTS

14.33 Advertising cost incurred in connection with acquiring initial continuing-care contracts should be accounted for in conformity with the guidance in SOP 93-7. Other costs of acquiring initial continuing-care contracts that are expected to be recovered from future contract revenues should be capitalized. These costs should be amortized to expenses on a straight-line basis over the average expected remaining lives of the residents under the contract or the contract term, if shorter. The costs of acquiring continuing-care contracts after a CCRC is substantially occupied or one year following completion should be expensed when incurred.[1]

FINANCIAL STATEMENTS

14.34 A complete set of illustrative financial statements for a CCRC is included in the Appendix.

14.35 The notes to the financial statements for each year presented should include—

- A description of the CCRC and the nature of the related continuing-care contracts entered into by the CCRC.
- The statutory escrow or similar requirements.
- The refund policy of the CCRC and the general amount of refund obligation under the existing contracts.
- The interest rate used to discount the liability to provide future services.

AUDITING

14.36 When auditing a CCRC, the independent auditor may need to consider the specific auditing objectives, selected control procedures, and auditing procedures presented in exhibit 14.3 at the end of this chapter.

---

[1] In accordance with existing practice, as mandated by SOP 90-8. Although SOP 90-8 is superseded with the issuance of this Audit and Accounting Guide, its provisions have been adopted in this chapter.

Exhibit 14.1

Accounting for Refundable and Nonrefundable Advance Fees

Assumptions

a. The unit is occupied for twenty years.
b. The facility has an estimated thirty-year life.
c. The resident is admitted on the first day of the year indicated and dies on the last day of year indicated.
d. The estimated remaining life expectancy is taken from an appropriate actuarial table.
e. The cost of providing future services is expected to be incurred equally over the remaining life.

Example

Year Admitted	*Dies*	*Resident*	*Entry Age*	*Advance Fees* *Total*	*Nonrefundable 25%*	*Refundable 75%*	*Refunded to the Previous Occupant**
1	4	A	68	$ 100,000	$ 25,000	$ 75,000	--
5	8	B	82	120,000	30,000	90,000	$ 75,000
9	13	C	79	150,000	37,500	112,500	90,000
14	--	D	80	130,000	32,500	97,500	97,500

Amortization of Nonrefundable Advance Fees

Resident A	*Unamortized Deferred Revenue*	*Estimated Remaining Life (in Years)*	*Income*
Year 1	$ 25,000	12.1 =	$ 2,066
2	22,934	11.5 =	1,994
3	20,940	11.1 =	1,886
4	19,054	10.6 =	1,798
Unamortized deferred revenue recognized upon the death of the resident			17,256
		Total	$ 25,000

*Per contact, the amount is limited to 75% of proceeds of reoccupancy up to amount originally paid by previous occupant.

*Amortization of Advance Fees Refundable to Residents**

$75,000/30 years = $2,500 per year for years 1 through 4
15,000/26 years = $577 additional or $3,077 per year for years 5 through 8
22,500/22 years = $1,023 additional or $4,100 per year for years 9 through next change in occupancy

Resident B	Unamortized Deferred Revenue	Estimated Remaining Life (in Years)	Income
Year 5	$ 30,000	6.1 =	$ 4,918
6	25,082	5.8 =	4,324
7	20,758	5.5 =	3,774
8	16,984	5.3 =	3,205
Unamortized deferred revenue recognized upon the death of the resident			13,779
		Total	$ 30,000

Resident C	Unamortized Deferred Revenue	Estimated Remaining Life (in Years)	Income
Year 9	$ 37,500	7.0 =	$ 5,357
10	32,143	6.7 =	4,797
11	27,346	6.4 =	4,273
12	23,073	6.1 =	3,783
13	19,290	5.8 =	3,324
Unamortized deferred revenue recognized upon the death of the resident			15,966
		Total	$ 37,500

Resident D	Unamortized Deferred Revenue	Estimated Remaining Life (in Years)	Income
Year 14	$ 32,500	6.7 =	$ 4,851
15	27,649	6.4 =	4,321
16	23,328	6.1 =	3,824
17	19,504	5.8 =	3,363
18	16,141	5.5 =	2,935
19	13,206	5.3 =	2,492
20	10,714	5.1 =	2,100

Amortization continues until the death of the resident.

Exhibit 14.2

Accounting for the Obligation to Provide Future Services and the Use of Facilities to Current Residents

Assumptions

a. All residents pay a $ 50,000 fee, which is refundable less 2 percent per month for the first 36 months. After that period, none of the fee is refundable. The CCRC opened on 1/1/X4. (See exhibit 14.1 for an illustration of how to compute refundable and deferred revenue.)

b. An additional periodic fee of $1,000 is payable monthly with a 5 percent increase annually.

c. The unamortized (deferred) costs of acquiring related initial contracts on 12/31/X6 are assumed to be $17,000.

Note: This illustration calculates the obligation to provide future services and use of facilities for Residents A, B, C, and D from the illustration in exhibit 14.1 only.

Present value of net cash flow on 12/31/X6

Cash inflows:

Resident	*Estimated Remaining Life (in Months) on 12/31/X6*	*Estimated Cash Inflows*			
		19X7	*19X8*	*19X9*	*19X0*
A	36	$ 12,000	$ 12,600	$ 13,230	--
B	22	12,000	10,500	--	--
C	27	12,000	12,600	3,308	--
D	38	12,000	12,600	13,230	$ 2,315
Estimated cash inflows		$ 48,000	$ 48,300	$ 29,768	$ 2,315

Cash outflows:

Resident	*Estimated Remaining Life (in Months) on 12/31/X6*	*Estimated Cash Outflows*			
		19X7	*19X8*	*19X9*	*19X0*
A	36	$ 10,000	$ 12,000	$ 15,000	--
B	22	15,000	11,000	--	--
C	27	14,000	17,000	5,000	--
D	38	8,000	12,000	14,000	$ 4,000
Estimated cash outflows		$ 47,000	$ 52,000	$ 34,000	$ 4,000

Recapitulation	*19X7*	*19X8*	*19X9*	*19X0*
Cash inflows	$ 48,000	$ 48,300	$ 29,768	$ 2,315
Cash outflows	(47,000)	(52,000)	(34,000)	(4,000)
	$ 1,000	$ (3,700)	$ (4,232)	$ (1,685)
Present value of net cash flows discounted at 10 percent				$ (7,137)

Depreciation of facilities to be charged to current residents

Original cost of facility		$17,000,000
Cost of facility allocable to revenue-producing service areas		$ (2,000,000)
Cost of facility to be allocated to residents (including common areas)		$15,000,000
Useful life	40 years	
Annual depreciation using straight-line method		$ 375,000
Number of residents expected to occupy the facility	200	
Annual depreciation per resident		$ 1,875
Monthly depreciation per resident		$ 156

Resident	*Estimated Remaining Life (in Months) on 12/31/X6*	*19X7*	*19X8*	*19X9*	*19X0*
A	36	$ 1,875	$ 1,875	$ 1,875	--
B	22	1,875	1,560	--	--
C	27	1,875	1,875	468	--
D	38	1,875	1,875	1,875	$ 312
Yearly estimated depreciation of facilities to be charged to current residents		$ 7,500	$ 7,185	$ 4,218	$ 312

Total estimated depreciation of the use of facilities to be charged to the current residents $19,215

Liability for providing future services and the use of facilities to current residents

Present value of future net cash outflows	$ 7,137
Minus:	
Unamortized deferred revenue on 12/31/X6	(27,027)
Plus:	
Depreciation to be charged to current residents	19,215
Unamortized costs of acquiring initial contracts--see assumption c above	17,000*
Liability for providing future services and the use of facilities to current residents on 12/31/X6	$16,325

* These numbers are for illustrative purposes only and no inference has been made as to the recoverability of the $17,000.

Exhibit 14.3
Auditing Considerations

Financial Statement Assertions	*Specific Auditing Objectives*	*Selected Control Procedures*	*Auditing Procedures*
Existence, completeness, and presentation and maturity	Liabilities relating to refundable fee arrangements are accounted for and reported properly.	Written documentation is prepared for refundable fee arrangements.	Review the refundable fee arrangements regarding stipulations for repayments and determine that such arrangements are classified and disclosed properly in the financial statements.
	Liabilities are accounted for and reported properly.	All liabilities are classified, described, and disclosed properly in the financial statements.	Compare the account balances with the prior periods' balance and the amortization schedules.
		Management monitors compliance with restrictive covenants.	Confirm any significant new obligations.
Deferred Revenue			
Completeness, rights and obligations, and presentation and disclosure	Deferred revenue and the obligation to provide future services to, and the use of facilities by, current residents of CCRCs are recognized and reported properly.	Procedures ensure that amounts received as advance fees are recognized in the proper period and that the obligation to provide future services and the use of facilities is reported.	Test the procedures related to the recognition of advance fees and determine that the obligation to provide future services and the use of facilities is properly reported.
Long-Term Obligations			
Existence, completeness, and presentation and maturity	Liabilities relating to refundable fee arrangements are accounted for and reported properly.	Written documentation is prepared for refundable fee arrangements.	Review the refundable fee arrangements regarding stipulations for repayments and determine that such arrangements are classified and disclosed properly in the financial statements.

Appendix

ILLUSTRATIVE FINANCIAL STATEMENTS

The following illustrative financial statements illustrate the applications of the reporting practices discussed in this guide. Specific types of health care organizations have been selected to illustrate a wide diversity of reporting practices. It is not intended that these illustrations represent either the only types of disclosure nor the only statement formats that would be appropriate. For example, the reporting of revenue, gains, expenses, and losses vary depending on the relationship of the underlying transaction to the entity's operations. More or less detail should appear either in the financial statements or in the notes to the financial statements, depending on the circumstances.

Governmental health care entities are required to follow the accounting and reporting requirements of the Governmental Accounting Standards Board (GASB). GASB pronouncements may require governmental health care entities to present information beyond or different from that presented by not-for-profit and investor-owned entities. For example, GASB Statement No. 3, *Deposits with Financial Institutions, Investments (including Repurchase Agreements), and Reverse Repurchase Agreements*, requires governmental entities to make certain disclosures about the credit and market risks of their investments. GASB Statement No. 27, *Accounting for Pensions by State and Local Governmental Employers*, requires certain accounting for and disclosures about pension benefits provided to employees of governmental health care entities. GASB Statement No. 9, *Reporting Cash Flows of Proprietary and Nonexpendable Trust Funds and Governmental Entities That Use Proprietary Fund Accounting*, requires governmental health care entities to present a statement of cash flows using a format that differs in some respects from that required by FASB Statement No. 95, *Statement of Cash Flows*, and that requires the reporting of cash flow information on both restricted and unrestricted funds. GASB Statement No. 12, *Disclosure of Information on Postemployment Benefits Other Than Pension Benefits by State and Local Governmental Employers*, requires certain disclosures about other postemployment benefits (OPEB) provided to employees of governmental health care entities. GASB Statement No. 12 also provides that governmental health care entities are not required to change their recognition and measurement of OPEB to comply with FASB Statement No. 106, *Accounting for Postretirement Benefits Other Than Pensions*, or FASB Statement No. 112, *Employer's Accounting for Postemployment Benefits*.

Other GASB pronouncements also may have implications for governmental health care entities. For example, GASB Statement No. 13, *Accounting for Operating Leases with Scheduled Rent Increases* (paragraph 6.10), may affect the accounting for and financial reporting of certain lease transactions. Discussed elsewhere in this audit and accounting guide are GASB Statement No. 10 (paragraph 8.2), GASB Statement No. 14 (paragraph 11.01), GASB Statement No. 16 (paragraph 7.3), GASB Statement No. 20 (footnote 1, chapter 1), and GASB Statement No. 23 (paragraph 7.19).

This Appendix contains illustrative financial statements for the following types of health care organizations:

1. Not-for-profit hospital
2. Governmental hospital
3. Nursing home
4. Continuing care retirement community
5. Home health agency
6. Health maintenance organization
7. Ambulatory care organization

ILLUSTRATIVE FINANCIAL STATEMENTS FOR A NOT-FOR-PROFIT HOSPITAL

Sample Not-for-Profit Hospital
Balance Sheets
December 31, 19X7 and 19X6
(in thousands)

	19X7	*19X6*
Assets		
Current assets:		
Cash and cash equivalents	$ 4,758	$ 5,877
Marketable securities	25,836	20,740
Assets limited as to use	970	1,300
Patient accounts receivable, net of allowance for doubtful accounts of $2,500 in 19X7 and $2,400 in 19X6	15,100	14,194
Other current assets	2,670	2,856
Total current assets	49,334	44,967
Assets limited as to use, net of amount required to meet current obligations	7,979	8,541
Long-term investments	5,000	5,200
Property and equipment, net	51,038	50,492
Other assets	1,695	1,370
Total assets	$ 115,046	$ 110,570
Liabilities and Net Assets		
Current liabilities:		
Current portion of long-term debt	$ 1,470	$ 1,750
Accounts payable and accrued expenses	5,818	5,382
Estimated third-party payor settlements	2,143	1,942
Other current liabilities	1,969	2,114
Total current liabilities	11,400	11,188
Long-term debt, net of current portion	23,144	24,014
Other liabilities	3,953	3,166
Total liabilities	38,497	38,368
Commitments and contingencies		
Net assets:		
Unrestricted	70,846	66,199
Temporarily restricted	2,115	2,470
Permanently restricted	3,588	3,533
Total net assets	76,549	72,202
Total liabilities and net assets	$ 115,046	$ 110,570

See accompanying notes to financial statements.

Sample Not-for-Profit Hospital
Statements of Operations
Years Ended December 31, 19X7 and 19X6
(in thousands)

	19X7	*19X6*
Unrestricted revenues, gains and other support:		
Net patient service revenue	$ 95,156	$ 88,942
Other, primarily interest income	7,951	9,562
Net assets released from restrictions	500	
Total revenues, gains and other support	103,607	98,504
Expenses:		
Operating expenses	88,521	80,585
Depreciation and amortization	4,782	4,280
Interest	1,752	1,825
Provision for bad debts	1,000	1,300
Other	2,000	1,300
Total expenses	98,055	89,290
Operating income	5,552	9,214
Contributions from Sample Hospital Foundation for property acquisitions	235	485
Transfers to parent	(640)	(3,000)
Increase in unrestricted net assets, before extraordinary item	5,147	6,699
Extraordinary loss from early extinguishment of debt	(500)	
Increase in unrestricted net assets	$ 4,647	$ 6,699

See accompanying notes to financial statements.

Sample Not-for-Profit Hospital
Statements of Changes in Net Assets
Years Ended December 31, 19X7 and 19X6
(in thousands)

	19X7	*19X6*
Unrestricted net assets:		
Operating income	$ 5,552	$ 9,214
Contributions from Sample Hospital Foundation	235	485
Transfers to parent	(640)	(3,000)
Extraordinary loss from early extinguishment of debt	(500)	
Increase in unrestricted net assets	4,647	6,699
Temporarily restricted net assets:		
Contributions for charity care	50	946
Net realized gains on investments	95	58
Net assets released from restrictions	(500)	
Increase (decrease) in temporarily restricted net assets	(355)	1,004
Permanently restricted net assets:		
Contributions for endowment funds		311
Net realized gains on investments	55	102
Increase in permanently restricted net assets	55	413
Increase in net assets	4,347	8,116
Net assets, beginning of year	72,202	64,086
Net assets, end of year	$76,549	$72,202

See accompanying notes to financial statements.

