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**The State of Texas vs. the
Methodist Hospital System:
An Accounting Case Study**

Working Paper Series 99-02 — Aug. 1999

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The State of Texas vs. the Methodist Hospital System: An Accounting Case Study

Craig Bain, Alan Blankley, and Dana Forgione

INTRODUCTION

The State of Texas' lawsuit against the Methodist Hospital System (MHS) in the late 1980's is an interesting and instructive case to study for several reasons. First, the case raises ethical issues concerning the use and alleged abuse of management prerogatives. Second, the case raises questions about the state's right to demand services and certain levels of performance in exchange for tax preferences. Third, we have found that in testing the case in our classes at each of our respective universities, the case is useful in discussing financial reporting issues, including managerial incentives with respect to reporting, GAAP, and specific provisions regarding not-for-profit (NFP) entities.

There are two criteria for a "case" as the term is used in this paper: (a) the material must contain a question or issue requiring a conclusion, and (b) there must be more than one possible reasonable conclusion (Campbell and Lewis 1991). Anthony (1974) suggests that the critical component of a case is that "there is no unique, correct solution." This means simply that at least two different and reasonable conclusions may be generated. Case issues may or may not be explicit, and all necessary information may or may not be included in the case. Cases as instructional tools are not an efficient means of acquiring basic knowledge in a field or of learning to apply it. They are, however, excellent tools for applying, synthesizing, and integrating knowledge, as well as presenting the complexities of real-world situations. The case of the MHS is a real-world situation that challenges students to integrate and synthesize information from several areas of accounting, and could be used effectively in many different accounting and business courses, including governmental and non-profit accounting, audit, financial accounting, health care accounting, taxation, and business ethics.

The next section lays out background information useful to an understanding of the issues involved in the case. Students should read this information carefully, then examine the attached financial statements and accompanying notes in Appendix A. After reviewing the information, students should then attempt to answer the case questions as specifically and completely as possible. Following the questions, we provide teaching notes which contain a discussion of the questions, including professional standards where appropriate, points and issues that may assist in class discussions, and possible answers to the questions.

THE METHODIST HOSPITAL SYSTEM CASE

Background Information

One of the principal ethical dilemmas facing both society and hospitals is the economic problem of how, and among whom, to distribute scarce medical resources. Clearly, many people cannot afford all of the medical procedures or health care they need, so they must either forgo health care or have it paid for by some other source. An underlying question is whether or not one has a "right" to costly medical care. If a right exists, and health care is a product unlike other products which are allocated by price, then a case could be made that one's ability to pay for medical care does not affect his or her right to that care. Many countries have adopted that perspective. That assertion, however, raises the question of exactly how society in the U.S. ought to decide between competing claims on scarce medical resources.

One way our society addresses this problem is through tax-exempt status for not-for-profit (NFP) hospitals. The idea is that a hospital will be economically able to provide health care services, including charity care to those unable to pay for it, at least up to the value of its tax exemption. In other words, through exemptions

from U.S. federal, state, and local taxes, as well as the ability to raise low cost capital through tax-exempt debt, the government encourages private pursuit of “charitable purposes.” These charitable purposes, according to United States Internal Revenue Code section 501(c)(3), are to include activities which “promote health.” In order to maintain tax-exempt status, a hospital must be considered NFP, have a charitable purpose, and must conduct health-promotion activities. Its assets must be dedicated to the public benefit, and no part of its earnings may inure to the benefit of any private shareholder or individual.

In an attempt, then, to provide some medical care for those who can’t afford it, the federal government and the states offer NFP hospitals tax-exempt status, and expect that hospitals receiving tax-exemption will offer some type and some degree of public benefit, typically charity care. Charity care is defined as care provided to those who are *unable* to pay (as distinguished from those who are *unwilling* to pay) (HFMA 1978). This means that the hospital has no expectation for payment (AICPA 1990a), and receives no payment for the services rendered. What complicates matters is that private, NFP hospitals have been functioning in an environment where their ability to raise revenues or prices is restricted while costs have been increasing. Political, regulatory, and economic pressures have curtailed the ability of hospitals to raise revenues or prices and pass on cost increases as in years past. The Medicare program, for example, has sharply restricted the amounts remitted for medical procedures by basing payments on fixed prices for illness categories known as Diagnosis Related Groups (DRGs) and by applying other cost containment measures. Insurance companies have also responded by forming Health Maintenance Organizations (HMOs) which capitate payments per patient member per month, scrutinize medical decisions, and may refuse certain treatments or put pressure on physicians to limit referrals or otherwise undertreat patients. Also, unlike large, public hospitals, private NFPs cannot expect direct support from federal or state governments beyond their Medicare and Medicaid patient benefits, making it difficult to offset, say, capital expenditures or medical education costs by simply passing the costs on in full to governmental entities.

Since revenue growth has been sharply curtailed, private hospitals have had to rely on cost shifting to private payers and containment measures to remain financially viable, but this has proven to be increasingly challenging. Medical costs rose sharply over the decade between 1982 and 1992, increasing by more than 110%. Advances in medical technology and computerization have contributed to rising medical costs, as well as the costs associated with staffing, malpractice, litigation, and insurance. So, too, has the demand for uncompensated services—notably, charity care. Mowil (1988) reports that in 1988, U.S. hospitals provided \$11.5 billion of service for which there was no compensation. Some researchers believe that the loss of revenue due to charity care threatens the financial survival of certain hospitals (Mowil 1988). Hospitals located in inner city areas are most heavily utilized by indigent patients.

Finally, the budgetary pressures at various levels of government (local, state, and federal) have made governmental hospitals and other entities less able to accommodate increasing levels of charity care and more aggressive in expecting private hospitals to carry a “fair share” of the charity care burden.

In summary, the government expects a certain, unspecified level of charity care to be performed as a public benefit in exchange for tax exemptions. This expectation occurs in an environment of increasing costs and curtailed revenues, and has the effect of further reducing revenues and increasing costs. The heart of the State of Texas’ lawsuit against MHS that management, allegedly acting in its own interest, spent too much on perquisites, and not enough on charity care. In the lawsuit, both sides use accounting numbers to defend their positions: the state Attorney General uses accounting numbers to support the state’s contention of breach of fiduciary responsibility; management uses accounting numbers to defend its charity care practices.

The Methodist Hospital¹

The MHS, which includes the Methodist Hospital and affiliated entities, operates in Houston, TX. It is a private not-for-profit organization established to provide medical services to society. Its financial resources are held in trust and must be used in accordance with the institution’s mission. It may have excess revenues over expenses for a given period, but excess revenues must be reserved for implementing programs, expanding services, or for covering deficits in future periods. They cannot be distributed to private individuals or used for purposes inconsistent with the institution’s exempt purpose and mission.

One of the largest hospitals in the United States, the Methodist Hospital was incorporated for “charitable, educational, and scientific purposes,” (*Articles of Incorporation* 1984). In keeping with State laws, “the

corporation is prohibited from allowing any part of net earnings to inure to the benefit of any private individual; carrying on propaganda; participating in a political campaign; or influencing the outcome of any election.” In addition, the hospital’s by-laws state that it shall, “charge reasonably for services, education, training facilities... to those able to pay, and shall furnish and provide services... free of charge to those unable to pay,” (*Bylaws* 1984).

In November 19X5, the Attorney General for the State, filed suit against the Methodist Hospital and the MHS, alleging that it failed as a charity hospital “to provide its required share of health care for poor people.” The suit alleges that the hospital has the duty under law to provide “charity care in an amount commensurate with its resources, the tax-exempt benefits received, and the needs of the community,” but that the hospital had failed in this duty. The state claimed it had failed to provide “a factual or meaningful amount of charity care.” In order to show that the hospital directors were in breach of their fiduciary responsibility, the suit cited accounting numbers: “From 19X1 through 19X5, the Hospital System, including the Methodist Hospital, had gross revenues of more than \$2 billion yet provided less than \$17 million in charity care, which equals less than one percent of gross revenues for charity care.” Furthermore, the suit cited realized profits (revenues less expenses) of \$250 million over the same period, and a \$330 million cash reserve fund at the end of 19X4.

There were also other factors to the case which came to light during the suit, and while not directly related to the state’s claim, they indirectly appear to support it. First, the hospital owned and operated a “gourmet” restaurant on its premises, offering menu items like sauteed prawns and Norwegian poached salmon. The restaurant reported annual losses of nearly \$250,000 in each of the years 1986–1988, while maintaining a \$600,000 payroll.

Second, the MHS owned a \$2 million duck hunting lodge in south Texas which it sold two weeks after the attorney general filed suit. The reason for the sale, according to MHS, was that the property did not fit the mission of the hospital (SoRelle 1991). Third, the hospital maintained an “Institute of Preventative Medicine,” which in reality included an exclusive health club containing a swimming pool, racquet ball courts, weight room, sauna, whirlpool, and massage area.

Fourth, the hospital’s décor was claimed to rival that of exclusive hotels. The hospital employed a concierge, bellmen, offered valet parking, and even placed wet bars in some patient room suites.