Sample Not-for-Profit Hospital
Statements of Cash Flows (Indirect Method)
Years Ended December 31, 19X7 and 19X6
(in thousands)

	19X7	*19X6*
Change in net assets	$ 4,347	$ 8,116
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Extraordinary loss from early extinguishment of debt	500	
Depreciation and amortization	4,782	4,280
Net realized gains on investments	(615)	(675)
Transfers to parent	640	3,000
Provision for bad debts	1,000	1,300
(Increase) decrease in:		
Patient accounts receivable	(1,906)	(2,036)
Other current assets	(99)	(2,481)
Other assets	(325)	(241)
Increase (decrease) in:		
Accounts payable and accrued expenses	436	358
Estimated third-party payor settlements	201	305
Other current liabilities	(145)	(257)
Other liabilities	787	(128)
Net cash provided by operating activities	9,603	11,541
Cash flows from investing activities:		
Purchases of investments	(6,000)	(3,500)
Proceeds from sale of investments	2,611	1,460
Capital expenditures	(5,093)	(5,860)
Net cash used in investing activities	(8,482)	(7,900)
Cash flows from financing activities:		
Transfers to parent	(640)	(3,000)
Contributions for indigent care	50	946
Contributions for endowment funds		311
Payments on long-term debt	(24,100)	(1,750)
Payments on capital lease obligations	(150)	(100)
Increase in long-term debt	22,600	500
Net cash used in financing activities	(2,240)	(3,093)
Net (decrease) increase in cash and cash equivalents	(1,119)	548
Cash and cash equivalents, beginning of year	5,877	5,329
Cash and cash equivalents, end of year	$ 4,758	$ 5,877

Supplemental Disclosures of Cash Flow Information:

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

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

See accompanying notes to financial statements.

Sample Not-for-Profit Hospital
Notes to Financial Statements
December 31, 19X7 and 19X6

1. Summary of Significant Accounting Policies

Organization. The Sample Not-for-Profit Hospital (the Hospital), located in Tulsa, Oklahoma, is a not-for-profit acute care hospital. The Hospital provides inpatient, outpatient and emergency care services for residents of Northeastern Oklahoma. Admitting physicians are primarily practitioners in the local area. The Hospital was incorporated in Oklahoma in 19X1 and is affiliated with the Sample Health System. In its capacity as the sole corporate member of the Hospital, the Sample Health System has the right to appoint Hospital trustees, approve major Hospital expenditures, and approve long-term Hospital borrowings.

Use of estimates. The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and cash equivalents. Cash and cash equivalents include certain investments in highly liquid debt instruments with original maturities of three months or less. At December 31, 19X7, the Hospital has cash balances in a financial institution that exceed federal depository insurance limits. The Hospital routinely invests its surplus operating funds in money market mutual funds. These funds generally invest in highly liquid U.S. government and agency obligations. Investments in money market funds are not insured or guaranteed by the U.S. government.

Marketable securities and assets limited as to use. Marketable securities and assets limited as to use are primarily investments in debt and equity securities. Equity securities are carried at the lower of cost or market value, with realized gains and losses reported as unrestricted, temporarily restricted, or permanently restricted net assets, as appropriate. Debt securities are reported at the lower of amortized cost or market value. The amortized cost of debt securities is adjusted for amortization of premiums and accretion of discounts to maturity. For unrestricted investments, interest and dividends, amortization, and realized gains and losses are included in other revenue and gains. The cost of securities sold is based on the specific identification method.

Assets limited as to use primarily include assets held by trustees under indenture agreements and irrevocable self-insurance trust arrangements. Amounts required to meet current liabilities of the hospital have been reclassified in the balance sheet at December 31, 19X7 and 19X6.

Long-term investments. Long-term investments include investments in debt securities with original maturities of more than one year and that are not intended to be used for current operations. Donor-restricted endowment gifts are reported as long-term investments.

Property and equipment. Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations 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. 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.

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of

cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Temporarily and permanently restricted net assets. Temporarily restricted net assets are those whose use by the Hospital has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Hospital in perpetuity.

The Board of Trustees has interpreted state law as requiring the preservation of the purchasing power (real value) of the permanent endowment funds unless explicit donor stipulations specify how net appreciation must be used. To meet that objective, the Hospital's endowment management policies require that net appreciation be retained permanently in an amount necessary to adjust the historic dollar value of original endowment gifts by the change in the Consumer Price Index. After maintaining the real value of the permanent endowment funds, any remainder of total return is available for appropriation. State law allows the board to appropriate so much of net appreciation as is prudent considering the Hospital's long- and short-term needs, present and anticipated financial requirements, expected total return on its investments, price-level trends, and general economic conditions.

Net patient service revenue. The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges and per diem payments. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Charity care. The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. The amount of charges foregone for services and supplies furnished under the Hospital's charity care policy aggregated approximately $4,500,000 and $4,100,000 in 19X7 and 19X6, respectively.

Donor-restricted gifts. Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received, which is then treated as cost. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the statement of activities as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reflected as unrestricted contributions in the accompanying financial statements.

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

Income taxes. The Hospital is a not-for-profit corporation and has been recognized as tax-exempt pursuant to Sec. 501(c)(3) of the Internal Revenue Code.

Operating indicator. The Hospital's operating income (loss) includes all unrestricted revenue, gains, expenses, and losses for the reporting period except for capital contributions to and from affiliates, contributions of long-lived assets, and extraordinary items.

2. Net Patient Service Revenue

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

- *Medicare*. Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Inpatient nonacute services, certain outpatient services, and defined capital and medical education costs related to Medicare beneficiaries are paid based on a cost reimbursement methodology. The Hospital is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicare fiscal intermediary. The Hospital's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization under contract with the Hospital. The Hospital's Medicare cost reports have been audited by the Medicare fiscal intermediary through December 31, 19X6.
- *Medicaid*. Inpatient and outpatient services rendered to Medicaid program beneficiaries are reimbursed under a cost reimbursement methodology. The Hospital is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicaid fiscal intermediary. The Hospital's Medicaid cost reports have been audited by the Medicaid fiscal intermediary through December 31, 19X6.
- *Blue Cross*. Inpatient services rendered to Blue Cross subscribers are reimbursed at prospectively determined rates per day of hospitalization. The prospectively determined per diem rates are not subject to retroactive adjustment.

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

3. Assets Limited As to Use

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

	19X7	*19X6*
Under indenture agreement—held by trustee:		
Cash and short-term investments	$ 352,000	$ 760,000
U.S. Treasury obligation	8,505,000	9,007,000
Interest receivable	92,000	74,000
	$ 8,949,000	$ 9,841,000

4. Property and Equipment

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

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

Depreciation expense for the years ended December 31, 19X7 and 19X6 amounted to approximately $4,600,000 and $4,100,000, respectively. Accumulated amortization for equipment under capital lease obligations was $689,000 and $453,000 at December 31, 19X7 and 19X6, respectively.

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

5. Long-Term Debt

A summary of long-term debt and capital lease obligations at December 31, 19X7 and 19X6, follows:

	19X7	*19X6*
7.25 percent 19X7 Tax-Exempt Revenue Bonds, principal maturing in varying annual amounts, due November 1, 19XX, collateralized by a pledge of the Hospital's gross receipts	$ 21,479,000	
8.50 percent 19X2 Tax-Exempt Revenue Bonds, principal maturing in varying annual amounts, due June 1, 19XX		$ 22,016,000
7.75 percent mortgage loan, principal maturing in varying annual amounts, 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

(continued)

	19X7	19X6
7.75 percent note payable, payable in monthly installments of $12,000, including interest, due March 19XX, unsecured	$ 125,000	$ 671,000
Capital lease obligations, at varying rates of imputed interest from 6.8 percent to 9.3 percent collateralized by leased equipment with an amortized cost of $1,500,000 at December 31, 19X7	1,000,000	950,000
	24,614,000	25,764,000
Less current portion	1,470,000	1,750,000
	$ 23,144,000	$ 24,014,000

Under the terms of the 19X7 and 19X2 revenue bond indentures, the Hospital is required to maintain certain deposits with a trustee. Such deposits are included with assets limited as to use in the financial statements. The revenue note indenture also places limits on the incurrence of additional borrowings and requires that the Hospital satisfy certain measures of financial performance as long as the notes are outstanding.

Scheduled principal repayments on long-term debt and payments on capital lease obligations are as follows:

Year Ending December 31,	*Long-Term Debt*	*Capital Leases Obligations*
19X8	$ 970,000	$ 550,000
19X9	912,000	260,000
19Y0	983,000	260,000
19Y1	1,060,000	45,000
19Y2	1,143,000	—
Thereafter	18,546,000	—
	$ 23,614,000	$ 1,115,000
Less amount representing interest under capital leases obligations		115,000
		$ 1,000,000

A summary of interest cost and investment income on borrowed funds held by the trustee under the 19X7 and 19X2 revenue bond indentures during the years ended 19X7 and 19X6 follows:

	19X7	*19X6*
Interest cost:		
Capitalized	$ 740,000	$ 700,000
Charged to operations	1,620,000	1,765,000
Total	2,360,000	2,465,000
Investment income:		
Capitalized	505,000	663,000
Credited to other revenue	330,000	386,000
Total	$ 835,000	$ 1,049,000

6. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes or periods:

	19X7	*19X6*
Health care services		
Purchase of equipment	$ 565,000	$ 520,000
Indigent care	550,000	950,000
Health education	350,000	400,000
For periods after December 31, 19X9	650,000	600,000
	$ 2,115,000	$ 2,470,000

Permanently restricted net assets are restricted to:

	19X7	*19X6*
Investments to be held in perpetuity, the income from which is expendable to support health care services (reported as operating income)	$ 2,923,000	$ 2,923,000
Endowment requiring income to be added to original gift until fund value is $1,500,000	665,000	610,000
	$ 3,588,000	$ 3,533,000

During 19X7, net assets were released from donor restrictions by incurring expenses satisfying the restricted purposes of indigent care and health care education in the amounts of $450,000 and $50,000, respectively.

7. Medical Malpractice Claims

The Hospital terminated its primary professional liability coverage effective December 31, 19X4, and entered into a self-insurance plan and trust agreement. Under the terms of the trust agreement, the trust assets can be used only for payment of professional liability losses, related expenses, and the costs of administering the trust. The professional liability trust assets at cost

(which approximates market) were approximately $2,500,000 and $1,800,000 at December 31, 19X7 and 19X6, respectively. These funds are included in assets limited as to use in the balance sheet.

There are known claims and incidents that may result in the assertion of additional claims, as well as claims from unknown incidents that may be asserted arising from services provided to patients since December 31, 19X4. The Hospital has employed independent actuaries to estimate the ultimate costs, if any, of the settlement of such claims.

Accrued malpractice losses have been discounted at 7 percent and in management's opinion provide an adequate reserve for loss contingencies.

The Hospital purchases excess professional and general liability insurance coverage of $20 million per incident and $20 million in the aggregate over the self-insurance retention amounts. Self-insurance limits provide for annual coverage of up to $3 million per incident and $7 million in the aggregate.

On March 15, 19X7, a patient filed a suit against the Hospital for malpractice during care received as an inpatient. The Hospital believes it has meritorious defenses against the suit; however, the ultimate resolution of the matter could result in a loss. The patient has claimed $16 million in actual damages. Under state law, punitive damages are determined at trial. The Hospital maintains insurance coverage for malpractice claims. The coverage does not include punitive damages awards. Trial is scheduled to occur within the next year.

8. Pension Plan

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

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

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

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

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

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

	19X7	*19X6*
Actuarial present value of benefit obligations:		
Vested benefit obligation	$ 8,020,000	$ 6,800,000
Nonvested benefit obligation	1,900,000	1,930,000
Accumulated benefit obligation	9,920,000	8,730,000
Effect of projected future compensation levels	1,000,000	980,000
Projected benefit obligation	10,920,000	9,710,000
Plan assets at fair value (primarily listed stocks and U.S. bonds)	11,050,000	9,800,000
Plan assets in excess of projected benefit obligation	130,000	90,000
Unrecognized net gain from past experience different from that assumed	(30,000)	(40,000)
Prior service cost not yet recognized in net periodic pension cost	50,000	55,000
Unrecognized net asset at January 1, 19X7, being recognized over 15 years	(15,000)	(20,000)
Prepaid pension cost, included in other assets in the accompanying balance sheets	$ 135,000	$ 85,000

9. Postretirement Plans

The Hospital sponsors two defined benefit postretirement plans that cover both salaried and nonsalaried employees. One plan provides medical and dental benefits, and the other provides for the payment of life insurance premiums. The postretirement health care plan is contributory, with retiree contributions adjusted annually; the life insurance plan is noncontributory. The accounting for the health care plan anticipates future cost-sharing changes to the written plan that are consistent with the Hospital's expressed intent to increase retiree contributions each year to 50 percent of the excess of the expected general inflation rate over 6 percent. On July 24, 19X6, the Hospital amended its postretirement health care plan to provide vision coverage. Beginning in 19X7, the Hospital adopted a funding policy for its postretirement health care plan similar to its funding policy for its life insurance plan — an amount equal to a level percentage of the employees' salaries is contributed to the plan annually. For 19X7, that percentage was 4.25, and the aggregate contribution for both plans was $34,000.

The following table sets forth the plans' combined funded status reconciled with the amount shown in the Hospital's balance sheet at December 31, 19X7 and 19X6:

	19X7	19X6
Accumulated postretirement benefit obligation:		
Retirees	$ (195,000)	$ (187,000)
Fully eligible active plan participants	(105,000)	(100,000)
Other active plan participants	(310,000)	(297,400)
	(610,000)	(584,400)
Plan assets at fair value, primarily listed stocks and U.S. bonds	100,000	87,960
Accumulated postretirement benefit obligation in excess of plan assets	(510,000)	(496,440)
Unrecognized net gain from past experience different from that assumed and from changes in assumptions	(30,000)	(40,000)
Prior service cost not yet recognized in net periodic postretirement benefit cost	16,000	19,000
Unrecognized transition obligation	445,500	470,250
Accrued postretirement benefit cost, included in other current liabilities in the accompanying balance sheets	$ (78,500)	$ (47,190)

Net periodic postretirement benefit cost for 19X7 and 19X6 include the following components:

	19X7	19X6
Service cost — benefits attributed to service during the period	$ 14,500	$ 15,000
Interest cost on accumulated postretirement benefit obligation	50,000	44,400
Actual return on plan assets	(4,500)	(3,960)
Amortization of transition obligation over 20 years	24,750	24,750
Net amortization and deferral	1,000	1,000
Net periodic postretirement benefit cost	$ 85,750	$ 81,190

For measurement purposes, a 7 percent annual rate of increase in the per capita cost of covered health care benefits was assumed for 19X8; the rate was assumed to decrease gradually to 5 percent over the next five years and remain at that level thereafter. The health care cost trend rate assumption has the assumed health care cost trend rates increasing by one percentage point in each year. This would increase the accumulated postretirement benefit obligation as of December 31, 19X7, by $73,000 and the aggregate of the service and interest cost components of net periodic postretirement benefit cost for the year then ended by $13,000.