Fifth, top executive salaries were in the range of \$300,000 annually, not including any retirement or deferred compensation arrangements. Of course, executives at large corporations and other large hospitals made comparable money, and for highly paid physicians who also work in administration, \$300,000 may not seem particularly generous. On the other hand, it is useful to draw some more immediate comparisons. For example, Columbia HCA Healthcare, a large, public healthcare enterprise comprised of 218 hospitals with a total of 41,452 beds,² paid executives approximately as follows.³

<i>Title</i>	<i>Salary</i>
President & CEO	\$305,682
Chief Operating Office	263,808
Chief Financial Office & Treasurer	184,247
Sr. VP Finance	180,059
Sr. VP General Counsel	173,189
Average Salary	\$221,397

Source: Columbia HCA Healthcare’s 1994 10K and DEF14A reports filed with the SEC.

It is also helpful to consider Humana, Inc., a large, for-profit provider of HMO and Preferred Provider Organizations (PPO) services. Humana paid top management average salaries of \$484,992 in 1985,⁴ largely on the strength of the salary paid to the CEO and Chairman of the Board, who earned nearly \$1.1 million.

Rounding out the salary comparison, a recent survey conducted by the *Chronicle of Philanthropy* (Billitteri and Blum 1998), found that the 1997 median salary for chief executives of 230 charities, foundations, hospitals, and universities was \$209,914. In addition, a report issued by the Hospital and Healthcare Compensation Service

(Arkansas 1997) stated that the 1997 national average total compensation of healthcare chief executives/administrators was \$244,279, and the *Wall Street Journal* recently reported that the 1998 average salary of CEO's of multi-hospital systems was \$283,333 (McCuan 1999).

Finally, the hospital was also alleged to have turned away charity-care patients and denied admission to members of HMOs. In response to the state's suit, the hospital argued that it had no legal obligation to provide charity care (Morales 1993).⁵

ASSIGNMENT QUESTIONS

Please review the accompanying financial statements and notes to the financial statements, then answer the following questions.

1. What amount of charity care does the Methodist Hospital's financial statements indicate the hospital was providing? How much does this differ from the state's contention? What accounts for the difference? What amount represents the "true" amount of charity care provided by the hospital?
2. What types of benefits does Methodist Hospital receive from its tax-exempt status? In other words, what benefits should be included in a calculation of the economic value of its tax-exemption? What is the approximate value of Methodist Hospital's tax exemption? The following data may help you in determining the amounts:
 - **Property Tax:** Methodist Hospital was estimated to hold tax-exempt real properties and tangible personal property with a market value of \$245 million. The applicable property taxes associated with this valuation would be about 2.32% annually.
 - **State Excise Tax:** Assume that state excise or franchise taxes are determined to be 5% of the annual change in net worth (*i.e.*, net income).
 - **Federal:** Assume that federal income taxes are based on an effective average rate of 36%.
 - **Sales Tax:** State sales tax on purchases in Texas was 8.25%.
 - **Reduction in debt costs:** Assume that the hospital was able to issue debt at two percentage points below corporate debt because of the tax preference for the debt.
 - **Other relevant benefits:** Are there other benefits that accrue to the hospital because it is a charitable entity and a teaching hospital that conducts significant medical research, and the government grants it a tax preference?
3. How much charity care should Methodist Hospital be required to provide to the community, if any? Was the state correct in its assessment that the hospital was not providing enough charity care to poor people, or was the state overreaching? What evidence do you have to support your position?
4. Did the hospital's accounting for charity care follow standard industry practice within Generally Accepted Accounting Principles (GAAP)? How does Methodist Hospital's accounting for charity care affect its claim of fulfilling its charitable mission? Financial statement users' perceptions of the hospital's performance? The state's case?
5. Examine Notes A, F, and H in the *Notes to the Financial Statements*. See if you can reproduce the nature of the related-party transactions reported upon in these notes. Do the related-party transactions seem appropriate? Do they have any direct or indirect bearing on the hospital's provision of charity care? If so, what?
6. What are the ethical dimensions to the case? As a starting place in your thinking, you may want to consider the entity's mandate for charity care, the fiscal incentives bearing on management, its related party transactions, cash reserves, perquisites, and the industry reporting standards.
7. What sort of audit opinion did Methodist Hospital receive? Does this constitute a form of audit failure? Why, or why not? What was the auditor's ethical and professional responsibility during the audit? In your opinion, what should the auditor have done? Upon what evidence are you basing your opinion? Consider the following areas in your assessment: audit risk assessment, audit planning, industry guidelines/practices, and what constitutes an adequate level of field work.

TEACHING NOTES

Suggestions for Classroom Use

The framework for the case is presented above. Have students read the background material, then examine the financial statements and accompanying Notes in Appendix A. At some point during the case, the instructor may also want to make available some of the additional information that follows in this note. It is up to the instructor to determine how much additional information beyond the financial statements to give out. This format allows the instructor to tailor the case for a variety of applications ranging from fairly simple to a more in-depth case analysis.

This case may be assigned in a variety of manners including individual or group analysis. Students can be assigned to look at the entire case in a sort of “what’s wrong with this picture” approach, or alternatively, students can take one or more major topics to explore in-depth. The instructor may also assign all end-of-case questions to the students, or only specific questions. Little additional information will be needed to facilitate basic discussion of the issues, since students are likely to form opinions on the basic material (background and financial statements), and our experience is that the discussions may freely range from accounting standards to ethical responsibility. On the other hand, more in-depth analysis of the case will likely require supplementing the basic information with some of the additional information contained in this teaching note. In either case, the instructor can facilitate in-class discussion that will bring the various alternative perspectives to light and emphasize the accounting issue(s). One case objective is to stimulate the students’ thinking about the legitimate and necessary role that accounting plays in our society. Having the students role-play as two opposing teams of expert witnesses in a civil court hearing provides a high level of realism and gives the students experience in the role of providing professional litigation support services.

Suggested Responses to Case Questions

Case Question 1:

What amount of charity care does the Methodist Hospital’s financial statements indicate the hospital was providing? How much does this differ from the state’s contention? What accounts for the difference? What amount represents the “true” amount of charity care provided by the hospital?

MHS reports \$70,142,650 in “free, uncompensated care” for 19X2, and \$39,168,402 for 19X1. Note that the reported \$70,142,650 includes the following items, buried in the various classifications reported:

- **Bad debts** (these amounts are uncollectible accounts due to those *unwilling* to pay)
- **Costs of compliance with anti-dumping laws** (these are laws requiring hospitals to provide emergency treatment to any person until they are stabilized enough to be safely transferred to another institution)
- **Contractual adjustments** (a contractual adjustment is when the hospital adjusts its charges to the amount that a third party payer pays by regulation or by contract terms. If, for example, the hospital charges \$1,000 for a procedure, but an insurer pays only \$900 for the procedure, then there would be a contractual adjustment of \$100)
- **Courtesy discounts** (these represent discounts provided to those having an affiliation with the hospital, such as employees).
- **Charity care** (care provided to those unable to pay for it)

The state of Texas claimed that MHS provided less than \$17 million in charity care over the preceding five-year period, which amounted to less than 1% of gross revenue over the period. Though this is a five-year average, if we apply 1% of gross revenue for 19X2, that would indicate charity care of \$3.134 million.

Apparently, the “true” charity care for 19X2 is the community care reported on MHS’s Combined Statement of Revenues and Expenses and Changes in Fund Balance of \$4.033 million. The difference between what the hospital reported in total and what the state claimed are the other items listed above: uncollectible accounts, contractual adjustments, courtesy discounts, and so forth.

Case Question 2:

What types of benefits does Methodist Hospital receive from its tax-exempt status? In other words, what benefits should be included in a calculation of the economic value of its tax-exemption? What is the approximate value of Methodist Hospital's tax exemption? The following data may help you in determining the amounts:

- **Property Tax:** Methodist Hospital was estimated to hold tax exempt real properties and tangible personal property with a market value of \$245 million. The applicable property taxes associated with this valuation would be about 2.32% annually.
- **State Excise Tax:** Assume that state excise or franchise taxes are determined to be 5% of the annual change in net worth (*i.e.*, net income).
- **Federal:** Assume that federal income taxes are based on an effective average rate of 36%.
- **Sales Tax:** State sales tax on purchases in Texas was 8.25%.
- **Reduction in debt costs:** Assume that the hospital was able to issue debt at two percentage points below corporate debt because of the tax preference for the debt.
- **Other relevant benefits:** Are there other benefits that accrue to the hospital because it is a charitable entity and a teaching hospital that conducts significant medical research and the government grants it a tax preference?

The list of items provided as a guide to students are the basic economic benefits the hospital receives from its tax-exempt status. We included the last item, "other benefits," to get the students thinking about other, less obvious benefits of the tax exemption. Interestingly, in the suit, MHS claimed that its tax benefit as an NFP was \$5.684 million per year. This its estimated value of the hospital's property tax exemption. The *State* took the position that MHS received an exemption benefit of approximately \$35 million per year. This included a more comprehensive list of benefits:

- Federal income tax exemption
- State excise and franchise tax exemption
- State property tax exemption
- State sales tax exemption
- Lower interest rates on bonds (approximately 2% below market rates. MHS reports \$301.1 million in revenue bonds in 19X2. With a 2% rate reduction, this amounts to \$6.022 million in interest cost savings per year)
- Accepting charitable contributions
- Donations from pharmaceutical companies and other suppliers for research
- Research grants
- Reduced labor costs

We estimate the approximate value of the tax exemption in 19X2 as follows:

Federal:	\$66,546,326	×	.36	=	\$23,956,677
State:	66,546,326	×	.05	=	3,327,316
Property:	245,000,000	×	.0232	=	5,684,000
Sales: ⁶	61,485,740	×	.0825	=	5,072,574
Interest:	301,100,000	×	.02	=	<u>6,022,000</u>
Sum of direct benefits:					<u>\$44,062,567</u>

This number does not include the inflows or other enhancement of assets the hospital receives because contributors are able to take tax deductions for their contributions, or the fact that, as a teaching hospital, the hospital receives tuition revenues, grants, R&D monies, lower labor costs of medical interns and residents, ability to attract high paying, complex patient cases due to the presence of medical education and research programs, and so forth. These other items should be included in a comprehensive economic evaluation of the value of MHS's tax-exempt status. Likewise, the hospital's education and research activities provide community benefits in addition to just charity care expenditures.

Case Question 3:

How much charity care should Methodist Hospital be required to provide to the community, if any? Was the state correct in its assessment that the hospital was not providing enough charity care to poor people, or was the state overreaching? What evidence do you have to support your position?

These questions are subjective in nature, and our experience in testing the case at each of our three universities is that they lead to considerable disagreement among students, as they do among individuals who grapple with these issues professionally. They are important questions to ask because they touch on the rights and expectations of individuals, private property, state's rights, compassion, and societal expectations for benefits, balanced against the responsibility for, and the necessity of, somehow paying for the cost of those benefits.

As discussed under Case Question 1, MHS claimed over \$70 million in charity care in 19X2, while the state claimed the hospital provided less than \$3.4 million (five-year average). Recall that the \$70.142 million claimed by MHS includes items not properly considered (or accounted for) as charity care under industry accounting guidance. The correct amount would be the amount reported as community care—for those *unable* to pay—which was \$4.033 million.

As discussed in the background information to the case, the value of tax exempt benefits is one measure that has been considered in determining whether a NFP hospital provides sufficient amounts of charity care. Advocates of this measure argue that a tax-exempt hospital should fulfill its duty to the community by providing at least the same amount in charity care as the economic value of its tax-exempt benefits. If this measure is used, and the value of MHS's tax-exempt status is, as we suggest in *Case Question 2* (\$44 million), then according to this criteria, Methodist should have provided at least an additional \$40 million per year in charity care.

The financial resources available to the Hospital are another measure that may be appropriately analyzed to determine whether the entity provides sufficient public charity-care benefits. This measure is designed to determine what a hospital can actually afford to provide, without endangering the financial viability of the hospital. According to this measure and based on nothing else but the income received from investments, MHS could provide an additional \$20 million in charity-care services each year. Their investment funds will continue to generate between \$25–30 million in investment income each year.

Note, too, that MHS has accumulated over \$600 million in unrestricted cash assets over an approximately 15-year period, or \$40 million per year on average. The hospital is the most profitable non-profit hospital in Harris County (Houston), yet ranks last in the provision of uncompensated care in its community. According to the state, they are also more profitable than most for-profit hospitals, but provide less uncompensated care than many for-profit hospitals.

Given the evidence that MHS provided only about 10% of the value of its tax-exemption in free, uncompensated charity care in 19X2, as well as the fact that it has the financial capability of providing more charity care without significantly affecting operations or cash flows, it appears that the state was not overreaching, and that its case was theoretically compelling. Of course, it can reasonably be argued that some percentage of the value of tax-exemption needs to be withheld for reinvestment in future operations, capital improvements, or the like, and that an entity's ability to pay does not therefore solely indicate a requirement to pay for charity care. The needs of the community, in light of those economic resources, were considered by the state with respect to a "fair share" assessment.

Case Question 4:

Did the hospital’s accounting for charity care follow standard industry practice within Generally Accepted Accounting Principles (GAAP)? How does Methodist Hospital’s accounting for charity care affect its claim of fulfilling its charitable mission? Financial statement users’ perceptions of the hospital’s performance? The state’s case?

No, the hospital did not follow standard industry practice in its reporting for charity care. As we saw in *Case Question 1*, the hospital used the term “free, uncompensated care” and included bad debts, contractual adjustments, and courtesy discounts in a presentation that was ambiguous at best, and potentially misleading with respect to actual charity care provided for those unable to pay. Until 1991, hospitals generally reported the three adjustments to revenue:

1. Contractual adjustments
2. Bad Debts
3. Charity care

The HFMA’s Principles and Practices Board (P&PB) issued Statements of Position Nos. 2 and 7 containing industry guidance on accounting for charity care. These pronouncements were in effect at the time of the case, and were explicitly recognized by the American Institute of Certified Public Accountants (AICPA) as part of the authoritative hierarchy of GAAP under the category of industry guidance. The pronouncements specifically exclude from charity care any item except services provided to patients deemed *unable* to pay. The pronouncements further require contractual arrangements, such as those made with Medicare patients, to be recorded only at amounts the payer is legally obligated to pay. In other words, hospitals were specifically required *not* to record revenues at gross charges, then record the difference between their charges and what Medicare agreed to pay as a reduction in revenue, much less charity care. Recording gross charges is explicitly identified in the pronouncements as an overstatement of both revenues and discounts.

In 1990 (effective for 1991) after consulting with the Financial Accounting Standards Board, the AICPA took an even more stringent position. Reported charity care is now no longer permitted as either a revenue or as a reduction of revenue; it is simply included within operating expenses and its disclosure is relegated to a footnote only (AICPA 1990). It is instructive to consider the AICPA’s guidance: “For financial reporting purposes, gross revenue does not include charity care,” and “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,” (AICPA 1990).

The hospital’s reporting for “free, uncompensated care” appears to lead the financial statement user to conclude that the public benefits provided are far in excess of the actual charity care services rendered. This reporting leaves the impression that this was an attempt to minimize the potential political costs (Forgione 1999) that eventually led to the suit and the adverse publicity accompanying the suit.

Case Question 5:

Examine Notes A, F, and H in the *Notes to the Financial Statements*. See if you can reproduce the nature of the related-party transactions reported upon in these notes. Do the related-party transactions seem appropriate? Do they have any direct or indirect bearing on the hospital’s provision of charity care? If so, what?

This question asks students to focus on the complex related-party transactions reported in Methodist’s Notes. It is important because it forces students to analyze and piece together a transaction that was rather obscure at first glance—an eye-opening analytical exercise. Once understood for its implications, the transaction raises questions as to the appropriateness of the transaction, particularly in light of first, the hospital’s charitable mission and second, IRS prohibitions against the inurement of hospital resources to private individuals (Silverberg 1988). The following information may prove useful in discussing the related-party transaction. *Statements on Auditing Standards No. 45* provides examples of related party transactions. AU Section 334 states:

Transactions that because of their nature may be indicative of the existence of related parties include:

1. Borrowing or lending on an interest-free basis or at a rate of interest significantly above or below market rates prevailing at the time of the transaction.
2. Selling real estate at a price that differs significantly from its appraised value.

FASB Statement No. 57 provides examples of related-party transactions which require disclosure. Examples of related-party transactions include transactions between an enterprise and its management (management normally includes the board of directors). These transaction examples include:

- Sales, purchases, and transfers of realty
- Borrowings and lendings
- Guarantees

The disclosures shall include:

- a. The nature of the relationship involved
- b. A description of the transactions
- c. Amounts due from or to related parties as of the date of each balance sheet presented

Study of the notes to the audited financial statements (*Note A—Organization, Note H—Commitments and Contingencies, and Note F—Related Party Transactions*) shows that management of MHS disclosed that a complex real estate transaction had been set up utilizing the MHSs' elaborate organizational structure of multiple subsidiaries. Upon analysis, the transaction provided what appears to be a very high risk-free return on a multimillion-dollar real estate venture to a group of private investors. The transaction is described in the notes as follows.

A limited partnership of investors was formed. Baytown Health Services, Inc. (a subsidiary of a subsidiary of a subsidiary of the MHS) served as the General Partner. The partnership took out a \$7.4 million mortgage loan and invested in a professional office building, which collateralized the mortgage. San Jacinto Methodist Hospital (Baytown's immediate parent entity) and Baytown Health Services, Inc. guaranteed the mortgage (relieving the limited partners of default risk). In 1986 the partnership leased the property to San Jacinto Methodist Hospital for 10 years at the rate of \$12/square foot—about \$933,720 per year. San Jacinto Methodist Hospital then was to sublet the property to tenants. Baytown Health Services Inc. was obligated to subsidize any operating losses on the property to the partnership (relieving the limited partners of operating loss risk). Baytown Health Services, Inc. was also obligated to provide any additional capital needs over and above proceeds from the mortgage—relieving the limited partners of having to contribute significant equity investment (see *Note H*)—and to repurchase the partnership units (one per square foot) at the end of ten years at \$200/unit, or about \$15.562 million, which is more than double the original mortgage value, thus relieving the limited partners of any market value decline risk. The amount of the equity investment of the partners, if any, was not disclosed in the notes, nor were any annual flow-through depreciation or tax benefits for the partners. If, for example, the partners' equity amounted to, say, as much as 20% of the fair value of the building, or \$1.85 million, the end-of-term buy-out alone would provide a gross return of 8.41 times the original equity (an approximately 24% annual compound ten-year internal rate of return). This provides an essentially risk-free, approximately 24%, annual return on investment for 10 continuous years (which actually ended in 1996). Note that we are assuming the partners put down 20% in this example. It is possible, however, that because Baytown was obligated to provide the additional capital over and above the mortgage loan proceeds, the limited partners put down little or nothing. Clearly, this would have the effect of increasing the returns to the limited partners to levels well above any reasonable market rate. If the limited partners were other NFP entities, no inurement would have taken place. However, if they were private individuals, inurement would no doubt be an issue. Our experience is that when students calculate the numbers and begin to realize the implications of this transaction they are impressed by the fact that MHS could afford to set up this type of apparent "sweetheart deal" for the benefit of investors yet failed to provide a greater amount of charity care for the poor. Incidentally, at one point MHS was paying its medical malpractice insurance premiums (a significant amount of money for any hospital system) to a Cayman Islands insurance company. While at the time there were legitimate tax cost savings reasons for setting up insurance companies in off-shore tax havens (which was also

frequently done by automobile dealerships), this represents one more attribute that raises the questions of who were the principals of the insurance company, and did they have any relationship to the top management of MHS?