The weighted-average discount rate used in determining the accumulated postretirement benefit obligation was 7 percent. The expected long-term rate of return on plan assets after

estimated taxes was 6.6 percent. The rate of increase in compensation used for the life insurance plan was 4 percent.

10. Concentrations of Credit Risk

The Hospital grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors for 19X7 and 19X6 was as follows:

	19X7	*19X6*
Medicare	36%	38%
Medicaid	17	14
Blue Cross	33	32
Other third-party payors	7	9
Patients	7	7
	100%	100%

11. Commitments and Contingencies

Operating Leases. The Hospital leases various equipment and facilities under operating leases. Total rental expense in 19X7 and 19X6 for all operating leases was approximately $859,000 and $770,000, respectively.

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,	*Amount*
19X8	$ 517,000
19X9	506,000
19Y0	459,000
19Y1	375,000
19Y2	343,000

Litigation. The Hospital is involved in litigation and regulatory investigations arising in the course of business. After consultation with legal counsel, it is management's opinion that these matters will be resolved without material adverse effect on the Hospital's financial position or results from operations.

12. Extraordinary Loss

In 19X7, the Hospital advance refunded its 19X2 Revenue Bonds in the amount of $22 million by issuing 19X7 Revenue Bonds. As a result of this in-substance defeasance transaction, an extraordinary loss totaling $500,000 was recorded. A portion of the proceeds of the 19X7 Revenue Bonds was placed in a trust sufficient to provide for all future debt service payments of the advance refunded obligations. As of December 31, 19X7, $21 million of advance refunded bonds, which are considered extinguished, remain outstanding.

13. Related Party Transactions

During the years ended December 31, 19X7 and 19X6, the Hospital contributed capital to Sample Health System in the amounts of $640,000 and $3 million, respectively. The Hospital intends to continue making capital contributions to Sample Health System as deemed necessary.

The Sample Hospital Foundation (the Foundation), which is controlled by Sample Health System, was established to solicit contributions from the general public and to support the operations of the Hospital. Funds are distributed to the Hospital as determined by the Foundation's Board of Directors. A summary of the foundation's assets, liabilities, and net assets, results of operations, and changes in net assets follows.

	December 31,	
	19X7	*19X6*
Assets, principally cash and cash equivalents	$ 521,000	$ 472,000
Liabilities	11,000	10,000
Net assets	510,000	462,000
Total liabilities and net assets	$ 521,000	$ 472,000
Support and revenue	$ 269,000	$ 535,000
Expenses		
Distributions to Sample Hospital	235,000	485,000
Other	13,000	16,000
Total expenses	248,000	501,000
Excess of support and revenue over expenses	21,000	34,000
Other changes in net assets	27,000	17,000
Net assets, beginning of year	462,000	411,000
Net assets, end of year	$ 510,000	$ 462,000

Liabilities include $10,000 payable at the end of each year to Sample Hospital. These amounts were paid after the end of each year.

14. Functional Expenses

The Hospital provides general health care services to residents within its geographic location including pediatric care, cardiac catheterization, and outpatient surgery. Expenses related to providing these services are as follows:

Health care services	$86,000
General and administrative	12,000
	$98,000

15. Fair Value of Financial Instruments

The following methods and assumptions were used by the Hospital in estimating the fair value of its financial instruments:

Cash and cash equivalents: The carrying amount reported in the balance sheet for cash and cash equivalents approximates its fair value.

Assets limited as to use: These assets consist primarily of cash and short-term investments and interest receivable. The carrying amount reported in the balance sheet approximates fair value.

Long-term investments: Fair values are based on quoted market prices, if available, or estimated using quoted market prices for similar securities.

Accounts payable and accrued expenses: The carrying amount reported in the balance sheet for accounts payable and accrued expenses approximates its fair value.

Estimated third-party payor settlements: The carrying amount reported in the balance sheet for estimated third-party payor settlements approximates its fair value.

Long-term debt: Fair values of the Hospital's revenue notes are based on current traded value. The fair value of the Hospital's remaining long-term debt is estimated using discounted cash flow analyses, based on the Hospital's current incremental borrowing rates for similar types of borrowing arrangements.

The carrying amounts and fair values of the Hospital's financial instruments at December 31, 19X7 and 19X6 are as follows:

	19X7		*19X6*	
	Carrying Amount	*Fair Value*	*Carrying Amount*	*Fair Value*
Cash and cash equivalents	$ 4,758	$ 4,758	$ 5,877	$ 5,877
Assets limited as to use	8,949	8,949	9,841	9,841
Long-term investments	5,000	4,950	5,200	5,460
Accounts payable and accrued expenses	5,818	5,818	5,382	5,382
Estimated third-party payor settlements	2,143	2,143	1,942	1,942
Long-term debt	24,614	23,980	25,764	24,918

16. 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.

Sample Governmental Hospital
Balance Sheets
December 31, 19X7 and 19X6
(in thousands)

	19X7	*19X6*
Assets		
Current assets:		
Cash and cash equivalents	$ 4,044	$ 4,995
Marketable securities	21,961	22,049
Assets limited as to use	825	1,105
Patient accounts receivable, net of estimated uncollectibles of $2,125 in 19X7 and $2,040 in 19X6	19,834	16,727
Supplies and other current assets	2,270	2,428
Total current assets	48,934	47,304
Assets limited as to use, net of amounts amounts required for current liabilities	4,033	2,598
Property and equipment, net	43,382	42,918
Other assets	1,441	1,165
Total assets	$ 97,790	$ 93,985
Liabilities and Fund Balance		
Current liabilities:		
Current maturities of long-term debt	$ 1,250	$ 1,488
Accounts payable and accrued expenses	4,945	4,575
Estimated third-party payor settlements	1,822	1,651
Other current liabilities	1,673	1,797
Total current liabilities	9,690	9,511
Long-term debt, net of current maturities	19,672	20,412
Other liabilities	3,361	2,690
Total liabilities	32,723	32,613
Fund balance:		
Unrestricted	60,219	56,269
Restricted	4,848	5,103
Total fund balance	65,067	61,372
Total liabilities and fund balance	$ 97,790	$ 93,985

See accompanying notes to financial statements.

Sample Governmental Hospital
Statements of Operations
Years Ended December 31, 19X7 and 19X6
(in thousands)

	19X7	*19X6*
Revenue and gains:		
Net patient service revenue	$ 54,864	$ 60,292
Ad valorem taxes	23,895	15,309
Other	9,083	8,540
Total revenue and gains	87,842	84,141
Expenses:		
Salaries and benefits	46,845	43,235
Medical supplies and drugs	12,746	7,986
Insurance	7,030	7,382
Other supplies	10,314	11,166
Provision for bad debts	859	938
Depreciation and amortization	4,065	3,638
Interest	1,489	1,552
Total expenses	83,348	75,897
Operating income	4,494	8,244
Transfers to county	(544)	(2,550)
Increase in unrestricted fund balance	$ 3,950	$ 5,694

See accompanying notes to financial statements.

Sample Governmental Hospital
Statements of Changes in Fund Balance
Years Ended December 31, 19X7 and 19X6
(in thousands)

	Unrestricted	*Restricted*	*Total*
Fund balance, January 1, 19X6	$50,575	$ 3,899	$54,474
Operating income	8,244		8,244
Unexpended research grants		853	853
Endowment funds		351	351
Transfers to county	(2,550)		(2,550)
	5,694	1,204	6,898
Fund balance, December 31, 19X6	56,269	5,103	61,372
Operating income	4,494		4,494
Unexpended research grants		170	170
Amounts released from restrictions		(425)	(425)
Transfers to county	(544)		(544)
	3,950	(255)	3,695
Fund balance, December 31, 19X7	$60,219	$ 4,848	$65,067

See accompanying notes to financial statements.

Sample Governmental Hospital
Statements of Cash Flows (Direct Method)*
Years Ended December 31, 19X7 and 19X6
(in thousands)

	19X7	19X6
Cash flows from operating activities:		
Cash received from patients and third-party payors	$ 76,791	$ 72,776
Cash paid to employees and suppliers	(75,832)	(69,284)
Cash received from contributors	954	769
Other receipts from operations	3,892	4,629
Net cash provided by operating activities	5,805	8,890
Cash flows from noncapital financing activities:		
Proceeds from contributions restricted for specific expenditure	21	683
Transfers to county	(544)	(2,550)
Net cash provided by noncapital financing activities	(523)	(1,867)
Cash flows from capital and related financing activities:		
Proceeds from contributions restricted for:		
Investment in equipment	149	170
	149	170
Other capital and related financing activities:		
Principal paid on long-term debt	(1,488)	(1,896)
Interest paid on long-term debt	(2,142)	(2,207)
Purchase of property and equipment	(3,819)	(4,111)
	(7,449)	(8,214)
Net cash used in capital and related financing activities	(7,300)	(8,044)
Cash flows from investing activities:		
Interest and dividends on investments	2,134	1,981
Purchase of investment securities	(1,634)	(2,786)
Investment in endowment		351
Net cash provided by (used in) investing activities	500	(454)
Net decrease in cash and cash equivalents	(1,518)	(1,475)
Cash and cash equivalents, beginning of year	6,539	8,014
Cash and cash equivalents, end of year	$ 5,021	$ 6,539
Reconciliation of cash and cash equivalents to the balance sheets:		
Cash and cash equivalents in current assets	$ 4,044	$ 4,995
Cash and cash equivalents in assets limited as to use		
Under malpractice funding arrangement	474	473
Under indenture agreement	503	1,071
Total cash and cash equivalents	$ 5,021	$ 6,539

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

Sample Governmental Hospital
Statements of Cash Flows (Direct Method)
(continued)
Year Ended December 31, 19X7 and 19X6
(in thousands)

	19X7	*19X6*
Reconciliation of operating income to net cash provided by operating activities:		
Operating income	$ 4,494	$ 8,244
Interest expense considered capital financing activity	1,489	1,552
Interest income considered investing activities	(2,777)	(2,292)
Adjustments to reconcile operating income to net cash provided by operating activities:		
Depreciation and amortization	4,065	3,638
Provision for bad debts	859	938
Net assets released from restrictions	(425)	
Changes in assets and liabilities:		
Increase in patient accounts receivable	(3,966)	(3,847)
(Increase) decrease in supplies and other current assets	1,230	(100)
Increase in other assets	(276)	
Increase in accounts payable, accrued expenses and other current liabilities	270	751
Increase (decrease) in estimated third-party payor settlements	171	(235)
Increase in other liabilities	671	241
Net cash provided by operating activities	$ 5,805	$ 8,890

Supplemental Disclosures of Cash Flow Information:

The Hospital entered into capital lease obligations of $510,000 for new equipment in 19X7.

See accompanying notes to financial statements.

Sample Governmental Hospital
Statements of Cash Flows (Indirect Method)*
Years Ended December 31, 19X7 and 19X6
(in thousands)

	19X7	*19X6*
Cash flows from operating activities:		
Operating income	$ 4,494	$ 8,244
Interest expense considered capital financing activity	1,489	1,552
Interest income considered investing activities	(2,777)	(2,292)
Adjustments to reconcile operating income to net cash provided by operating activities:		
Depreciation and amortization	4,065	3,638
Provision for bad debts	859	938
Net assets released from restrictions	(425)	
Changes in assets and liabilities:		
Increase in patient accounts receivable	(3,966)	(3,847)
(Increase) decrease in supplies and other current assets	1,230	(100)
Increase in other assets	(276)	
Increase in accounts payable, accrued expenses and other current liabilities	270	751
Increase (decrease) in estimated third-party payor settlements	171	(235)
Increase in other liabilities	671	241
Net cash provided by operating activities	5,805	8,890
Cash flows from noncapital financing activities:		
Proceeds from contributions restricted for specific expenditure	21	683
Transfers to county	(544)	(2,550)
Net cash provided by noncapital financing activities	(523)	(1,867)
Cash flows from capital and related financing activities:		
Proceeds from contributions restricted for:		
Investment in equipment	149	170

(continued)

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

Sample Governmental Hospital
Statements of Cash Flows (Indirect Method)
(continued)
December 31, 19X7 and 19X6
(in thousands)

	19X7	*19X6*
Other capital and related financing activities:		
Principal paid on long-term debt	(1,488)	(1,896)
Interest paid on long-term debt	(2,142)	(2,207)
Purchase of property and equipment	(3,819)	(4,111)
	(7,449)	(8,214)
Net cash used by capital and related financing activities	(7,300)	(8,044)
Cash flows from investing activities:		
Interest and dividends on investments	2,134	1,981
Purchase of investment securities	(1,634)	(2,786)
Investment in endowment		351
Net cash provided by (used in) investing activities	500	(454)
Net decrease in cash and cash equivalents	(1,518)	(1,475)
Cash and cash equivalents, beginning of year	6,539	8,014
Cash and cash equivalents, end of year	$ 5,021	$ 6,539
Reconciliation of cash and cash equivalents to the balance sheets:		
Cash and cash equivalents in current assets	4,044	4,995
Cash and cash equivalents in assets limited as to use		
Under malpractice funding arrangement	474	473
Under indenture agreement	503	1,071
Total cash and cash equivalents	$ 5,021	$ 6,539

See accompany notes to financial statements.

Sample Governmental Hospital
Notes to Financial Statements†
December 31, 19X7 and 19X6

1. Summary of Significant Accounting Policies

Reporting entity. The Sample Hospital (the Hospital) is operated under the Sample Hospital Authority (the Authority), a public trust.

On January 1, 19XX, the Board of County Commissioners of Feeling County, Illinois, created the Authority to operate, control, and manage all matters concerning the Hospital and the Trust Estate. The Board of County Commissioners appoints the Board of Trustee members of the Authority. Under generally accepted accounting principles, the Authority and Hospital constitute a component unit of Feeling County, Illinois (Primary Government), for financial reporting purposes. The Authority and Hospital are presented as discretely presented component units in the financial statements of Feeling County, Illinois.

Proprietary fund accounting. The Hospital utilizes the propriety fund method of accounting whereby revenue and expenses are recognized on the accrual basis. Substantially all revenue and expenses are subject to accrual.

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.

Cash and cash equivalents. Cash and cash equivalents include investments in highly liquid debt instruments with an original maturity of three months or less.

Ad Valorem Taxes. The Hospital received approximately 29 percent in 19X7 and 10 percent in 19X6 of its financial support from ad valorem taxes. These funds were used as follows:

	19X7	*19X6*
Percentage used to support operations	24%	8%
Percentage used for debt service on general obligation bonds	3%	2%

Current taxes are received beginning in October of each year and become delinquent after January 31 of the following year. Ad valorem revenue is recognized ratably over the fiscal year taxes are assessed.

2. Restricted Fund Balance

Temporarily restricted fund balance is available for the following purposes:

† Includes only disclosures unique to a governmental hospital.

	19X7	19X6
Program A activities:		
Purchase of equipment	$ 404	$ 321
Research	553	683
General	46	63
Program B activities:		
Purchase of equipment	235	235
General	79	110
Program C activities:		
General	206	400
Buildings and equipment	94	72
Annuity trust agreements	44	65
For periods after December 31, 19X7 and 19X6	184	151
Total temporarily restricted fund balance	$ 1,845	$ 2,100

Permanently restricted fund balance as of December 31, 19X7 and 19X6, is restricted to investment in perpetuity, the income from which is expendable to support:

	19X7	19X6
Program A activities	$ 158	$ 158
Program B activities	176	176
Program C activities	423	423
Any activities of the Hospital	854	854
	1,611	1,611
Endowment requiring income to be added to original gift until fund's value is $2,125	1,392	1,392
Total permanently restricted fund balance	3,003	3,003
Total temporarily and permanently restricted fund balance	$ 4,848	$ 5,103

3. Donor Restrictions Released

Fund balance was released from donor restrictions by incurring expenses satisfying the restricted purposes or by occurrence of other events specified by donors:

	19X7
Purpose restrictions accomplished:	
Program A expenses	$ 168
Program B expenses	31
Program C expenses	206
	405
Time restrictions expired:	
Passage of specified time	20
Total restrictions released	$ 425

4. Charity Care

Charges excluded from revenue under the Hospital's charity care policy were $5,100 and $4,845 for 19X7 and 19X6, respectively.

5. Assets Limited as to Use

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

	19X7	*19X6*
Under malpractice funding arrangement held by trustee:		
Cash and short-term investments	$ 474	$ 473
U.S. Treasury obligations	771	450
	$ 1,245	$ 923
Under indenture agreement held by trustee:		
Cash and short-term investments	$ 503	$ 1,071
U.S. Treasury obligations	3,047	1,646
Interest receivable	63	63
	$ 3,613	$ 2,780

6. Bank Deposits and Investments

At December 31, 19X7 and 19X6, the Hospital's investments consisted of securities issued by the U.S. government. At December 31, 19X7 and 19X6, the carrying value (which approximates the market value) of U.S. government obligations held by the Hospital was approximately $25,779 and $24,145, respectively. All securities are held in the Hospital's name by a custodial bank that is the agent of the Hospital.

At December 31, 19X7 and 19X6, the Hospital had bank balances as follows:

	19X7	*19X6*
Insured (FDIC) or collateralized with securities held by Hospital	$ 3,687	$ 5,677
Collateralized by securities held by the pledging financial institution's trust department in the Hospital's name	600	300
Uncollateralized	553	
Total	$ 4,840	$ 5,977
Carrying Value	$ 5,021	$ 6,539

Hospital bylaws require that investments be made only in U.S. government obligations and that all bank balances be insured or collateralized by U.S. government securities held by the Hospital's third-party agent or the pledging financial institution's trust department in the name of the Hospital.

The Hospital violated its bylaws by allowing certain bank balances to be uninsured and uncollateralized. Due to significantly higher cash flows at certain times during the year, the Hospital's bank balances which were uncollateralized were significantly higher than the balance at year-end.

7. Long-Term Debt

A summary of long-term debt, including capital lease obligations, at December 31, 19X7 and 19X6, follows:

	19X7	*19X6*
7.25 percent Revenue Notes, due November 1, 20XX, collateralized by a pledge of the Hospital's gross receipts	$ 18,257	$ 18,714
9.25 percent mortgage loan, due January 20XX, collateralized by a mortgage on property and equipment with a depreciated cost of $1,530 at December 31, 19X7	1,709	1,808
9.75 percent note payable, due March 19XX, unsecured	106	570
Total long-term debt	20,072	21,092
Less current maturities of long-term debt	825	1,020
Long-term debt net of current maturities	$ 19,247	$ 20,072
Capital lease obligations, at varying rates of imputed interest from 9.8 percent to 12.3 percent collateralized by leased equipment with an amortized cost of $1,275 at December 31, 19X7	$ 850	$ 808
Less current portion of capital lease obligations	425	468
Capital lease obligations, excluding current portion	$ 425	$ 340

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 limited as to use in the financial statements. The Revenue Note Indenture also places limits on the incurrence of additional borrowings and requires that the Hospital satisfy certain measures of financial performance as long as the notes are outstanding.

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

Year Ending December 31,	*Long-Term Debt*	*Capital Lease Obligations*
19X8	$ 825	$ 506
19X9	775	221
20Y0	836	221
20Y1	900	—
20Y2	972	—
Thereafter	15,764	—
	$ 20,072	948
Less amount representing interest on capital lease obligations		98
Total		$ 850

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

	19X7	*19X6*
Interest cost:		
Capitalized	$ 629	$ 629
Charged to operations	1,489	1,551
Total	$ 2,118	$ 2,180
Investment income:		
Capitalized	$ 429	$ 564
Credited to other revenue	280	328
Total	$ 709	$ 892

8. Pension Plan

Plan Description. Sample Hospital Pension Plan (SHPP) provides retirement and disability benefits, annual cost-of-living adjustments, and death benefits to plan members and beneficiaries. SHPP is affiliated with County Employees Pension Plan (CEPP), an agent multiple-employer pension plan administered by the Illinois Retirement System. Article 39 of the Regulations of the State of Illinois assigns the authority to establish and amend the benefit provisions of the plans that participate in CEPP to the respective employer entities; for CEPP, that authority rests with the County of Feeling, Illinois. The Illinois Retirement System issues a publicly available financial report that includes financial statements and required supplementary information for SHPP. That report may be obtained by writing to Illinois Retirement System, State Government Lane, Anytown, USA 01000 or by calling 1-800-555-PLAN.

Funding Policy. The contribution requirements of plan members and the Hospital are established and may be amended by the CEPP Board of Trustees. Plan members are required to contribute 7.8 percent of their annual covered salary. The Hospital is required to contribute at an actuarially determined rate; the current rate is 11.9 percent of annual covered payroll.

Annual Pension Cost and Net Pension Obligation. The Hospital's annual pension cost and net pension obligation to SHPP for the current year were as follows:

Annual required contribution	$ 26
Interest on net pension obligation	3
Adjustment to annual required contribution	(3)
Annual pension cost	26
Contributions made	(12)
Increase (decrease) in net pension obligation	14
Net pension obligation beginning of year	66
Net pension obligation, end of year	$ 80

The annual required contribution for the current year was determined as part of the December 31, 19X6, actuarial valuation using the entry age actuarial cost method. The actuarial assumptions included (a) 7.5% investment rate of return (net of administrative expenses) and (b) projected salary increases ranging from 5.5% to 9.5% per year. Both (a) and (b) included an inflation component of 5.5%. The actuarial assumptions also include a 2% per year cost-of-living adjustment. The actuarial value of assets was determined using techniques that smooth the effects of short-term volatility in the market value of investments over a four-year period. The unfunded actuarial accrued liability is being amortized as a level percentage of projected payroll on an open basis. The remaining amortization period at December 31, 19X6, was 23 years.

Three-Year Trend Information

Fiscal Year Ending	*Annual Pension Cost (APC)*	*Percentage of APC Contributed*	*Net Pension Obligation*
12/31/X5	$ 20	94%	$ 49
12/31/X6	23	68	65
12/31/X7	26	46	80

(The preparer of the financial statements should consider the need for required supplementary information (RSI) as required by GASB Statement No. 27, *Accounting for Pensions by State and Local Governmental Employers*, paragraph 22.)

9. Postretirement Plan

In addition to the pension benefits described above, the Hospital provides postretirement health care benefits, in accordance with the Hospital Authority's bylaws, to all employees who retire from the Hospital on or after attaining age 60 with at least 15 years of service. Currently 250 retirees meet these eligibility requirements. The Hospital reimburses 75 percent of the amount of validated claims for medical, dental, and hospitalization costs incurred by pre-Medicare retirees and their dependents. The Hospital also reimburses a fixed amount of $25 per month for a Medicare supplement for each retiree eligible for Medicare. Expenditures for postretirement health care benefits are recognized as retirees report claims and include a provision for estimated claims incurred but not yet reported to the Hospital. During the year, expenditures of $764 were recognized for postretirement health care. Approximately $64 of the $128 increase in expenditures over the previous year was caused by the addition of dental benefits, effective July 1, 19X7.

10. Classification of Expenses

	Total	Program A	Program B	Program C	General and Administrative	Fund Raising
Expenses incurred for the year ended December 31, 19X7, were for:						
Salaries and benefits	$ 46,845	$ 19,559	$ 8,200	$ 8,622	$ 8,583	$ 1,881
Medical supplies and drugs	12,746	7,160	3,355	2,231	—	—
Insurance	7,030	2,933	1,403	1,505	679	510
Other supplies	10,314	2,281	2,637	2,502	2,540	354
Provision for bad debts	859	—	—	—	859	—
Depreciation and amortization	4,065	1,516	716	776	765	292
Interest	1,489	—	—	—	1,489	—
Total expenses	$ 83,348	$ 33,449	$ 16,311	$ 15,636	$ 14,915	$ 3,037
Expenses incurred for the year ended December 31, 19X6, were for:						
Salaries and benefits	$ 43,235	$ 18,678	$ 7,167	$ 6,373	$ 9,615	$ 1,402
Medical supplies and drugs	7,986	3,800	1,868	2,318	—	—
Insurance	7,382	3,060	1,471	1,581	713	557
Other supplies	11,166	2,111	2,528	2,639	2,723	1,165
Provision for bad debts	938	—	—	—	938	—
Depreciation and amortization	3,638	1,267	632	734	764	241
Interest	1,552	—	—	—	1,552	—
Total expenses	$ 75,897	$ 28,916	$ 13,666	$ 13,645	$ 16,305	$ 3,365

Other disclosures that may be required include the following:

11. Property, plant, and equipment*

12. Off-balance-sheet risk and concentration of credit risk*

13. Fair value of financial instruments*

14. Contingent liabilities, claims, and judgments*

15. Operating leases*

16. Subsequent events*

*The disclosures contained in these notes would be similar to the disclosures contained in the notes to the financial statements for not-for-profit hospital and, therefore, are not repeated here.

Sample For-Profit Nursing Home, Inc.
Balance Sheets
December 31, 19X5 and 19X4

	19X5	*19X4*
Assets		
Current assets:		
Cash and cash equivalents	$ 95,000	$ 129,000
Investments	150,000	
Assets limited as to use	50,000	50,000
Patient accounts receivable, net of allowance for doubtful accounts of $6,700 in 19X5 and $5,300 in 19X4	162,000	152,000
Estimated third-party payor settlements	71,000	62,000
Interest receivable	7,000	
Supplies	47,000	43,000
Prepaid expenses	3,000	2,000
Deferred tax asset	12,000	14,000
Total current assets	597,000	452,000
Assets limited as to use, net of amount required for current liabilities	173,000	150,000
Property and equipment:		
Land	205,000	205,000
Land improvements	37,000	32,000
Buildings	1,399,000	1,399,000
Furniture, fixtures, and equipment	228,000	189,000
	1,869,000	1,825,000
Less accumulated depreciation	210,000	141,000
Property and equipment, net	1,659,000	1,684,000
Other assets	150,000	127,000
Total assets	$2,579,000	$2,413,000

(continued)

Sample For-Profit Nursing Home, Inc.
Balance Sheets
(continued)
December 31, 19X5 and 19X4

	19X5	*19X4*
Liabilities and Shareholders' Equity		
Current liabilities:		
Current maturities of long-term debt	$ 50,000	$ 50,000
Accounts payable	78,000	52,000
Accrued expenses	175,000	188,000
Deposits from patients	50,000	45,000
Other current liabilities	74,000	15,000
Total current liabilities	427,000	350,000
Deferred tax liability	6,000	14,000
Long-term debt, net of current maturities	1,700,000	1,750,000
Total liabilities	2,133,000	2,114,000
Shareholders' equity:		
Common stock, $20 par value; authorized 5,000 shares; issued and outstanding 3,500 shares	70,000	70,000
Retained earnings	376,000	229,000
Total shareholders' equity	446,000	299,000
Total liabilities and shareholders' equity	$2,579,000	$2,413,000

See accompanying notes to financial statements.

Sample For-Profit Nursing Home, Inc.
Statements of Income and Retained Earnings
Years Ended December 31, 19X5 and 19X4

	19X5	*19X4*
Revenue:		
Net patient service revenue	$2,163,000	$1,949,000
Other revenue	67,000	22,000
Interest and dividends	18,000	7,000
Total revenue	2,248,000	1,978,000
Expenses:		
Salaries and benefits	969,000	919,000
Medical supplies and drugs	511,000	499,000
Insurance and other	216,000	176,000
Provision for bad debts	92,000	83,000
Depreciation	69,000	57,000
Interest	164,000	172,000
Total expenses	2,021,000	1,906,000
Income before provision for income taxes	227,000	72,000
Provision for income taxes	80,000	29,000
Net income	147,000	43,000
Retained earnings, beginning of year	229,000	186,000
Retained earnings, end of year	$ 376,000	$ 229,000

See accompanying notes to financial statements.

Sample For-Profit Nursing Home, Inc.
Statements of Cash Flows
Years Ended December 31, 19X5 and 19X4

	19X5	*19X4*
Cash flows from operating activities:		
Cash received from residents and third-party payors	$2,019,000	$1,796,000
Cash received from others	67,000	22,000
Cash paid to employees and suppliers	(1,679,000)	(1,495,000)
Interest and dividends received	10,000	10,000
Interest paid	(160,000)	(170,000)
Taxes paid	(29,000)	(30,000)
Deposits received from patients	35,000	15,000
Deposits refunded to patients	(30,000)	(20,000)
Net cash provided by operating activities	233,000	128,000
Cash flows from investing activities:		
Purchase of investments	(150,000)	
Proceeds from sale of property		2,000
Capital expenditures	(44,000)	(79,000)
Cash invested in assets limited as to use	(23,000)	
Net cash used in investing activities	(217,000)	(77,000)
Cash flows from financing activities:		
Repayment of long-term debt	(50,000)	(50,000)
Net cash used in financing activities	(50,000)	(50,000)
Net increase (decrease) in cash and cash equivalents	(34,000)	1,000
Cash and cash equivalents, beginning of year	129,000	128,000
Cash and cash equivalents, end of year	$ 95,000	$ 129,000

(continued)

Sample For-Profit Nursing Home, Inc.
Statements of Cash Flows
(continued)
Years Ended December 31, 19X5 and 19X4

	19X5	*19X4*
Reconciliation of net income to net cash provided by operating activities:		
Net income	$ 147,000	$ 43,000
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation	69,000	57,000
Provision for bad debts	92,000	83,000
Loss on sale of property	—	11,000
Change in deferred income taxes	(6,000)	(14,000)
(Increase) decrease in:		
Patient accounts receivable	(102,000)	(41,000)
Other current assets	(21,000)	(15,000)
Other assets	(23,000)	(23,000)
Increase (decrease) in:		
Accounts payable and accrued expenses	13,000	43,000
Deposits from patients	5,000	(5,000)
Other current liabilities	59,000	(11,000)
Net cash provided by operating activities	$ 233,000	$ 128,000

See accompanying notes to financial statements.