There is also another related-party transaction that you may wish to discuss. Note F indicates that San Jacinto Methodist Hospital purchased 12.5 acres of land in Baytown, TX from a trustee acting for a member of the Methodist Hospital Board of Directors. The purchase price was \$2.4 million—which computes to \$192,000 per acre. The note does not state whether the board member had any control over the decisions of the trustee or what prevailing market prices were for real estate in Baytown. If the price exceeded fair market value of comparable land in Baytown, Texas, inurement would again be an issue.

Working through these related-party transactions with your students reveals the complex nature of some related-party transactions, and also allows for stimulating discussion of the potential trade-offs inherent in the transaction. Is this transaction, for example, a legitimate transaction allowing MHS to finance asset purchases, or was MHS enriching private investors while allegedly shunning charity care? Is this transaction in keeping with the hospital's charitable mission? Even if the transaction was arms-length, how would this appear to contributors and other interested parties? Or, to the indigent patients who registered their complaints with the Texas Attorney General?

Case Question 6:

What are the ethical dimensions to the case? As a starting place in your thinking, you may want to consider the entity's mandate for charity care, the fiscal incentives bearing on management, its related party transactions, cash reserves, perquisites, and the industry reporting standards.

The case raises many difficult ethical questions pertaining not just to MHS, but to society's expectations for health care and who pays for it. Is there, for example, an ethical obligation for NFP hospitals to provide charity care? If so, at what level? What should such levels be based upon? If resources allow, should the required levels be greater than some value of the tax exemption? Should NFP hospitals be permitted to make investments in areas clearly outside of their charitable purposes and still be allowed to maintain their tax exemptions, e.g., on the basis of their teaching and research activities? To what extent? How is this clouded by complex joint ventures with for-profit organizations? What if such investments occur after considerable charity care has already been provided? If more charity care had been provided would any of the other issues in this case ever have been brought into question?

It is important to remind students that charity care, by its nature, raises costs and reduces revenue. Further, when products or services are offered for free, demand for those products and services will increase dramatically, and the costs are born by other paying patients. Generally speaking, responsible managers avoid taking actions that increase costs and reduce revenue, or unfairly penalize one group of customers for services provided to another group. On the other hand, the hospital has a charitable mission, accepts donor contributions, and avoids paying taxes precisely so that it will be able to provide public benefits such as charity care for those who need it. Its assets are, after all, dedicated to the public benefit as a not-for-profit organization, and the same dynamics do not necessarily apply to management in this case as applies to management in a for-profit organization where private benefit is a major motivating factor.

Second, according to the state, the accounting for the charity care was clearly non-standard, and appears to be an attempt to mitigate the adverse political cost effects of the minimal charity care the organization did offer to those unable to pay.

Third, the related-party transactions raise questions, at best, about the appearance of propriety in the actions of management, and the availability of resources to pay for charity care.

Fourth, it may also be fruitful to discuss the trade-offs between what is necessary to support a world-class medical organization and the needs of the community. For example, physicians and staff clearly need a restaurant of some sort to allow them to eat while on the job, but is it necessary to maintain a gourmet restaurant at an operating loss and with a payroll equal to roughly 15 percent of the total amount of charity care given (\$600,000 / \$4 MM)? In this case, and in other instances, it is a matter of both kind, and of degree, that shapes the ethical situation.

Fifth, what about the moral and ethical responsibilities of the hospital's accountants and auditors? We discuss this under *Case Question 7*.

Case Question 7:

What sort of audit opinion did Methodist Hospital receive? Does this constitute a form of audit failure? Why, or why not? What was the auditor's ethical and professional responsibility during the audit? In your opinion, what should the auditor have done? Upon what evidence are you basing your opinion? Consider the following areas in your assessment: audit risk assessment, audit planning, industry guidelines/practices, and what constitutes an adequate level of fieldwork.

Given the facts of this case, it seems reasonable to question what the auditor's response should have been. This is not to suggest that based on hindsight the auditor erred in giving a clean opinion, but simply that it is useful to have students think over the auditing issues and risks represented by the case. This exercise may be particularly useful for students taking auditing. We start by discussing audit and ethics, then provide some authoritative literature as reference.

Gaa (1992) believes that moral expertise is evidenced by the auditor's ability to make ethical judgments in accordance with the "moral point of view." That is, the moral agency role of auditors requires that they consider the interests of all the stakeholders in the auditing process. The public has a right to expect truthful and non-deceptive financial information. Trustworthiness is an essential character trait for an accounting professional. The Due Care Principle in the AICPA Code (1992) requires that technical and ethical standards should be properly adhered to while performing professional services. In some situations it may be difficult for the client or the public to make this assessment. If the observer of professional conduct is not an expert, it is the auditor's trustworthiness that gives the public confidence that professional services have been performed with due care.

The legal standard for the proper and careful performance of an accountant's duties is not merely limited to the application of promulgated GAAP and GAAS. Instead, judges and juries expect an accountant to apply professional judgment to each circumstance and each engagement.

To meet the challenges of this role, auditors must have the ability to frame, process, and resolve ethical conflict. To understand the role of the auditor in an ethical dilemma, we must look at the auditor along two related dimensions—one of technical performance, and the other of ethical competence. The profession defines and enforces standards of competence and ethical conduct which help to assure that the public interest is being served.

With respect to technical performance, the principle of due care seems particularly relevant. Article V of the Principles of the Code of Professional Conduct (AICPA 1992) states that "Members should be diligent in discharging responsibilities to clients, employers, and the public. Diligence imposes the responsibility to render services promptly and carefully, to be thorough, and to observe applicable technical and ethical standards." Why did the auditors not respond to the financial report presentation of charity care items? Why would the auditors not have required the "free, uncompensated care" items to be clearly presented according to the guidance of P&PB statements Nos. 2 and 7? If it were that the amounts were immaterial to the financial statements taken as a whole, is this not evidence in support of the state's contention—that charity care was not provided in a factual and meaningful amount? Alternatively, did the auditors simply consider that the descriptions provided in the financial statement footnotes constituted adequate disclosure, and the engagement presented low audit risk? In this case, it is also important to raise questions concerning the nature of the audit. First, did the auditor properly plan the audit given its risk assessment? Second, if the auditor had the appropriate industry knowledge, would there properly have been a "clean" opinion? Third, was there sufficient fieldwork performed? Sufficient compliance review? We have found that having students find the relevant authoritative literature and determine what the auditors' responsibility is in light of the facts of the case is both an interesting and useful exercise. It takes what is for the students purely conceptual material and gives it a real-world context.

The other dimension, ethical competence, is addressed in various articles in the Principles of the Code of Professional Conduct. Article II states that "members should accept the obligation to act in a way that will serve the public interest, honor the public trust, and demonstrate commitment to professionalism." The public interest is defined as the collective well being of the community of people and institutions the profession serves. In addition, Article III requires that "To maintain and broaden confidence, members should perform all professional responsibilities with the highest sense of integrity.... Integrity is an element of character fundamental to professional recognition. It is the quality from which public trust derives and the benchmark against which a member must ultimately test all decisions."

Auditors must make superior moral judgments in order to be effective members of their profession. It is hypothesized that the concept of moral expertise in auditing pertains to three of the four components in Rest's

(1986) model. First, an expert auditor must maintain healthy skepticism in order to be good at recognizing the existence of ethical problems in the work place. Second, an expert auditor must be better than non-experts at comparing and evaluating the alternative courses of action, and making a judgment about which is the best course to take. Third, and most importantly, the expert auditor must be skilled at implementing moral judgments. This allows the auditor to consider the welfare of those affected by his/her actions. The students will, of course, take various positions on these issues. We have found that the class discussions that ensue are typically lively and confront the students with some of the real-life implications for their professional careers.

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U.S. Internal Revenue Code. Section 501 (c)(3).