Sample For-Profit Nursing Home, Inc.
Notes to Financial Statements
December 31, 19X5 and 19X4

1. Summary of Significant Accounting Policies

The Sample Nursing Home, Inc. (the Company) was incorporated in New State in 19X1 and operates a 128-bed nursing home in Abacus, New State. A summary of the Company's significant accounting policies follows:

Use of estimates. The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

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

Investments. Investments in debt instruments are classified as held-to-maturity when the Hospital has the positive intent and ability to hold the securities until maturity. Held-to-maturity securities are carried at cost adjusted for amortization of premiums and accretion of discounts.

Assets limited as to use. Assets set aside under terms of the note indenture are classified as assets limited as to use.

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

Bond issuance costs. Costs incurred in issuing the Series 19X1 bonds are being amortized based on the effective interest method.

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

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

Income taxes. The provisions for income taxes are based on amounts estimated to be currently payable and those deferred because of temporary differences between the financial statement and tax bases of assets and liabilities. These differences consist principally of bad debts and depreciation.

2. Assets Limited as to Use

Assets limited as to use under the Series 19X1 note indenture agreement at December 31, 19X5 and 19X4, are summarized as follows:

	19X5	*19X4*
U.S. Government obligations	$197,000	$177,000
Cash	23,000	21,000
Accrued interest income	3,000	2,000
	$223,000	$200,000

Assets set aside by the Board of Directors for capital improvements in the amount of $47,000 for 19X5 and 19X4 consist of certificates of deposit, at cost that approximates market and have been included in cash and cash equivalents.

3. Investments

The amortized cost and approximate fair value of held-to-maturity securities are as follows:

	December 31, 19X5			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized (Losses)	Approximate Fair Value
U.S. Treasury obligations	$197,000	$ 11,000	$ (16,000)	$192,000
U.S. Government agency obligations	83,000		(7,000)	76,000
Other debt securities	67,000		(18,000)	49,000
	$347,000	$ 11,000	$ (41,000)	$317,000

	December 31, 19X4			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized (Losses)	Approximate Fair Value
U.S. Treasury obligations	$127,000	$	$ (10,000)	$117,000
U.S. Government agency obligations	50,000	2,000		52,000
	$177,000	$ 2,000	$ (10,000)	$169,000

Maturities of held-to-maturity securities at December 31, 19X5, are as follows:

	Amortized Cost	Approximate Fair Value
One year or less	$178,000	$173,000
After one through five years	31,000	29,000
After five through ten years	68,000	62,000
After ten years	70,000	53,000
	$347,000	$317,000

4. Long-Term Debt

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

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

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

Future maturities of long-term debt as of December 31, 19X5, follow:

Year ending December 31,	*Amount*
19X6	$ 50,000
19X7	50,000
19X8	50,000
19X9	50,000
19Y0	50,000
Thereafter	1,500,000
Total	$ 1,750,000

5. Income Taxes

The provisions for income taxes are as follows:

	19X5	*19X4*
Current:		
Federal	$ 72,000	$ 15,000
State	2,000	
Total current	74,000	15,000
Deferred:		
Federal	6,000	13,000
State		1,000
Total deferred	6,000	14,000
Total provision for income taxes	$ 80,000	$ 29,000

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

For the years ended December 31, 19X5 and 19X4, the effective tax rate approximated the statutory rate of 34 percent and 40 percent, respectively.

The net current and noncurrent components of deferred income taxes recognized in the balance sheet at December 31, 19X5 and 19X4, follows:

	19X5	*19X4*
Net current assets	$ 12,000	$ 14,000
Net noncurrent liabilities	6,000	14,000
	$ 6,000	$ 0

Management has determined that no valuation allowance related to deferred tax assets is necessary at December 31, 19X5 and 19X4, respectively.

6. Concentration in State Medicaid Program

The Company has 100 of its 128 beds designated for care of patients under the state's Medicaid program. The current funding of that program is 90 days behind filed claims. The current state budget has no provision for reducing that lag and, while the proposed budget for 19X6 includes additional funding, there is no assurance that the final budget will include the needed additional funds.

7. Risks and Uncertainties Disclosures*

8. Pension Plan*

9. Postretirement Benefits*

10. Fair Values of Financial Instruments*

11. Concentrations of Credit Risk*

---

*The disclosures contained in these notes would be similar to the disclosures contained in the notes to the financial statements for not-for-profit hospital and, therefore, are not repeated here.

ILLUSTRATIVE FINANCIAL STATEMENTS FOR A CONTINUING CARE RETIREMENT COMMUNITY

Sample Not-for-Profit Continuing Care Retirement Community
Balance Sheets
December 31, 19X5 and 19X4

	19X5	*19X4*
Assets		
Cash	$ 375,000	$ 330,000
Accounts receivable, net of allowance for doubtful accounts of $4,000 in 19X5 and $5,000 in 19X4	187,000	197,000
Supplies	40,000	21,000
Prepaid expenses	115,000	73,000
Assets limited as to use	2,130,000	1,753,000
Property and equipment, net	14,893,000	15,280,000
Deferred financing costs, net of accumulated amortization of $28,000 in 19X5 and $21,000 in 19X4	83,000	90,000
Total assets	$ 17,823,000	$ 17,744,000
Liabilities and Net Assets		
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
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	6,304,000	6,585,000
Total liabilities	15,775,000	16,233,000
Net assets:		
Unrestricted	1,286,000	833,000
Temporarily restricted	311,000	294,000
Permanently restricted	451,000	384,000
Total net assets	2,048,000	1,511,000
Total liabilities and net assets	$ 17,823,000	$ 17,744,000

See accompanying notes to financial statements.

Sample Not-for-Profit Continuing Care Retirement Community
Statements of Operations
Years Ended December 31, 19X5 and 19X4

	19X5	*19X4*
Revenue, gains and other support:		
Resident services, including amortization of advance fees of $935,000 in 19X5 and $915,000 in 19X4	$ 3,946,000	$ 3,152,000
Patient revenue from nonresidents	249,000	275,000
Change in obligation to provide future services	12,000	(82,000)
Contributions	54,000	39,000
Net assets released from restrictions used for operations	24,000	50,000
Investment income	29,000	30,000
Other	75,000	68,000
Total revenue, gains and other support	4,389,000	3,532,000
Expenses:		
Salaries and benefits	1,708,000	1,250,000
Medical supplies and drugs	543,000	742,000
Insurance	291,000	311,000
Depreciation	452,000	447,000
Interest	967,000	955,000
Total expenses	3,961,000	3,705,000
Operating income (loss)	428,000	(173,000)
Net assets released from restriction-purchase of equipment	25,000	45,000
Increase (decrease) in unrestricted net assets	$ 453,000	$ (128,000)

See accompanying notes to financial statements.

Sample Not-for-Profit Continuing Care Retirement Community
Statements of Changes in Net Assets
Years Ended December 31, 19X5 and 19X4

	19X5	19X4
Unrestricted net assets:		
Operating income (loss)	$ 428,000	$ (173,000)
Net assets released from restriction — purchase of equipment	25,000	45,000
Increase (decrease) in unrestricted net assets	453,000	(128,000)
Temporarily restricted net assets:		
Contributions	40,000	15,000
Net assets released from restrictions used for operations	(24,000)	(50,000)
Net assets released from restriction — purchase of equipment	(25,000)	(45,000)
Investment income	26,000	15,000
Increase (decrease) in temporarily restricted net assets	17,000	(65,000)
Permanently restricted net assets:		
Contributions	67,000	52,000
Increase in permanently restricted net assets	67,000	52,000
Increase (decrease) in net assets	537,000	(141,000)
Net assets, beginning of year	1,511,000	1,652,000
Net assets, end of year	$ 2,048,000	$ 1,511,000

See accompanying notes to financial statements.

Sample Not-for-Profit Continuing Care Retirement Community
Statements of Cash Flows
Years Ended December 31, 19X5 and 19X4

	19X5	*19X4*
Cash flows from operating activities:		
Cash received from residents and third-party payors	$ 3,252,000	$ 2,341,000
Other receipts from operations	75,000	68,000
Investment income received	109,000	73,000
Contributions received (unrestricted)	52,000	44,000
Cash paid to employees and suppliers	(2,576,000)	(2,053,000)
Interest paid	(950,000)	(945,000)
Net cash used in operating activities	(38,000)	(472,000)
Cash flows from investing activities:		
Acquisition of property and equipment	(65,000)	(250,000)
Cash invested in assets limited as to use	(377,000)	229,000
Net cash used in investing activities	(442,000)	(21,000)
Cash flows from financing activities:		
Proceeds from contributions restricted for:		
Purchase of equipment	10,000	15,000
Investment in endowment	15,000	30,000
	25,000	45,000
Other financing activities:		
Proceeds from advance fees	654,000	857,000
Refunds of deposits and refundable fees	(103,000)	(52,000)
Proceeds from issuance of long-term debt	26,000	
Principal payments of long-term debt	(77,000)	(307,000)
	500,000	498,000
Net cash provided by financing activities	525,000	543,000
Net increase in cash	45,000	50,000
Cash, beginning of year	330,000	280,000
Cash, end of year	$ 375,000	$ 330,000

(continued)

Sample Not-for-Profit Continuing Care Retirement Community
Statements of Cash Flows
(continued)
Years Ended December 31, 19X5 and 19X4

	19X5	*19X4*
Reconciliation of change in net assets to net cash used in operating activities:		
Change in net assets	$ 537,000	$ (141,000)
Adjustments to reconcile change in net assets to net cash used in operating activities:		
Net assets released from restriction used for purchase of equipment	(25,000)	(45,000)
Amortization of advance fees	(935,000)	(915,000)
Loss (gain) on obligation to provide future services	(12,000)	82,000
Depreciation	452,000	447,000
Amortization of deferred financing costs	7,000	34,000
Provision for bad debts	3,000	3,000
(Increase) decrease in:		
Accounts receivable	7,000	(33,000)
Other assets	(61,000)	(4,000)
Increase (decrease) in:		
Accounts payable and accrued expenses	(11,000)	100,000
Net cash used in operating activities	$ (38,000)	$ (472,000)

See accompanying notes to financial statements.

1. Summary of Significant Accounting Policies

The Sample Continuing Care Retirement Community (the CCRC) is a nonprofit organization that 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 located in Evergreen Park, Illinois. The CCRC was incorporated in Illinois in 19X1. A summary of significant accounting policies follows.

Use of estimates. The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

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

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

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

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

Donor restrictions. The CCRC reports gifts of cash and other assets as restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires (that is, when a stipulated time restriction ends or a purpose restriction is accomplished), temporarily restricted net assets are reclassified as unrestricted net assets and reported in the statement of operations as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reflected as unrestricted contributions in the accompanying financial statements.

The CCRC reports gifts of property and equipment (or other long-lived assets) as unrestricted support unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, the CCRC reports expirations of donor restrictions when the donated or acquired long-lived assets are placed in service.

Income taxes. The CCRC has been recognized by the Internal Revenue Service as a not-for-profit corporation as described in Sec. 501(c)(3) of the Internal Revenue Code (IRC) and is exempt from federal income taxes pursuant to Sec. 501(a) of the IRC.

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

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

2. Property and Equipment

A summary of property and equipment at December 31, 19X5 and 19X4, follows:

	19X5	*19X4*
Land	$ 557,000	$ 557,000
Land improvement	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
Less: accumulated depreciation	(1,194,000)	(742,000)
	$ 14,893,000	$ 15,280,000

3. Temporarily Restricted Net Assets

Temporarily restricted net assets are available for the following purposes:

	19X5	*19X4*
Program A activities:		
Purchase of equipment	$ 169,000	$ 152,000
Charity care	142,000	142,000
	$ 311,000	$ 294,000

4. Permanently Restricted Net Assets

Permanently restricted net assets are restricted to investment in perpetuity:

	19X5	*19X4*
Program A activities:		
Charity care	$ 168,000	$ 168,000
Community activities	283,000	216,000
	$ 451,000	$ 384,000

5. Net Asset Released from Restrictions

Net assets were released from donor restrictions by incurring expenses satisfying the restricted purposes or by occurrence of other events specified by donors:

	19X5	*19X4*
Program restrictions accomplished		
Program A activities:		
Charity care	$ 24,000	$ 50,000
Purchase of equipment	$ 25,000	$ 45,000

6. Long-Term Debt

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

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

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

As required by the mortgage note agreement, the CCRC established an initial debt service reserve fund of $1,000,000 at April 15, 19X3. All resident fees received thereafter, net of resident fee refunds and debt service payments not to exceed $300,000 annually in the first four years and $200,000 annually thereafter, are to be added to the debt service reserve fund until the total sum of $2,050,000 is accumulated. Since June 1, 19X4, the CCRC has been required to deliver to the trustee $5,500 per month to establish maintenance reserves until the aggregate of such payments equals a residential unit reserve and a health care center reserve of $240,000 and $90,000, respectively. At December 31, 19X5 and 19X4, the trustee held investments aggregating $2,130,000 and $1,753,000, respectively. Such amount has been classified as assets limited as to use.

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

Year ending December 31,	*Amount*
19X6	$ 90,000
19X7	90,000
19X8	95,000
19X9	105,000
20Y0	105,000

7. Classification of Expenses

	Total	Program A	Program B	Program C	General and Administrative
Expenses incurred for the year ended December 31, 19X5, were for:					
Salaries and benefits	$1,708,000	$ 478,000	$ 498,000	$ 368,000	$ 364,000
Medical supplies and drugs	543,000	342,000	100,000	101,000	
Insurance	291,000	43,000	68,000	148,000	32,000
Depreciation	452,000	183,000	63,000	72,000	134,000
Interest	967,000	431,000	208,000	265,000	63,000
Total expenses	$3,961,000	$1,477,000	$ 937,000	$ 954,000	$ 593,000
Expenses incurred for the year ended December 31, 19X4, were for:					
Salaries and benefits	$1,250,000	$ 433,000	$ 285,000	$ 243,000	$ 289,000
Medical supplies and drugs	742,000	277,000	100,000	365,000	
Insurance	311,000	62,000	42,000	169,000	38,000
Depreciation	447,000	163,000	58,000	72,000	154,000
Interest	955,000	382,000	189,000	295,000	89,000
Total expenses	$3,705,000	$1,317,000	$ 674,000	$1,144,000	$ 570,000

(The preparer of the financial statements may wish to include a brief disclosure of the types of programs.)

8. Assets Limited as to Use*

9. Risks and Uncertainties Disclosures*

10. Pension Plan*

11. Postretirement Benefits*

12. Fair Values of Financial Instruments*

13. Concentrations of Credit Risk*

*The disclosures contained in these notes would be similar to the disclosures contained in the notes to the financial statements for the not-for-profit hospital and, therefore, are not repeated here.

Sample Not-for-Profit Home Health Agency
Balance Sheets
December 31, 19X5 and 19X4

	19X5	*19X4*
Assets		
Current assets:		
Cash and cash equivalents	$ 74,000	$ 41,000
Investments	147,000	137,000
Accounts receivable, net of allowance for doubtful accounts of $61,000 in 19X5 and $30,000 in 19X4	752,000	476,000
Other receivables	27,000	22,000
Total current assets	1,000,000	676,000
Investments	100,000	100,000
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)
Equipment, net	61,000	52,000
Deferred finance charges, net of accumulated amortization of $15,000 in 19X5 and $10,000 in 19X4	20,000	25,000
Total assets	$ 1,181,000	$ 853,000
Liabilities and Net Assets		
Current liabilities:		
Current maturities of long-term debt	$ 13,000	$ 13,000
Accounts payable	40,000	21,000
Accrued payroll and vacation costs	496,000	352,000
Estimated third-party payor settlements	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	105,000	118,000
Total liabilities	752,000	601,000
Net assets:		
Unrestricted	330,000	167,000
Temporarily restricted	9,000	5,000
Permanently restricted	90,000	80,000
Total net assets	429,000	252,000
Total liabilities and net assets	$ 1,181,000	$ 853,000

See accompanying notes to financial statements.

Sample Not-for-Profit Home Health Agency
Statements of Operations
Years Ended December 31, 19X5 and 19X4

	19X5	*19X4*
Revenue, gains and other support:		
Net patient service revenue	$ 4,042,000	$ 2,687,000
Contributions	5,000	22,000
Net assets released from restrictions	5,000	—
Investment income	13,000	6,000
Other revenue	27,000	32,000
Total revenue, gains and other support	4,092,000	2,747,000
Expenses:		
Salaries and benefits	2,714,000	1,835,000
Medical supplies and drugs	1,042,000	675,000
Insurance and other	90,000	83,000
Provision for bad debts	46,000	21,000
Depreciation	21,000	15,000
Interest	16,000	19,000
Total expenses	3,929,000	2,648,000
Operating income and change in unrestricted net assets	$ 163,000	$ 99,000

See accompanying notes to financial statements.

Sample Not-for-Profit Home Health Agency
Statements of Changes in Net Assets
Years Ended December 31, 19X5 and 19X4

	19X5	*19X4*
Unrestricted net assets:		
Operating income	$ 163,000	$ 99,000
Increase in unrestricted net assets	163,000	99,000
Temporarily restricted net assets:		
Contributions	9,000	5,000
Net assets released from restrictions	(5,000)	—
Increase in temporarily restricted net assets	4,000	5,000
Permanently restricted net assets:		
Contributions	10,000	6,000
Increase in permanently restricted net assets	10,000	6,000
Increase in net assets	177,000	110,000
Net assets, beginning of year	252,000	142,000
Net assets, end of year	$ 429,000	$ 252,000

See accompanying notes to financial statements.

Sample Not-for-Profit Home Health Agency
Statements of Cash Flows
Years Ended December 31, 19X5 and 19X4

	19X5	*19X4*
Cash flows from operating activities:		
Cash received from patients and third-party payors	$3,721,000	$2,542,000
Other receipts from operations	22,000	32,000
Cash paid to employees and suppliers	*(3,683,000)*	*(2,540,000)*
Interest paid	(11,000)	(14,000)
Nonoperating revenue	23,000	22,000
Net cash provided by operating activities	72,000	42,000
Cash flows from investing activities:		
Purchase of equipment	(30,000)	(19,000)
Purchase of investments	(10,000)	(15,000)
Net cash used in investing activities	(40,000)	(34,000)
Cash flows from financing activities:		
Proceeds from contributions restricted for:		
Purchase of equipment	9,000	5,000
Investment in endowment	5,000	–
	14,000	5,000
Other financing activities:		
Payment of long-term debt	(13,000)	–
Net cash provided by financing activities	1,000	5,000
Net increase in cash and cash equivalents	33,000	13,000
Cash and cash equivalents, beginning of year	41,000	28,000
Cash and cash equivalents, end of year	$ 74,000	$ 41,000

(continued)

Sample Not-for-Profit Home Health Agency
Statements of Cash Flows
(continued)
Years Ended December 31, 19X5 and 19X4

	19X5	*19X4*
Reconciliation of change in net assets to net cash provided by operating activities:		
Change in net assets	$ 177,000	$ 98,000
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Increase (decrease) in temporarily restricted net assets	(4,000)	7,000
Increase in permanently restricted net assets	(10,000)	(6,000)
Provision for bad debts	46,000	21,000
Depreciation	21,000	15,000
Amortization of deferred financing charges	5,000	5,000
(Increase) decrease in:		
Accounts receivable	(322,000)	(150,000)
Other receivables	(5,000)	(2,000)
Increase (decrease) in:		
Accounts payable, accrued payroll and vacation costs	163,000	50,000
Estimated third-party payor settlements	1,000	4,000
Net cash provided by operating activities	$ 72,000	$ 42,000

See accompanying notes to financial statements.

Sample Not-for-Profit Home Health Agency
Notes to Financial Statements
Years Ended December 31, 19X5 and 19X4

1. Summary of Significant Accounting Policies

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

Use of estimates. The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and cash equivalents. Cash and cash equivalents include investments in highly liquid debt instruments with an original maturity of three months or less.

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

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

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

Donor restrictions. The Agency reports gifts of cash and other assets as restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the statement of operations as net assets released from restrictions. When long-lived assets are placed in service, thus satisfying purpose restrictions, the amount is included as a change in net assets, restricted and unrestricted. Donor-restricted contributions whose restrictions are met within the same year as received are reflected as unrestricted contributions in the accompanying financial statements.

The Agency reports gifts of equipment (or other long-lived assets) as unrestricted support unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, the Agency reports expirations of donor restrictions when the donated or acquired long-lived assets are placed in service.

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

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

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

2. Temporarily Restricted Net Assets

Temporarily restricted net assets are available for the following purposes:

	19X5	*19X4*
Program activities:		
Charity care	$ —	$ 5,000
Purchase of equipment	9,000	—
	$ 9,000	$ 5,000

3. Permanently Restricted Net Assets

Permanently restricted net assets are restricted to investment in perpetuity, the income from which is expendable to support:

	19X5	*19X4*
Program A activities	$ 10,000	$ —
Any activities of the Agency	80,000	80,000
	$ 90,000	$ 80,000

4. Donor Restrictions Released

Net assets were released from donor restrictions by incurring expenses satisfying the restricted purposes or by occurrence of other events specified by donors:

	19X5	*19X4*
Program restrictions accomplished		
Charity care expenditures	$ 5,000	$ —

5. Third-Party Rate Adjustments and Revenue

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

6. Board-Designated Assets

The Board of Directors has designated cash and investments aggregating $135,000 to be used for future major capital improvements. Those assets are classified in the balance sheet as investments.

7. Long-Term Debt

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

	19X5	*19X4*
Note payable to bank, interest at 15 percent, payable in monthly installments of $2,200 per month, including interest, collateralized by equipment with a depreciated cost of $42,000	$ 118,000	$ 131,000
Less current maturities	13,000	13,000
	$ 105,000	$ 118,000

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

Year ending December 31,	*Amount*
19X6	$ 13,000
19X7	13,000
19X8	13,000
19X9	13,000
20Y0	13,000
Thereafter	53,000
Total	$ 118,000

8. Classification of Expenses

	Total	Program A	Program B	Program C	General and Administrative
Expenses incurred for the year ended December 31, 19X5, were for:					
Salaries and benefits	$2,714,000	$1,363,000	$ 699,000	$ 363,000	$ 289,000
Medical supplies and drugs	1,042,000	511,000	246,000	285,000	
Insurance and other	90,000	58,000			32,000
Provision for bad debts	46,000	16,000	30,000		
Depreciation	21,000	5,000			16,000
Interest	16,000	10,000	3,000		3,000
Total expenses	$3,929,000	$1,963,000	$ 978,000	$ 648,000	$ 340,000
Expenses incurred for the year ended December 31, 19X4, were for:					
Salaries and benefits	$1,835,000	$ 915,000	$ 463,000	$ 216,000	$ 241,000
Medical supplies and drugs	675,000	335,000	211,000	129,000	
Insurance and other	83,000	64,000			19,000
Provision for bad debts	21,000	21,000			
Depreciation	15,000	6,000			9,000
Interest	19,000	12,000	5,000		2,000
Total expenses	$2,648,000	$1,353,000	$ 679,000	$ 345,000	$ 271,000

(The preparer of the financial statements may wish to include a brief description of the types of programs.)

9. Charity Care

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

10. Risks and Uncertainties Disclosures*

11. Pension Plan*

12. Postretirement Benefits*

13. Fair Value of Financial Statements*

14. Concentrations of Credit Risk*

---

*The disclosures contained in these notes would be similar to the disclosures contained in the notes to the financial statements for the not-for-profit hospital and, therefore, are not repeated here.

ILLUSTRATIVE FINANCIAL STATEMENTS FOR A HEALTH MAINTENANCE ORGANIZATION

Sample Not-for-Profit Health Maintenance Organization
Balance Sheets
June 30, 19X5 and 19X4

	19X5	*19X4*
Assets		
Current assets:		
Cash and cash equivalents	$ 2,937,000	$ 1,021,000
Premiums receivable, net of allowance for doubtful accounts of $36,000 in 19X5 and $42,000 in 19X4	358,000	407,000
Other receivables	263,000	261,000
Supplies	190,000	184,000
Prepaid expenses	197,000	99,000
Total current assets	3,945,000	1,972,000
Property and equipment, net	5,756,000	5,626,000
State guaranty fund deposit	150,000	150,000
Debt issuance costs, net of accumulated amortization of $42,000 in 19X5 and $39,000 in 19X4	18,000	21,000
Total assets	$ 9,869,000	$ 7,769,000
Liabilities and Net Assets		
Current liabilities:		
Unsecured 12 percent note payable to a bank	$ —	$ 44,000
Current maturities of long-term debt	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 current maturities	4,295,000	2,382,000
Total liabilities	7,751,000	4,869,000
Commitments and contingencies		
Net assets — unrestricted	2,118,000	2,900,000
Total liabilities and net assets	$ 9,869,000	$ 7,769,000

See accompanying notes to financial statements.

Sample Not-for-Profit Health Maintenance Organization
Statements of Operations and Changes in Net Assets
Years Ended June 30, 19X5 and 19X4

	19X5	*19X4*
Revenue:		
Premiums earned	$ 27,682,000	$ 22,500,000
Coinsurance	689,000	500,000
Interest and other income	242,000	100,000
Total revenue	28,613,000	23,100,000
Expenses:		
Salaries and benefits	16,173,000	13,348,000
Medical supplies and drugs	8,507,000	5,988,000
Insurance	3,963,000	2,463,000
Depreciation	367,000	336,000
Interest	385,000	375,000
Total expenses	29,395,000	22,510,000
Operating income (loss)	(782,000)	590,000
Net assets, beginning of year	2,900,000	2,310,000
Net assets, end of year	$ 2,118,000	$ 2,900,000

See accompanying notes to financial statements.

Sample Not-for-Profit Health Maintenance Organization
Statements of Cash Flows
Years Ended June 30, 19X5 and 19X4

	19X5	*19X4*
Cash flows from operating activities:		
Cash received from premiums, stop-loss insurance recoveries, and coinsurance	$ 28,969,000	$ 24,410,000
Cash paid to employees and to providers of health care services	(28,405,000)	(22,818,000)
Interest and other income received	230,000	90,000
Interest paid	(382,000)	(372,000)
Net cash provided by operating activities	412,000	1,310,000
Cash flows from investing activities:		
Capital expenditures	(497,000)	(121,000)
Net cash used in investing activities	(497,000)	(121,000)
Cash flows from financing activities:		
Proceeds from long-term debt	2,300,000	—
Principal payments on long-term debt	(255,000)	(1,000,000)
Principal payments on note payable	(44,000)	—
Net cash provided by (used in) financing activities	2,001,000	(1,000,000)
Net increase in cash and cash equivalents	1,916,000	189,000
Cash and cash equivalents, beginning of year	1,021,000	832,000
Cash and cash equivalents, end of year	$ 2,937,000	$ 1,021,000

(continued)

Sample Not-for-Profit Health Maintenance Organization
Statements of Cash Flows
(continued)
Years Ended June 30, 19X5 and 19X4

	19X5	*19X4*
Reconciliation of change in net assets to net cash provided by operating activities:		
Change in net assets	$ (782,000)	$ 590,000
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	370,000	339,000
(Increase) decrease in:		
Premiums receivables	49,000	84,000
Other current assets	230,000	(93,000)
Increase (decrease) in:		
Accounts payable — medical services	774,000	335,000
Other accounts payable and accrued expenses	(168,000)	(60,000)
Unearned premium revenue	(61,000)	115,000
Net cash provided by operating activities	$ 412,000	$ 1,310,000

See accompanying notes to financial statements.

Sample Not-for-Profit Health Maintenance Organization
Notes to Financial Statements
June 30, 19X5 and 19X4

1. Organization

The Sample Health Maintenance Organization (the HMO) was incorporated in 19X0 in New State 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.

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

2. Summary of Significant Accounting Policies

Use of estimates. The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and cash equivalents. Cash and cash equivalents include investments in highly liquid debt instruments with an original maturity of three months or less.

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

Property and equipment. Property and equipment are recorded at cost. Maintenance and repairs are charged to expense, and betterments are capitalized. Property and equipment costing approximately $700,000 was financed by health maintenance organization initial development grants received in 19X1 and 19X2 from the U.S. Department of Health and Human Services (HHS). This property will be owned by the HMO as long as the equipment and facilities are used for projects related to the objectives of the Public Health Service Act.

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

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

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

Health care service cost recognition. The HMO contracts with various health care providers for the provision of certain medical care services to its members. The HMO compensates these providers on a capitation basis. As part of a cost control incentive program, the HMO retains up to 20 percent of the capitation as a risk-sharing fund. In the event of hospital utilization in excess of budget, those providers bear the risk to the extent of 15 percent of the capitation fee. Operating expenses include all amounts incurred by the HMO under the aforementioned contracts.

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

Premiums revenue. Membership contracts are on a yearly basis subject to cancellation by the employer group or the HMO upon 30 days written notice. Premiums are due monthly and are recognized as revenue during the period in which the HMO is obligated to provide services to members.

Reinsurance (stop-loss insurance). Reinsurance premiums are reported as health care costs, and reinsurance recoveries are reported as a reduction of related health care costs.

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

3. Property and Equipment

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

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

4. Long-Term Debt

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

	19X5	*19X4*
HHS loan, interest at 7.5 percent, payable in monthly installments of $50,000, including interest	$ 2,020,000	$ 111,000
HHS loan, interest at 9.25 percent, payable in monthly installments of $10,000, including interest	1,658,000	1,694,000
Secured equipment loans, payable in monthly installments of $15,000, including interest	858,000	686,000
	4,536,000	2,491,000
Less current maturities	241,000	109,000
	$ 4,295,000	$ 2,382,000

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

Year ending December 31,	*Amount*
19X6	$ 241,000
19X7	259,000
19X8	280,000
19X9	800,000
20Y0	2,956,000
	$ 4,536,000

5. State Guarantee Fund Deposit

In August 19X4 the state in which the HMO is domiciled enacted legislation specifically governing HMOs. Under this legislation, the corporation is required to maintain a deposit of $150,000 with the director of the division of insurance of the state.