APPENDIX A

Audited Combined Financial Statements And Other Financial Information

Board of Directors
The Methodist Hospital System
Houston, Texas

We have examined the combined balance sheets of The Methodist Hospital System and Related Corporations as of December 31, 19X2 and 19X1, and the related combined statements of revenue and expense and changes in fund balance and cash flows for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the financial statements referred to above present fairly the combined financial position of The Methodist Hospital System and Related Corporations at December 31, 19X2 and 19X1, and the combined results of their operations and cash flows for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Houston, Texas
February 28, 19X3

Combined Balance Sheets
The Methodist Hospital System and Related Corporations

ASSETS	December 31 19X2	19X1
CURRENT ASSETS		
Cash and cash equivalents	\$ 18,967,544	\$ 28,345,964
Patient accounts receivable, net of allowance for Uncollectible accounts (19X2—\$7,600,000; 19X1—\$7,831,000)	61,591,341	41,464,603
Inventory of pharmaceuticals and supplies	2,842,472	2,717,610
Other current assets	7,112,735	7,517,188
Current portion of assets limited as to use—Note C	16,232,243	2,240,891
TOTAL CURRENT ASSETS	106,746,335	82,286,256
ASSETS LIMITED AS TO USE—Note C		
Commercial Paper	140,574,948	204,628,704
Certificates of deposit and other investments	4,852,371	23,042,036
Bonds and securities	275,172,972	193,783,397
TOTAL ASSETS LIMITED AS TO USE	420,600,291	421,454,137
PROPERTY, PLANT, AND EQUIPMENT—Notes D and F		
Buildings and improvements	161,884,975	156,001,964
Equipment	104,562,743	91,209,537
Less accumulated depreciation	(125,797,672)	(108,046,790)
	140,650,046	139,164,711
Land	13,370,321	13,327,405
Construction in progress—Note H	84,455,832	15,544,329
TOTAL PROPERTY, PLANT, AND EQUIPMENT	238,476,199	168,036,445
OTHER ASSETS		
Restricted assets	14,030,492	13,079,631
Deferred financing costs	3,639,928	3,739,810
Other—Note F	17,116,795	9,826,682
TOTAL OTHER ASSETS	34,787,215	26,646,123
	\$ 800,610,040	\$ 698,422,961

Combined Balance Sheets—Continued
The Methodist Hospital System and Related Corporations

LIABILITIES AND FUND BALANCE	December 31 19X2	19X1
CURRENT LIABILITIES		
Accounts payable and accrued expenses	\$ 24,287,533	\$ 26,443,977
Construction accounts payable	16,232,243	2,240,891
Accrued salaries and payroll related costs	8,417,115	7,344,823
Accrued vacation benefits	7,486,126	6,620,748
Retroactive Medicare and Medicaid settlements	1,435,000	3,615,000
Current portion of long-term debt	2,318,214	579,995
TOTAL CURRENT LIABILITIES	60,176,231	46,845,434
LONG-TERM DEBT, less current portion		
Revenue bonds	301,100,000	264,650,000
Mortgages payable and other debt	29,043,091	47,729,007
OTHER LONG-TERM OBLIGATIONS, principally related to self-insurance trust—Note E	8,709,377	5,786,754
DEFERRED GIFTS AND GRANTS	14,030,492	13,079,631
FUND BALANCE	387,550,849	320,332,135
COMMITMENTS AND CONTINGENCIES—Note H	\$ 800,610,040	\$ 698,422,961

See *Notes to Combined Financial Statements*.

**Combined Statements of Revenue and Expense and Changes in Fund Balance
The Methodist Hospital System and Related Corporations**

	Year Ended Dec. 31 19X2	19X1
Gross patient revenue	\$ 383,533,111	\$ 319,632,600
Deductions from revenue:		
Free, uncompensated care:		
Community	4,033,177	3,214,035
Policy	5,357,658	2,623,410
Program	48,233,984	24,200,374
Uncollectible	12,517,831	9,130,583
	70,142,650	39,168,402
NET PATIENT REVENUE	313,390,461	280,464,198
Other operating revenue	18,467,241	17,773,616
TOTAL OPERATING REVENUE	331,857,702	298,237,814
Operating expense:		
Salaries, wages, and related personnel costs	178,939,755	157,997,214
Supplies and pharmaceuticals	61,360,878	53,150,285
Services and other expenses	51,549,496	42,734,643
Depreciation and amortization	18,644,474	16,965,897
Interest	4,240,234	4,329,772
TOTAL OPERATING EXPENSE	314,734,837	275,177,811
NET INCOME FROM OPERATIONS	17,122,865	23,060,003
Nonoperating revenue:		
Unrestricted gifts	6,703,763	1,461,063
Interest and income from investments	42,592,712	26,769,027
Income (loss) from subsidiaries and partnerships	126,986	(346,626)
	49,423,461	27,883,464
EXCESS OF REVENUE OVER EXPENSE	66,546,326	50,943,467
Restricted gifts and grants expended for buildings and equipment	672,388	790,153
Fund balance at beginning of year	320,332,135	268,598,515
FUND BALANCE AT END OF YEAR	\$ 387,550,849	\$ 320,332,135

See Notes to Combined Financial Statements.

Combined Statements of Cash Flows
The Methodist Hospital System and Related Corporations

	Year Ended Dec. 31	19X2	19X1
OPERATING ACTIVITIES AND NONOPERATING REVENUE			
Cash received from patient services	\$	291,083,720	\$ 282,203,706
Other receipts from operations		19,903,849	16,295,716
Interest and dividends received (net of capitalized interest)		43,438,651	26,063,931
Cash paid to/or on behalf of employees		(177,002,085)	(153,896,776)
Cash paid for supplies and services		(112,269,052)	(86,774,210)
Interest paid (net of capitalized interest)		(4,240,234)	(4,329,772)
NET CASH PROVIDED BY OPERATING ACTIVITIES AND NONOPERATING REVENUE		60,914,849	79,562,595
INVESTING ACTIVITIES			
Purchase of property, plant, and equipment		(74,818,560)	(32,149,745)
Transfer from donor-restricted fund for purchase of property, plant, and equipment		672,388	790,153
Investment in subsidiaries and partnership		(1,581,787)	(346,626)
Assets limited as to use:			
Net decrease (increase) in cash and cash Equivalents		16,171,394	(24,750,259)
Costs of sales and maturities of investment Securities		576,528,747	204,315,116
Proceeds from sales and maturities of investment securities		(605,837,647)	(218,513,111)
NET CASH USED BY INVESTING ACTIVITIES		(88,865,465)	(70,654,472)
FINANCING ACTIVITIES			
Proceeds from issuance of debt		50,500,000	4,366,933
Principal payments		(30,997,697)	(1,238,518)
Cash paid for debt issuance costs		(930,107)	(114,904)
NET CASH PROVIDED (USED) BY FINANCING ACTIVITIES		18,572,196	3,013,511
INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS		(9,378,420)	11,921,634
CASH AND CASH EQUIVALENTS AT BEGINNING OF YEAR		28,345,964	16,424,330
CASH AND CASH EQUIVALENTS AT END OF YEAR		\$ 18,967,544	\$ 28,345,964

Combined Statements of Cash Flows—Continued
The Methodist Hospital System and Related Corporations

	Year Ended Dec. 31 19X2	19X1
RECONCILIATION OF EXCESS OF REVENUE OVER EXPENSE TO NET CASH PROVIDED BY OPERATING ACTIVITIES AND NONOPERATING REVENUE		
EXCESS OF REVENUE OVER EXPENSES	\$ 66,546,326	\$ 50,943,467
Adjustments to reconcile excess of revenue over expense to net cash provided by operating activities and nonoperating revenue:		
Depreciation and amortization	18,644,474	16,965,897
Noncash donations included in unrestricted Gifts		(705,096)
Loss (gain) on investment in subsidiaries and partnership	(126,986)	346,626
Change in net amounts due to third-party Payors	(2,180,000)	3,724,191
Change in liability for estimated self-insurance costs	2,922,623	886,754
Change in patient accounts receivable	(20,126,738)	(1,984,683)
Change in inventories and other assets	(124,862)	163,815
Change in accounts payable and accrued Expenses	(2,156,444)	8,060,149
Change in accrued salaries and payroll-related costs	1,072,292	3,415,092
Change in accrued vacation benefits	865,378	685,346
Change in other current assets	404,453	(1,956,698)
Change in other assets	(5,671,606)	(982,265)
Other	845,939	
	(5,631,477)	28,619,128
NET CASH USED PROVIDED BY OPERATING ACTIVITIES AND NONOPERATING REVENUE	\$ 60,914,849	\$ 79,562,595

See Notes to Combined Financial Statements.

Notes To Combined Financial Statements

The Methodist Hospital System and Related Corporations

December 31, 19X2

NOTE A—ORGANIZATION

The combined financial statements of The Methodist Hospital System and Related Corporations include the accounts of the following:

- The Methodist Hospital System (corporation)
- The Methodist Hospital
- The Methodist Hospital Foundation and its controlled corporations:
 - TMH Development Corporation
 - TMH Research and Development, Inc.
 - Scurlock Tower Corporation
- TMH Health Care Group and its controlled corporations:
 - The Methodist Health Case Network, Inc.
 - TMH Services
 - San Jacinto Methodist Hospital and subsidiary
 - Nan Travis Memorial Hospital and subsidiary
- TMH Business Group, Inc. and its controlled corporations:
 - Scurlock Tower Pharmacy, Inc.
 - Chez Eddy, Inc.
 - Delhomme Conference Center, Inc.