6. Employee Retirement Plan

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

7. Stop-Loss Insurance

The HMO entered into a stop-loss insurance agreement with an insurance company to limit its losses on individual claims. Under the terms of this agreement, the insurance company will reimburse the HMO approximately 25 percent of the cost of each member's annual hospital services, in excess of a $1,000 deductible, up to a lifetime limitation of $500,000 per member. In the event the HMO ceases operations, (a) plan benefits will continue for members who are confined in an acute care hospital on the date of insolvency until their discharge, and (b) plan benefits will continue for any other member until the end of the contract period for which premiums have been paid.

Stop-loss insurance premiums of approximately $700,000 and $500,000 are included in insurance expense (Note 9) in 19X5 and 19X4, respectively. Approximately $600,000 and $400,000 in stop-loss insurance recoveries are deducted from insurance expense in 19X5 and 19X4, respectively.

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

8. Malpractice Claims

Malpractice claims have been asserted against the 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 operating income of the HMO. Incidents occurring through June 30, 19X5, may result in the assertion of additional claims. Other claims may be asserted arising from past services provided. Management believes that these claims, if asserted, would be settled within the limits of insurance coverage.

9. Classification of Expenses

	Total	Program A	Program B	Program C	General and Administrative
Expenses incurred for the year ended June 30, 19X5, were for:					
Salaries and benefits	$ 16,173,000	$ 6,062,000	$ 3,000,000	$ 5,128,000	$ 1,983,000
Medical supplies and drugs	8,507,000	3,863,000	2,489,000	2,155,000	—
Insurance	3,963,000	1,666,000	985,000	927,000	385,000
Depreciation	367,000	43,000	68,000	150,000	106,000
Interest	385,000	198,000	63,000	124,000	—
Total expenses	$ 29,395,000	$ 11,832,000	$ 6,605,000	$ 8,484,000	$ 2,474,000
Expenses incurred for the year ended June 30, 19X4, were for:					
Salaries and benefits	$ 13,348,000	$ 6,380,000	$ 2,940,000	$ 2,644,000	$ 1,384,000
Medical supplies and drugs	5,988,000	2,984,000	1,684,000	1,320,000	—
Insurance	2,463,000	1,200,000	643,000	514,000	106,000
Depreciation	336,000	68,000	46,000	111,000	111,000
Interest	375,000	221,000	—	154,000	—
Total expenses	$ 22,510,000	$ 10,853,000	$ 5,313,000	$ 4,743,000	$ 1,601,000

(The preparer of the financial statements may wish to include a brief description of the types of programs.)

10. Risks and Uncertainties Disclosures*

11. Pension Plan*

12. Postretirement Benefits*

13. Fair Value of Financial Instruments*

14. Concentrations of Credit Risk*

*The disclosures contained in these notes would be similar to the disclosures contained in the notes to the financial statements for the not-for-profit hospital and, therefore, are not repeated here.

ILLUSTRATIVE FINANCIAL STATEMENTS FOR AN AMBULATORY CARE ORGANIZATION

Sample Not-for-Profit Ambulatory Care, Inc.
Balance Sheets
December 31, 19X5 and 19X4

	19X5	*19X4*
Assets		
Current assets:		
Cash	$ 65,000	$ 76,000
Patient accounts receivable, net of allowance for doubtful accounts of $15,000 in 19X5 and $5,000 in 19X4	290,000	278,000
Estimated retroactive adjustments — third-party payors	19,000	32,000
Accounts receivable — other	13,000	8,000
Supplies	21,000	18,000
Prepaid expenses and deposits	5,000	9,000
Total current assets	413,000	421,000
Property and equipment, at cost:		
Land	100,000	100,000
Land improvements	322,000	322,000
Buildings	682,000	682,000
Equipment	1,390,000	1,389,000
	2,494,000	2,493,000
Less accumulated depreciation	217,000	100,000
Property and equipment, net	2,277,000	2,393,000
Other assets:		
Advances receivable	14,000	5,000
Total assets	$ 2,704,000	$ 2,819,000
Liabilities and Net Assets		
Current liabilities:		
Notes payable	$ 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	30,000	24,000
Financing advance from third-party payors	—	1,000
Total current liabilities	253,000	278,000
Commitments and contingencies		
Net assets — unrestricted	2,451,000	2,541,000
Total liabilities and net assets	$ 2,704,000	$ 2,819,000

See accompanying notes to financial statements.

Sample Not-for-Profit Ambulatory Care, Inc.
Statements of Operations and Changes in Net Assets
Years Ended December 31, 19X5 and 19X4

	19X5	*19X4*
Revenue and gains:		
Net patient service revenue	$ 860,000	$ 357,000
Other	29,000	15,000
Total revenue and gains	889,000	372,000
Expenses:		
Salaries and benefits	485,000	243,000
Medical supplies and drugs	189,000	66,000
Insurance	154,000	98,000
Provision for bad debts	14,000	4,000
Depreciation	117,000	100,000
Interest	20,000	18,000
Total expenses	979,000	529,000
Operating loss	(90,000)	(157,000)
Net assets, beginning of year	2,541,000	2,698,000
Net assets, end of year	$ 2,451,000	$ 2,541,000

See accompanying notes to financial statements.

Sample Not-for-Profit Ambulatory Care, Inc.
Statements of Cash Flows
Years Ended December 31, 19X5 and 19X4

	19X5	*19X4*
Cash flows from operating activities:		
Cash received from patients and third-party payors	$ 866,000	$ 368,000
Cash received from others	21,000	6,000
Interest received	3,000	11,000
Interest paid	(15,000)	(16,000)
Cash paid to employees and suppliers	(870,000)	(432,000)
Net cash provided by (used in) operating activities	5,000	(63,000)
Cash flows from investing activities:		
Purchase of equipment	(1,000)	(4,000)
Advances made to XYZ Affiliate	(9,000)	(5,000)
Net cash used in investing activities	(10,000)	(9,000)
Cash flows from financing activities:		
Proceeds from notes payable	—	144,000
Payments on notes payable	(6,000)	—
Net cash provided by (used in) financing activities	(6,000)	144,000
Net increase (decrease) in cash	(11,000)	72,000
Cash, beginning of year	76,000	4,000
Cash, end of year	$ 65,000	$ 76,000

(continued)

Sample Not-for-Profit Ambulatory Care, Inc.
Statements of Cash Flows
(continued)
Years Ended December 31, 19X5 and 19X4

	19X5	*19X4*
Reconciliation of change in net assets to net cash provided by (used in) operating activities:		
Change in net assets	$ (90,000)	$ (157,000)
Adjustments to reconcile change in net assets to net cash provided by (used in) operating activities:		
Depreciation	117,000	100,000
Provision for bad debts	14,000	4,000
(Increase) decrease in:		
Patient accounts receivable	(12,000)	(19,000)
Other current assets	1,000	(2,000)
Increase (decrease) in:		
Accounts payable and accrued payroll, benefits, and taxes	(24,000)	10,000
Other current liabilities	(1,000)	1,000
Net cash provided by (used in) operating activities	$ 5,000	$ (63,000)

See accompanying notes to financial statements.

Sample Not-for-Profit Ambulatory Care, Inc.
Notes to Financial Statements
December 31, 19X5 and 19X4

1. Summary of Significant Accounting Policies

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

Three area hospitals — ABC Hospital and Health Center, DEF Hospital, and GHI Hospital — entered into a members' agreement to develop this ambulatory care center. In accordance with this agreement, each hospital contributed capital of $947,000 to Ambulatory Care, Inc. Ambulatory Care, Inc. began operations in October 19X3.

Use of estimates. The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

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

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

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

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

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

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

2. Advances Receivable

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

3. Related Party Transactions

During 19X3, Ambulatory Care, Inc. entered into a contract with one of the member hospitals (the managing hospital) for the management of the business and affairs of Ambulatory Care, Inc. Under this agreement, Ambulatory Care, Inc. pays $4,000 per month to the managing hospital. The agreement with the managing hospital was to remain in effect through December 31, 19X5, but has been extended on a month-to-month basis.

In addition, during 19X4 each hospital loaned $48,000 to Ambulatory Care, Inc. in the form of promissory notes at an interest rate of prime rate plus 1 percent (effective rates of 10 percent and 9 percent in 19X5 and 19X4, respectively). Of the total $144,000 liability, $48,000 is payable on demand after November 28, 19X5, to one member hospital, with the remaining portion ($96,000) payable on demand after December 8, 19X5, to the other two member hospitals. During 19X5, Ambulatory Care, Inc. paid $2,000 to each member hospital, thereby reducing the obligation to $138,000.

4. Revenue From Contracting Agencies

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

5. Charity Care

Ambulatory Care, Inc. has a policy of providing charity care to indigent patients in emergency situations. These services, which are excluded from revenues, amounted to $27,000 and $13,000 in 19X5 and 19X4, respectively, when measured at Ambulatory Care, Inc.'s established rates.

6. Classification of Expenses

		Program			
	Total	*A*	*B*	*C*	*General and Administrative*
Expenses incurred for the year ended December 31, 19X5, were for:					
Salaries and benefits	$ 485,000	$ 216,000	$ 102,000	$ 121,000	$ 46,000
Medical supplies and drugs	189,000	98,000	43,000	48,000	—
Insurance	154,000	79,000	45,000	14,000	16,000
Provision for bad debts	14,000	9,000	—	5,000	—
Depreciation	117,000	100,000	—	17,000	—
Interest	20,000	9,000	—	—	11,000
Total expenses	$ 979,000	$ 511,000	$ 190,000	$ 205,000	$ 73,000

(continued)

	Total	Program A	Program B	Program C	General and Administrative
Expenses incurred for the year ended December 31, 19X4, were for:					
Salaries and benefits	$ 243,000	$ 111,000	$ 46,000	$ 57,000	$ 29,000
Medical supplies and drugs	66,000	31,000	15,000	20,000	—
Insurance	98,000	45,000	19,000	26,000	8,000
Provision for bad debts	4,000	—	4,000	—	—
Depreciation	100,000	56,000	—	44,000	—
Interest	18,000	7,000	—	—	11,000
Total expenses	$ 529,000	$ 250,000	$ 84,000	$ 147,000	$ 48,000

(The preparer of the financial statements may wish to include a brief description of the types of programs.)

7. Risks and Uncertainties Disclosures*

8. Pension Plan*

9. Postretirement Benefits*

10. Fair Value of Financial Instruments*

11. Concentrations of Credit Risk*

*The disclosures contained in these notes would be similar to the disclosures contained in the notes to the financial statements for the not-for-profit hospital and, therefore, are not repeated here.

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

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 continuing care retirement community (CCRC) resident prior to, or at the time of, admission to the CCRC for future services and the use of facilities specified in a contract that remains in effect for as long as the resident resides in the CCRC.

Advance refunding. A transaction in which refunding debt is issued to pay the refunded debt at a specified future date(s), with the proceeds placed in trust or otherwise restricted to pay the refunded debt.

Allocated loss adjustment expense (ALAE). Claim expense that can be assigned to individual claims (for example, attorney's fees, claim adjusting service fees, or court costs).

Ambulatory care organization. A partnership, association, corporation, or other legal entity organized to deliver health care services to patients that come or are brought to a health care facility for a purpose other than admission as an inpatient (for example, emergency room services, clinic services, or outpatient surgery).

Ancillary services. Services performed for diagnostic or therapeutic purposes. Ancillary services generally are those special services for which charges in addition to routine charges customarily are made (for example, laboratory, radiology, surgical, or other services).

Anticipated revenues. Amounts including third-party payments (for example, those from Blue Cross), contractually or statutorily committed investment income from sources related to the activities of a continuing care retirement community (CCRC), contributions pledged by donors to support CCRC activities, periodic fees expected to be collected, or the balance of deferred nonrefundable advance fees.

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

Assets limited as to use. Assets that are segregated and limited by outside third parties (other than a donor or a grantor) as to what the assets may be used for. These assets may be limited as to use by bond indenture agreements or malpractice funding arrangements.

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

Bad-debt expense. The provision for actual or expected doubtful accounts resulting from the extension of credit.

Capitation fee. A fixed amount per individual that is paid periodically (usually monthly) to a provider as compensation for providing comprehensive health care services for the period. The fee is set by contract between a prepaid health care plan and the provider. These contracts are generally with medical groups, independent practice associations (IPAs), hospitals, and other similar providers. Capitation fees may be determined actuarially or negotiated based on expected costs to be incurred.

Charity care. Health care services that never were expected to result in cash inflows. Charity care results from a provider's policy to provide health care services free of charge to individuals who meet certain financial criteria.

Claims-made insurance policy. A policy that covers only malpractice claims reported to the insurance carrier during the policy term, regardless of the date of the incident giving rise to the claim.

Clinic. A freestanding facility or part of another health care organization used for diagnosis and treatment of outpatients.

Commercial paper. Short-term, unsecured promissory notes that represent a flexible and low-cost form of short-term financing. Taxable commercial paper is sold on a discount basis, rather than on an interest-bearing basis, with the discount determined by the maturity of the notes, the creditworthiness of the issuer or its credit support, and general market demand. The primary risk is the variable interest rate exposure. Issuance often requires some form of credit enhancement or liquidity support.

Comprehensive medical plan (CMP). A health plan option that may be available to Medicare beneficiaries and provides a more limited range of services than health maintenance organizations but includes physician services, laboratory, radiology, emergency, preventive, and inpatient services. A CMP assumes the financial risk for the provision of services and for out-of-area coverage.

Conditional promise to give. A promise to give that depends on the occurrence of a specified future or uncertain event to bind the promisor.

Continuing-care contract. An agreement between a resident and a CCRC specifying the services and facilities to be provided by the CCRC 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 or guaranteeing residential facilities, meals, and health care services for a community of retired persons who may reside in apartments, other living units, or in some cases a nursing center. (Also referred to as a residential care facility or a life-care retirement community.)

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

Contractual adjustments. The differences between revenue at established rates and the amounts realizable from third-party payors under contractual agreements.

Contribution. An unconditional transfer of cash or other assets to an entity or a settlement or cancellation of its liabilities in a voluntary nonreciprocal transfer by another entity acting other than as an owner.

Costs of acquiring initial continuing-care contracts. Costs incurred to originate a contract that result from and are essential to the acquisition of the initial contracts and are incurred through the date of substantial occupancy but no later than one year from the date of completion of construction.

These costs include--

- The costs of processing the contract, such as evaluating the prospective resident's financial condition; evaluating and recording guarantees, collateral, and other security arrangements; negotiating contract terms; preparing and processing contract documents; and closing the transaction.

- The costs from activities in connection with soliciting potential initial residents (such as model units and their furnishings, sales brochures, semipermanent signs, tours, grand openings, and sales salaries). These costs do not include advertising, interest, administrative costs, rent, depreciation, or any other occupancy or equipment costs.

- The portion of an employee's compensation and benefits that relates to the initial contract acquisitions.

Courtesy and policy discounts. The differences between revenue recorded at established rates and amounts realizable for services provided to specific individuals such as employees, medical staff, and clergy.