The Methodist Hospital System (corporation) is a nonprofit, nonmember corporation organized and existing under the laws of the State of Texas and is exempt from Federal income taxes. It serves as the parent holding company of the three sub-tier holding companies; The Methodist Hospital Foundation, TMH Health Care Group and TMH Business Group, Inc. Its purpose is to provide strategic management to the sub-tier holding companies and their controlled corporations and subsidiaries, and to support the activities of The Methodist Hospital.

The Methodist Hospital is a nonprofit, nonmember corporation organized and existing under the laws of the State of Texas and is exempt from federal income taxes. The affairs of The Methodist Hospital are directed by a Board of Directors elected by the Texas Conference of the South Central Jurisdiction of the United Methodist Church.

The Methodist Hospital Foundation is a nonprofit corporation organized and existing under the laws of the State of Texas and is exempt from federal income taxes. It functions as a sub-tier holding company whose purpose is to raise funds to support the special financial needs of The Methodist Hospital System and Related Corporations, to own and operate enterprises, and to pursue investment activities.

TMH Health Care Group is a nonprofit corporation organized and existing under the laws of the State of Texas and is exempt from federal income taxes. It functions as a sub-tier nonoperating holding company whose purpose is to support The Methodist Hospital System and to coordinate, on a limited basis, the acquisition and development of health care-related ventures through its controlled corporations.

TMH Business Group, Inc. is a for-profit taxable Texas business corporation with taxable subsidiaries. It functions as a sub-tier holding company whose purpose is to own, develop, and coordinate, to a limited extent, the operations of its subsidiaries.

The Board of Directors of The Methodist Hospital make up at least 60 percent of the Boards of Directors of The Methodist Hospital System (corporation), The Methodist Hospital Foundation, TMH Health Care Group, and TMH Business Group, Inc.

The Methodist Hospital System and Related Corporations were reorganized effective April 1, 19X1, into the present structure. The reorganization had no effect on the combined financial position of the combined group at April 1, 19X1, nor on the combined results of operations for the years ended December 31, 19X2 and 19X1.

All material transactions between combined corporations have been eliminated.

NOTE B—SIGNIFICANT ACCOUNTING POLICIES

Cash Equivalents: All liquid investments with a maturity of three months or less when purchased are considered cash equivalents excluding amounts whose use is limited by board designation or restricted-under debt agreements.

Accounts Receivable: Accounts receivable are reflected in the combined balance sheets net of an estimated allowance for free, uncompensated care. Current earnings are charged with a provision for free, uncompensated care based on experience, eligibility, and any unusual circumstances which may affect the ability of patients to meet their obligations.

Free, Uncompensated Care: Free, uncompensated care represents the difference between standard charges for services rendered and the amount, if any, ultimately received. Four specific components of free, uncompensated care are utilized:

- Community free, uncompensated care—generally represents free, uncompensated care provided in response to specific medical or financial needs; characterized by the patient’s inability to pay and a voluntary lack of collection effort.
- Policy free, uncompensated care—generally represents free, uncompensated care provided in accordance with established policies and procedures; characterized by the patient’s close affiliation with The Methodist Hospital System or a Related Corporation and a voluntary lack of collection effort.
- Program free, uncompensated care—generally represents free, uncompensated care provided to patients who participate in and are members of specific programs/organizations; characterized by payment rates from these programs/organizations at other than standard charges.
- Uncollectible free, uncompensated care—generally represents free, uncompensated care provided to patients who are unwilling to pay for any or all of their care.

Inventory of Pharmaceuticals and Supplies: Inventory is valued at the lower of cost (first-in, first-out method) or market.

Property, Plant, and Equipment: Property, plant, and equipment are carried at cost or fair market value at the time of donation and include expenditures for new facilities and equipment and those which substantially increase the useful life of existing property, plant, and equipment. Ordinary maintenance and repairs are charged to expense when incurred.

Depreciation of plant facilities and equipment is provided using the straight-line method. Useful lives assigned are generally as recommended in the American Hospital Association publication, Estimated Useful Lives of Depreciable Hospital Assets.

Interest expense of \$12,710,000 and \$14,018,000 in 19X2 and 19X1, respectively, on revenue bonds issued for System-related corporations and interest income of \$13,663,000 and \$16,957,000 in 19X2 and 19X1, respectively, earned an unexpended bond proceeds have been capitalized and are included in construction in progress.

Land at the Texas Medical Center, contributed for The Methodist Hospital’s existing facilities and its subsequent additions, is carried at a nominal value of \$1.

Deferred Financing Costs: All costs associated with the issuance of revenue bonds for The Methodist Hospital, San Jacinto Methodist Hospital, and Nan Travis Memorial Hospital have been capitalized and are being amortized using the bonds outstanding method over the term of the respective bond issues.

Vacation and Sick Leave Benefits: The cost of employees’ vacation benefits is recorded at the time benefits are earned. The cost of employees’ sick leave benefits is recorded when such benefits are taken.

Medicare and Medicaid Contractual Allowances: Patient revenues are recorded at standard charges for all patients. Certain System-related corporations have contracted with the Medicare and Medicaid Programs and certain other third parties to provide services to eligible beneficiaries at amounts determined through the provisions of certain reimbursement/payment formulas which are usually less than standard charges. Medicare and Medicaid are federal and state programs, respectively, generally designed to provide services to elderly and indigent patients. The amounts by which the established billing rates exceed the amounts recoverable from these Programs are written off and accounted for as program free, uncompensated care in the combined statements of revenue and expense.

Certain payments for services provided to Medicare inpatients are subject to independent “medical review entity” verification of the medical necessity of admission and propriety of discharge diagnosis and coding. Final determination of annual retroactive settlements with the Medicare and Medicaid Programs are subject to review by appropriate governmental authorities or their agents. Management is of the opinion that adequate allowance has been provided for possible adjustments that might result from such verifications and reviews.

Pledges and Contributions: Unrestricted contributions are recorded as nonoperating revenue in the period in which the contribution is made. Donor-restricted pledges and contributions are recorded as restricted assets and deferred gifts and grants when the pledge or contribution is made. Subsequent expenditures for capital items are recorded as an increase in fund balance. Subsequent expenditures to reimburse operating expenses are recorded as credits to the applicable operating expense accounts.

Teaching and Education Expenses: The Methodist Hospital incurred certain identified direct and indirect expenses of approximately \$22,000,000 and \$20,000,000, respectively, related to fulfilling its teaching and education mission for 1987 and 1986. Such expenses are included principally in salaries, wages and related personnel costs, services and other expenses, and depreciation in the combined statements of revenue and expense.

Reclassifications: Certain amounts have been reclassified in 1986 to conform to the current year’s presentation. These changes had no effect on either 1987 or 1986 operations.

NOTE C—ASSETS LIMITED AS TO USE

Assets limited as to use represent those assets whose use has been legally restricted by bond indenture (see *Note D*), internally designated for capital expansion or replacement, or internally restricted in connection with self-insurance programs (see *Note E*). The following table sets forth the components of assets limited as to use at December 31, 19X2.

Description of Assets	Limited by Bond Indentures	Limited by Board for Expansion	Limited Through Self-Insurance Trust	Total
Commercial paper	\$147,969,771	\$6,016,093	\$ 942,369	\$154,928,233
Certificates of deposit and other investments		2,124,666	3,027,705	5,152,371
Bonds and securities	<u>22,206,793</u>	<u>247,596,381</u>	<u>6,948,756</u>	<u>276,751,930</u>
	<u>\$170,176,564</u>	<u>\$255,737,140</u>	<u>\$10,918,830</u>	436,832,534
Less funds required for current liabilities				<u>(16,232,243)</u>
				<u>\$420,600,291</u>

Assets limited as to use are valued at cost which approximated market at December 31, 19X2 and 19X1.

NOTE D—LONG-TERM DEBT

The Methodist Hospital

During December 1984, The Methodist Hospital issued Hospital Revenue Bonds, Series 1984 in the principal amount of \$196,900,000. In December 1985, The Methodist Hospital issued an additional \$53,000,000 in Hospital Revenue Bonds, Series 1985. The proceeds of these issues are to be used for (i) the construction and equipping of a 10-story patient tower, (ii) renovations to portions of The Methodist Hospital's existing facilities, (iii) the acquisition and installation of equipment, renovations, and other capital improvements included in The Methodist Hospital's capital budgets for 1985 and 1986, and (iv) the construction and equipping of a professional office building adjacent to The Methodist Hospital. The Series 1984 and 1985 Bonds ("Bonds") are variable-rate bonds bearing interest, payable monthly, at a tax-exempt interest rate established daily by the remarketing agent. This interest rate ranged from 3.25 percent to 12 percent in 1987 and 3.1 percent to 9.25 percent in 1986. The average interest rate paid on the bonds was 4.5 percent and 4.4 percent in 1987 and 1986, respectively. The Bonds are convertible into fixed-rate obligations, at The Methodist Hospital's option, at the then market rate of interest for similar securities at the time of conversion. The Bonds are payable upon demand of the bondholder(s) and may be redeemed at par in whole or in part by the Hospital at any time. Any Bonds presented for payment are to be remarketed under the terms of a remarketing agreement for an annual fee of 0.15 percent of the amount of outstanding Bonds. Unless otherwise repaid, the Bonds are to be retired over a 25-year period beginning December 1, 1990.

In conjunction with the issuance of the Series 1984 and 1985 Bonds, The Methodist Hospital entered into a standby bond purchase agreement with a bank which commits the bank to make available any funds necessary to purchase tendered bonds and accrued interest. The annual fee for this commitment is 0.25 percent on outstanding bonds plus accrued interest. The Methodist Hospital covenants to maintain this or a similar agreement for an amount at least equal to the aggregate principal and interest of bonds outstanding until all bonds are repaid or have been converted to fixed-rate obligations.

The obligation to make payments under the Bond issues is collateralized by a pledge of revenues of The Methodist Hospital only. Related corporations are not obligated to make any payments. Pursuant to certain Bond agreements, however, The Methodist Hospital agrees to subject itself and each Restricted Affiliate, which includes The Methodist Hospital System (corporation) and all related corporations except San Jacinto Methodist Hospital, Nan Travis Memorial Hospital and Scurlock Tower Corporation, to certain operational and financial restrictions and other contractual obligations. In addition, The Methodist Hospital covenants to cause the Restricted Affiliates to transfer, to the extent permitted by law, to The Methodist Hospital, by dividend, loan, advance, grant, or otherwise, funds or assets for the purpose of enabling The Methodist Hospital to satisfy the debt service requirements.

San Jacinto Methodist Hospital

On March 22, 1987, the San Jacinto Methodist Hospital issued Hospital Revenue Bonds, Series 1987, in the principal amount of \$35,000,000. The proceeds of the 1987 Bonds were to be used to (1) retire the Hospital's 1985 Revenue Bonds, (2) pay debt issuance costs of the 1987 issue, (3) repay other debt due in 1987, and (4) finance the construction of a new hospital facility. The 1987 Bonds are variable-rate bonds, bearing interest at varying rates established by the remarketing agent based on the length of the interest term selected by San Jacinto. San Jacinto initially selected a 180-day term with an interest rate of 4.1 percent. On September 23, 1987, San Jacinto selected a 360-day term with an interest rate of 5.9 percent. The 1987 Bonds may be redeemed at par, in whole or in part, by San Jacinto at any time during an interest term of less than 365 days. Unless otherwise repaid, San Jacinto has agreed to retire the Bonds over a 28-year period beginning March 1, 1990.

In conjunction with the issuance of the Series 1987 Bonds, San Jacinto entered into a reimbursement agreement with a bank which commits the bank to make available any funds necessary to retire the Bonds. The fee for this commitment is one percent of the outstanding balance of the bank's maximum commitment. San Jacinto covenants to maintain this or a similar agreement for an amount at least equal to the aggregate principal and interest of Bonds outstanding the last date on which any 1987 Bonds remain outstanding.

Nan Travis Memorial Hospital

During April 1987, the Nan Travis Memorial Hospital issued Hospital Revenue Refunding Bonds, Series 1987, in the principal amount of \$14,000,000. The proceeds of these Bonds were used to retire the letter-of-credit borrowing from a financial institution related to their 1985 Bond issue. The Series 1987 Bonds are variable-rate bonds bearing interest at a tax-exempt interest rate established by the remarketing agent. At Nan Travis' option, the bonds may exist in a choice of modes (weekly, semiannual, annual, term, or fixed) which governs the interest rate, term, and rights of Nan Travis and individual bondholders. Since issuance, the Bonds have been in the semiannual mode with a semiannual interest rate ranging from 5.5 percent to the current rate of 6.5 percent. The Bonds are eligible for mode conversion and/or interest rate revision in May 1988.

In conjunction with the issuance of the Bonds, Nan Travis entered into a reimbursement agreement with a bank which commits the bank to make available any funds necessary to retire the Bonds. The fee for this commitment is 1.25 percent on the outstanding balance of the bank's maximum commitment. Nan Travis covenants to maintain this or a similar agreement for an amount at least equal to the aggregate principal and interest of Bonds outstanding until all Bonds have been repaid or have been converted to the fixed-rate mode.

At December 31, 1987 and 1986, the Methodist Hospital System and Related Organizations were responsible for the obligations totaling \$31,361,305 and \$63,059,002, respectively, in addition to the revenue bonds described above. At December 31, 1986, significant components of these other obligations included (1) a 1985 revenue bond issue at San Jacinto Methodist Hospital, (2) a letter of credit borrowing at Nan Travis Memorial Hospital, and (3) mortgages payable on the professional office building jointly owned by The Methodist Hospital and Scurlock Tower Corporation. At December 31, 1987, the only remaining significant other obligation was the professional office building mortgages.

Maturities for all long-term debt for the five fiscal years subsequent to December 31, 1987, are approximately: 1988—\$2,318,000; 1989—\$859,000; 1990—\$3,615,000; 1991—\$3,952,000; and 1992—\$4,273,000.

NOTE E—PROFESSIONAL AND GENERAL LIABILITY SELF-INSURANCE

Effective November 1, 1977, The Methodist Hospital became self-insured for professional liability up to \$500,000 per occurrence and \$1,500,000 in the aggregate. Effective January 1, 1982, the amounts were increased to \$1,000,000 per occurrence and \$3,000,000 in the aggregate. Effective September 1, 1985, the amounts were increased to \$2,000,000 per occurrence and \$4,000,000 in the aggregate. Effective September 1, 1986, the self-insurance was revised to include general liability and the amounts were increased to \$15,000,000 per occurrence and \$30,000,000 in the aggregate. Excess coverage has been maintained with independent insurance carriers at varying amounts since the inception of the self-insurance program. At December 31, 1986, the amount of excess coverage for professional, general and auto liability combined was \$25,000,000. Excess coverage was increased to \$100,000,000 effective February 1, 1987.

In conjunction with this program, The Methodist Hospital established a self-insurance trust for payment of professional and general liability losses, related expenses, and the cost of administering the trust. The assets of the trust as well as the actuarially determined liabilities, which are discounted at a rate of 7 percent, are reported in the combined balance sheets. Income from the trust assets, professional and general liability losses, and administrative costs are reported in the combined statements of revenue and expense.

Effective May 22, 1987, Nan Travis Memorial Hospital established a self-insurance program for its professional and general liability. In conjunction with this program, the Hospital established a trust for payment of professional and general liability losses of up to \$1,000,000 per occurrence, related expenses, and the cost of administering the trust. The trust is supplemented by umbrella insurance coverage for individual incidents between \$1,000,000 and \$3,000,000, up to an annual aggregate of \$3,000,000.

NOTE F—RELATED PARTY TRANSACTIONS

At December 31, 1987, TMH Business Group, Inc. owns a 50 percent stock ownership in Rice Laundry, Inc. ("RLI"), a commercial laundry primarily serving health care entities. This investment was accounted for using the equity method in both 1987 and 1986.

At December 31, 1987 and 1986, the Methodist Hospital System had a receivable due from RLI in the amount of \$1,538,000 and \$2,002,000, respectively, resulting primarily from the original acquisition of the RLI assets in 1983 and a subsequent working capital loan.

The Methodist Hospital and Baylor College of Medicine are tenants-in-common, owning equal undivided interests in the land and improvements of The Neurosensory Center of Houston and The Alkek Tower. The Methodist Hospital's one-half interest in the assets, principally property, plant, and equipment, with an undepreciated cost of approximately \$19,600,000 at December 31, 1987, is included in the combined balanced sheets. The ownership agreements provide, among other things, that either party will have the right to use any part of the land and building; however, the parties shall agree, from time to time, to the parts used by each and the parts to be used jointly.

The Methodist Hospital acts as the manager for both facilities. The duties of the manager, among other things, include contracting for the service and maintenance of the buildings. Expenses incurred by The Methodist Hospital as manager are shared under the agreement pro rata by the parties based on the proportionate parts of the building being used by each.

In November 1986, San Jacinto Methodist Hospital purchased 12.5 acres of land in Baytown, Texas, from a trustee acting for a member of The Methodist Hospital Board of Directors. The purchase price was \$2,400,000. This land will serve as the site for a San Jacinto Methodist Hospital replacement facility.

NOTE G—PENSION AND RETIREMENT PLANS

The Methodist Hospital System and Related Corporations, excluding San Jacinto Methodist Hospital and Nan Travis Memorial Hospital, have a noncontributory, defined-benefit pension plan covering substantially all employees. The plan benefits are based on a percentage of average monthly compensation multiplied by years of service and vest after five years of service. The funding policy is to contribute amounts to the Plan sufficient to meet the minimum funding requirements set forth in the Employee Retirement Income Security Act of 1974. At December 31, 1987, this minimum funding requirement totaled approximately \$3,200,000 and will be funded in 1988.

The System also sponsors a noncontributory executive annuity plan. Contributions are determined as a percentage of each covered employee's salary.

In 1986, employees of tax-exempt corporations with monthly earnings in excess of \$550 were eligible to participate in supplemental group annuity plans. The basic plan provided for the matching of employee contributions up to 4 percent of compensation of excess of \$550 a month. Employees of taxable corporations are eligible to participate in retirement income plans, which are approximately equivalent to the group annuity plans available for tax-exempt corporation employees. Effective January 1, 1987, the 4 percent matching of employee contributions was disclosed.

In 1987, the System adopted FASB Statement No. 87, "Employers' Accounting for Pensions." Pension expense for 1986 has not been restated, as permitted under FASB Statement No. 87.

San Jacinto Methodist Hospital has a defined-contribution plan covering substantially all full-time employees. Contributions to individual employees ranging from 2 to 4 percent are made by San Jacinto after the completion of one year of service.