Credibility. A measure of the statistical significance of a provider's own data, dependent on its stability and volume in relation to the stability and volume of the industry data. Actuaries use credibility to blend an estimate from a provider's own experience with a broader estimate based on the experience of similar institutions. A provider's own experience may be assigned a credibility weight less than 100 percent due to year-to-year volatility. Such volatility is often a function of the size of the provider. Large providers generally have less volatility than small providers. In such an instance, a broader and more stable body of experience of similar providers would be used to supplement the specific provider's experience.

Credit enhancement. Typically, a bank letter of credit that guarantees investors will receive principal and interest in the event of an issuer default. A line of credit provides liquidity support to an issuer but does not provide a guarantee of the repayment of principal and interest in the event of issuer default. The liquidity support provides a loan to issuers in the event the issuer is unable to place large amounts of maturing commercial paper with investors.

Crossover refunding (also called a *delayed defeasance*). A type of advance refunding in which the old debt is not immediately replaced. The proceeds from the new debt, additional cash deposits (if any), and the income earned on the related investments are sufficient to pay the principal and any call premium of the old debt and the interest on the new debt until the date of crossover. Until the crossover, the proceeds from the new debt serve as collateral for that debt. The old debt is serviced by the entity until the date of crossover, at which time the proceeds from the new debt are used to retire the old debt and the entity becomes obligated to service the new debt. The old debt remains as a liability on the issuer's books until the crossover, when it is called in accordance with the call provisions of its indenture.

Deductions from revenue. Reductions in gross revenue arising from contractual adjustments, courtesy and policy discounts, or other adjustments and deductions.

Defeasance. Legal satisfaction of refunded debt without the debt necessarily being retired.

Development factor. A computed factor used to project future changes in estimated losses from the date of the occurrence of the incident to the date-of-claim payment resulting from inflation, claimed cost growth, industry trends, and court awards. The development factor can be applied to incurred losses, paid losses, claim counts, and average values.

Diagnosis-related group (DRG). A patient classification scheme that categorizes patients who are related medically with respect to primary and secondary diagnosis, age, or complications.

Donor-imposed condition. A donor stipulation that specifies a future and uncertain event whose occurrence or failure to occur gives the promisor a right of return of the assets it has transferred or releases the promisor from its obligation to transfer its assets.

Donor-imposed restriction. A donor stipulation that specifies the use for a contributed asset that is more specific than broad limits resulting from the nature of the organization, the environment in which it operates, and the purposes specified in its articles of incorporation or bylaws of comparable documents for an unincorporated association. A restriction on an organization's use of the asset contributed may be temporary or permanent.

Endowment fund. An established fund of cash, securities, or other assets used to provide income for the maintenance of a not-for-profit organization. The use of the assets of the fund may be permanently restricted, temporarily restricted, or unrestricted. Endowment funds generally are established by donor-restricted gifts and bequests to provide a permanent endowment (to provide a permanent source of income) or a term endowment (to provide income for a specific period). The principal of a permanent endowment must be maintained permanently, that is, not used up, expended, or otherwise exhausted--and is classified as permanently restricted net assets. The principal of a term endowment must be maintained for a specified term and is classified as temporarily restricted net assets. An organization's governing board may earmark a portion of its unrestricted net assets as a board-designated endowment (sometimes called *funds functioning as endowment* or *quasi-endowment funds*) to be invested to provide income for a long but unspecified period. The principal of a board-designated endowment, which results from an internal designation, is not donor restricted and is classified as unrestricted net assets.

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

Estimated costs of future services. Amounts that are expected to be incurred to provide services and the use of facilities to individuals over their remaining lives under continuing-care contracts. Examples include resident care, dietary, health care, facility, general and administrative, interest, depreciation, and amortization costs.

Exposure. The amount of potential claim risk. The basis for reflecting differences in the claim potential among providers' bases for charging insurance premiums or allocating member contributions to a captive. Exposure bases for hospital professional liability include number of occupied beds, outpatient visits, emergency room visits, and number of residents by specialty.

Floating rate note (FRN). A debt instrument that allows issuers to borrow at a floating short-term rate with a long-term stated maturity without some of the risks traditionally associated with commercial paper. The investor is subject to principal risk to the degree the issuer's credit

deteriorates or investor demand for FRNs decreases. Most health care issuers of FRNs require credit enhancement and a bank liquidity facility in conjunction with an FRN program.

Functional classification. A method of grouping expenses according to the purpose for which costs are incurred. The primary functional classifications are program services and supporting activities.

Fund. A self-contained accounting entity set up to account for a specific activity or project.

Gross service revenues. All revenues from the provision of health care services excluding charity care.

Health care services. Services provided to individuals related to the diagnosis or treatment of physical or mental illness.

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

Home health agency. An agency organized to provide health and supportive services in a person's home. These services may include nursing, nutritional, and therapeutic aid (such as physical therapy and dialysis) and the rental, as well as sale of medical equipment.

Increased limit factor. The relationship between losses limited to a per-occurrence limit at which the provider's own experience is meaningful to losses limited to the provider's total retained limit per occurrence.

Incremental costs. Costs that vary with and are directly attributable to changes in business, such as an additional employer or HMO contract. Fixed costs such as building depreciation or general overhead that do not change with the addition or loss of a contract are not incremental costs.

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

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 provide or arrange for the delivery of health care services to members of a prepaid health care plan and nonmember patients. In return, the IPA receives either a capitation fee or a specified fee for services rendered.

Inpatient. Under most circumstances, a patient who is provided with room, board, and general nursing service and is expected to remain in the health care facility at least overnight and occupy a bed.

In substance defeasance. A transaction whereby an advance refunding of refunded debt has been in substance satisfied and the defeased debt has been removed from the entity's balance sheet.

Integrated delivery system. A provider or group of providers that is organized to deliver and finance acute and preventive health care services. An integrated delivery system generally will provide (or arrange to provide) a complete continuum of health care services (inpatient acute care, ambulatory care, outpatient surgery, home health care, including long-term care) to an enrolled population, generally for fixed prepaid fees called premiums.

Interest rate swaps. An agreement to exchange interest payments without actually exchanging the underlying principal. The two parties each agree to make interest payments based on the calculation formula for the other's debt. Swaps can be used for a variety of purposes, such as to reduce the overall cost of borrowing, lock in forward rates, reduce interest rate risk, or adjust the ratio of variable and fixed-rate debt liabilities. Interest rate swaps do not change the amount or type of debt outstanding, but they do affect the issuer's debt portfolio and risk profile.

Intermediate care facility (ICF). A facility that provides care to individuals whose mental or physical conditions require services that are above the level of room and board and that can be made available only through institutional facilities. The care provided at an ICF does not require hospitals or skilled nursing facilities.

Maintenance costs. Costs associated with maintaining enrollment records and processing premium collections and payments.

Margin for risk of adverse deviation. Actuarially determined estimate of the additional funding requirement to obtain a specific confidence level that losses will not exceed the amount paid into the self-insurance fund. Margins are determined using statistical simulation techniques.

Medical group. An association of physicians and other licensed health care professionals organized on a group basis to practice medicine.

Medium-term notes. An intermediate-term security offered on a continuous basis providing flexibility for an issuer to vary the amount of outstanding notes as its funding requirements change. The broad range of possible maturities enables an issuer to borrow at the most attractive yield at the time of each issuance. They can be issued domestically or abroad.

Member. An individual who is enrolled as a subscriber or as an eligible dependent of a subscriber in a prepaid health care plan.

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

Natural classification. A method of classifying expenditures according to the nature of the expense such as salaries and wages, employee benefits, supplies, and purchased services.

Net advance refunding. A type of advance refunding in which the proceeds from the new debt, additional cash deposits (if any) and the income earned on the related investments are sufficient to pay the interest, principal, and call premium on the old debt. After the advance refunding, the old debt is serviced by the investments in trust and the new debt is serviced by the entity.

Net service revenue. Gross service revenue less provisions for contractual adjustments with third-party payors.

Nonfinancial assets. Nonmonetary assets such as inventories, investments in common stocks, or property, plant, and equipment.

Not-for-profit organization. An entity that possesses the following characteristics that distinguish it from a business enterprise: (a) contributions of significant amounts of resources from resource providers that do not expect commensurate or proportionate pecuniary return, (b) operating purposes other than to provide goods or services at a profit, and (c) absence of ownership interests like those of business enterprises. Not-for-profit organizations possess these characteristics in varying degrees.

Nursing center. A facility that provides nursing care to residents with a variety of needs or medical conditions. A nursing center may be a component of a continuing care retirement community. (Also called a health center, skilled-nursing facility, intermediate-care facility, continuing-care facility, or basic-care home.)

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

Outliers. In referring to the Medicare Prospective Payment System, additional payments that are made for cases that either have unusually long lengths of stay or have charges in excess of the cost outlier threshold.

Outpatient. A patient who is not confined overnight in a health care institution.

Peer review organization (PRO). Under federal statutory provision, PROs are required in each state to monitor hospital activity under the prospective payment system. Each hospital must contract with a PRO, which will review (a) the validity of diagnostic information, which establishes the diagnosis-related group; (b) the appropriateness of admissions; (c) the appropriateness of care to outliers; and (d) the adequacy of care provided.

Periodic fees. Amounts paid to a continuing care retirement community by a resident at periodic intervals for continuing-care services. Such fees may be fixed or adjustable. (Also called *maintenance fees* or *monthly fees*.)

Periodic interim payment (PIP). A plan under which the health care organization receives cash payments from a third-party payor (usually Medicare) in constant amounts periodically.

Permanent restriction. A donor-imposed restriction that stipulates that resources be maintained permanently but permits the organization to use up or expend part or all of the income (or other economic benefits) derived from the donated assets.

Permanently restricted net assets. The part of the net assets of a not-for-profit organization resulting from (a) contributions and other inflows of assets whose use by the organization is limited by donor-imposed stipulations that neither expire by the passage of time nor can be fulfilled or otherwise removed by the actions of the organization, (b) other asset enhancements and diminishments subject to the same kind of stipulations, and (c) reclassification from (or to) other classes of net assets as a consequence of donor-imposed stipulations.

Premium. The consideration paid for providing contract coverage. (Also called a *subscriber fee*.)

Premium period. The period to which a premium payment applies (generally one month) that entitles a member to health care services according to the contract provisions.

Prepaid health care plan. A plan in which the provider is compensated in advance by the sponsoring organization. The sponsoring organization pays or compensates the provider based on either a fixed sum or a per-enrollee amount. Prepaid health care plans include health maintenance organizations, preferred provider organizations, eye care plans, dental care plans, and similar plans. Under such plans, the financial risk of delivering the health care is transferred to the provider of services.

Prepaid health care services. Any form of health care service provided to a member in exchange for a scheduled payment (or payments) established before care is provided, regardless of the level of service subsequently provided.

Prevailing charge. A charge that falls within the range of charges most frequently used in a locality for a particular service or procedure.

Primary care. Care that is rendered in an ambulatory fashion, such as in an emergency room, an outpatient clinic, or other outpatient department.

Prospective payment system (PPS). Medicare payment made at a predetermined, specific rate for each Medicare discharge, based on the patient's diagnosis. Each discharge is classified according to a series of diagnosis-related groups. (See also *diagnosis-related group*.)

Provider. A person or entity that undertakes to provide health care services.

Providers of prepaid health care services (prepaid health care providers). Organizations that provide or arrange for the delivery of health care services in accordance with the terms and provisions of a prepaid health care plan. Providers assume the financial risk of the cost of delivering health care services in excess of preestablished fixed premiums. However, some or all of the financial risk may be contractually transferred to other providers (affiliated entities) or by purchasing stop-loss insurance. Other providers of prepaid health care services may include comprehensive medical plans, physicians groups (for example, independent practice associations), and hospitals.

Refundable advance fees. The portion of an advance fee that is payable to a resident of a continuing care retirement community or the resident's estate.

Refunded debt. Debt for which payment at a specified future date has been provided by the issuance of refunding debt.

Refunding debt. Debt issued to provide funds to pay for refunded debt at a specified future date.

Reported incident. An occurrence identified by a health care organization as one in which improper professional service may be alleged at a future time that would result in a malpractice claim.

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

Risk contract. A contract between a provider of health care services and a prepaid health care plan that exposes the provider to the uncertainty of financial gain or loss by obligating the provider to provide specified health care services to enrollees of the plan for a negotiated price, which may be an amount per case, service, or day. The price may vary based on the volume of services furnished during the contract period.

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

Self-insurance. That portion of risk or loss assumed by a health care organization. There is no external insurance coverage.

Skilled nursing facilities (SNF). These facilities provide services on a daily, inpatient basis. The services provided by an SNF are ordered by a physician and require the skilled services of technical or professional personnel.

Stop-loss (or reinsurance) insurance. A contract in which a company agrees to indemnify providers for certain health care costs incurred by members.

Subscriber. The person who is responsible for the payment of premiums or whose employment is the basis for eligibility for membership in a prepaid health care plan.

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

Taxable variable rate demand notes. Issuers may call the notes on any monthly interest payment date, which provides issuers the opportunity to refinance short-term obligations with long-term bonds if market conditions make this alternative attractive.

Temporarily restricted net assets. The part of the net assets of a not-for-profit organization resulting (a) from contributions and other inflows of assets whose use by the organization is limited by donor-imposed stipulations that either expire with the passage of time or can be fulfilled and removed by actions of the organization pursuant to those stipulations, (b) from other asset enhancements and diminishments subject to the same kinds of stipulations, or (c) from reclassification to (or from) other classes of net assets as a consequence of donor-imposed stipulations, their expiration by passage of time, or their fulfillment and removal by actions of the organization pursuant to those stipulations.

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

Third-party payor. Any agency (such as Blue Cross, Medicare, or commercial insurance companies) that contracts with health care organizations and patients to pay for the care of covered patients.

Trend factor. A factor used in actuarial methodology to adjust ultimate losses from historical experience periods to the loss cost levels of the projection period, due to the impact of economic, jurisdictional, and social changes affecting hospital professional liability loss costs.

Trust fund. A fund established with an outside entity to be used for a specific purpose, such as to pay malpractice claims and related expenses as they arise.

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

Unasserted claim. A medical malpractice claim that has not been asserted formally against a health care provider by or on behalf of a patient alleging improper professional service. It may relate to either reported incidents or to unreported incidents.

Unreported incident. An occurrence in which improper professional service may have been administered by a health care provider, which may result in a malpractice claim of which the provider is not yet aware.

Unrestricted net assets. The part of net assets of a not-for-profit organization that is neither permanently restricted nor temporarily restricted by donor-imposed stipulations.

Voluntary health and welfare organizations. Organizations formed for the purpose of performing voluntary services for various segments of society. They are tax-exempt (organized for the benefit of the public), supported by the public, and operated on a not-for-profit basis. Most voluntary health and welfare organizations concentrate their efforts and expend their resources in an attempt to solve health and welfare problems of society and, in many cases, those of specific individuals. As a group, voluntary health and welfare organizations include not-for-profit organizations that derive their revenue primarily from voluntary contributions from the general public to be used for general or specific purposes connected with health, welfare, or community services.

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