Nan Travis Memorial Hospital has a voluntary, defined-contribution retirement plan covering all permanent employees who meet certain service requirements. Employees electing coverage contribute three percent of their compensation to the plan and Nan Travis contributes an additional five percent of such compensation.

A summary of the components of net periodic pension cost for the defined benefit plan in 1987, the net pension cost thereof for 1986, and the total contributions charged to pension expense for the defined contribution plans follows:

	<u>19X2</u>	<u>19X1</u>
Defined Benefit plans:		
Service cost—benefits earned during the period	\$1,437,000	
Interest cost on projected benefit obligation	1,072,000	
Actual return on plan assets	(299,000)	
Net amortization and deferral	<u>505,000</u>	
Net pension cost of defined benefit plan	2,715,000	\$ 1,520,000
Defined contribution plans	<u>1,763,000</u>	<u>2,428,000</u>
	<u>\$4,478,000</u>	<u>\$3,948,000</u>

Pension costs are included in salaries, wages, and related personnel costs in the combined statements of revenue and expense.

Assumptions used in the accounting for the defined benefit plans at December 31, 19X2 and 19X1, were:

Weighted-average discount rates	8.5% to 9.25%
Rates of increase in compensation levels	0.0% to 5.50%
Expected long-term rate of return on assets	8.50%

The following table sets forth the funded status and amounts recognized in the balance sheet for the defined benefit plan at December 31:

	<u>19X2</u>	<u>19X1</u>
Actuarial present value of benefit obligations:		
Vested benefit obligations	\$ 8,770,142	\$ 8,576,189
Nonvested benefit obligations	<u>484,808</u>	<u>413,553</u>
Accumulated benefit obligation	9,254,950	8,989,742
Additional benefits based on estimated future salary levels	<u>3,768,389</u>	<u>3,687,118</u>
Projected benefit obligation	13,023,339	12,676,860
Plan assets at fair value	<u>(3,138,016)</u>	<u>(3,582,577)</u>
Funded status—projected benefit obligation in excess of plan assets	<u>\$ 9,885,323</u>	<u>\$ 9,094,283</u>
Comprised of:		
Accrued pension cost	\$ 4,028,243	\$ 1,518,000
Unrecognized net gain	(1,214,117)	
Unrecognized net obligation at January 1, 1987, net of amortization	<u>7,071,197</u>	<u>7,576,283</u>
	<u>\$ 9,885,323</u>	<u>\$9,094,283</u>

At December 31, 19X2 and 19X1, the plan assets are invested in a life insurance company deposit administration contract.

NOTE H—COMMITMENTS AND CONTINGENCIES

Professional liability claims that fall within adopted policies of self-insurance (see *Note E*) have been asserted by various claimants. The claims are in various stages of processing and some may ultimately be brought to trial. There are also known incidents that have occurred through December 31, 19X2, that may result in the assertion of additional claims. In the opinion of Management, adequate provision has been made for these and all other contingent losses.

At December 31, 19X2, construction in progress related primarily to various remodeling programs and construction costs of a professional office building and patient tower and capitalized interest related to The Methodist Hospital's four-year expansion program. At December 31, 19X2, the estimated cost to complete the expansion program was approximately \$146,212,000. See *Note D*.

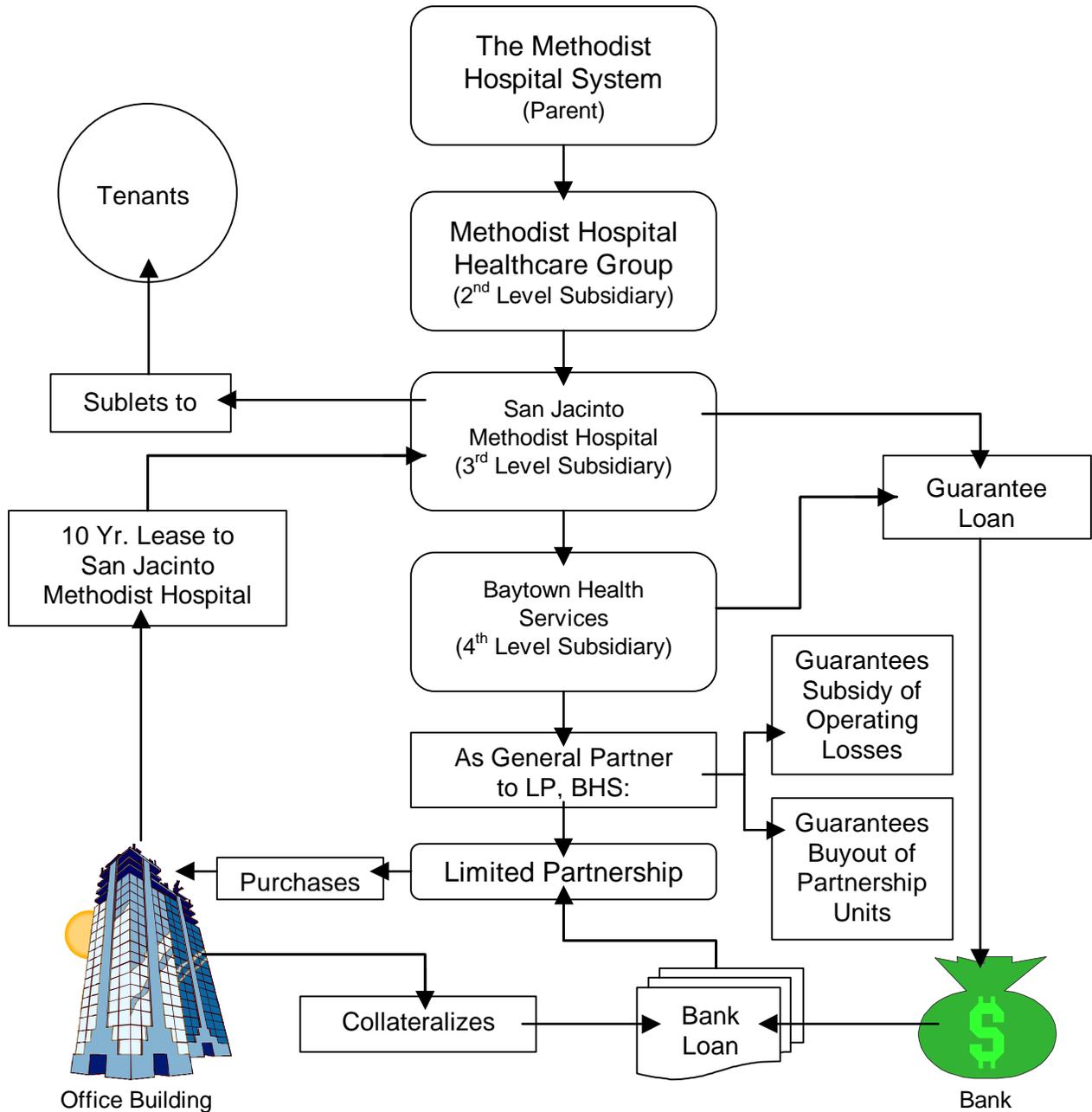
Baytown Health Services, Inc. (BHS) is a wholly owned subsidiary of San Jacinto Methodist Hospital. BHS is the general partner in a Texas limited partnership which owns and operates a professional office building. In November 19X1, San Jacinto Methodist Hospital entered into an agreement with the partnership to lease the 77,810 square feet of net rentable space in the professional building for an annual cost of \$12 per square foot for a term of 10 years. Rental income from subleases should approximate this lease expense.

The partnership's purchase of the professional office building and subsequent improvements were primarily financed through a bank loan of approximately \$7,400,000. This loan is collateralized by the building and a guarantee by San Jacinto Methodist Hospital and BHS.

The partnership agreement provides for the repurchase by BHS of 77,810 partnership units for \$200 each at the end of 10 years. BHS, as general partner, is responsible for additional capital contributions to the extent such contributions are necessary to fund (1) capital costs in excess of loan proceeds and limited partner capital contributions (2) operating losses, or (3) the repurchase of partnership units.

APPENDIX B

Baytown Health Services, Inc. Real Estate Transaction



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- ¹ All references to the case were drawn from Petition No. 494,212, obtained from the Texas State Attorney General's office.
- ² The number of beds is a common measure of size for hospitals. The Methodist Hospital System (MHS) maintained between 1,172 beds and 1,527 beds.
- ³ The data were obtained from Columbia HCA Healthcare's 1994 10K and DEF14A reports filed with the SEC. The 1994 reports are the earliest available on the SEC's EDGAR database. The 1994 DEF14A, the shareholder proxy statement for that year, reports executive compensation back to 1991. We took the 1991 data and discounted it back to 1985, the contemporaneous year of the lawsuit, using an assumed 3% discount rate.
- ⁴ To arrive at 1985 salaries, we took the 1991 reported executive compensation and discounted it at an assumed 3% rate back to 1985.
- ⁵ These details were first summarized in Blankley and Forgione (1996).
- ⁶ The \$61,485,740 is the estimated supplies and pharmaceuticals purchases, calculated as the increase in inventory level for these items plus the amount expensed during the period, taken from the financial statements ($[\$2,842,472 - 2,717,610] + 61,360,878$). We are making the assumption that these purchases would all be subject to sales tax were it not for the tax-exemption the hospital enjoys.