CHAPTER 2

ORGANIZATION OF FINANCIAL MANAGEMENT

The successful accomplishment of organizational purposes requires a sound organizational structure. After the governing body has established a healthcare organization’s purposes, management must determine the best way to accomplish them. To do this, management must identify and assign tasks to employees, departments, and divisions, or management must organize. According to Dunn (2002), organizing includes:

- **Specialization**: dividing tasks into manageable categories and assigning the categories to employees with the appropriate skills.
- **Departmentalization**: dividing employees into groups or teams that have similar responsibilities.
- **Defining the span of management**: determining the optimum number of employees that a manager can manage based on the nature of the tasks and the background of the employees.
- **Defining authority**: determining the amount of authority to delegate to employees so that they can perform their assigned tasks.
- **Defining responsibility**: determining the obligation necessary to perform assigned tasks.
- **Establishing a unity of command**: appointing one manager to be responsible for a group of employees.
- **Defining the nature of relationships**: determining whether managers and employees have a line or staff relationship in the organization. In a line relationship, the manager or employee is directly responsible for resources such as employees and supplies. In a staff relationship, the manager or employee acts in an advisory capacity without direct control over resources.

Most healthcare organizations are organized as legal entities called corporations. Corporate status is granted by the state and provides advantages for the healthcare organization. Corporate status provides limited liability, meaning that the owners of the corporation are seldom found to be personally liable for the contracts or negligence of the corporation. Another advantage of corporate status is its continuity of existence, meaning that the corporation continues even after the death of an owner. The third advantage of corporate status is the increased ability to raise capital because investors share only
limited risks, but have a proportionately greater opportunity for reward. In the case of for-profit corporations, free transferal of risk is a fourth advantage of corporate status. This means that shareholders of a for-profit healthcare organization are free to sell their shares at any time. For further discussion of these advantages, refer to Southwick’s *The Law of Hospital and Health Care Administration* (Showalter 2003).

The purpose of this chapter is to provide a comprehensive description of the organization of financial management in healthcare organizations.

**Governing Body**

The governing bodies of healthcare organizations with corporate status cannot be held personally liable for either the contracts of the corporation or the negligence of the corporation’s employees or agents (i.e., physicians). However, the governing body can be held collectively liable for a breach of its duty to act as a fiduciary, which means its duty to act as a person in a position of great trust and confidence. The legal duties of a fiduciary include loyalty and responsibility. Loyalty requires fiduciaries to act in the best interests of the healthcare organization and to subordinate their personal interests to those of the organization. Responsibility requires fiduciaries to act with reasonable care, skill, and diligence in accomplishing their duties as members of the governing body (Showalter 2003).

In addition to several other duties, the governing body of a healthcare organization is responsible for the proper development, utilization, and maintenance of all resources in the healthcare organization (AHA 1990). The governing body typically delegates the authority for accomplishing this duty to the organization’s CEO and maintains the responsibility by monitoring performance through committees. Although the governing body delegates a great deal of authority to the CEO for this and other duties, the governing body maintains legal responsibility. Because of this fact, courts continue to stress the importance of the governing body’s duty of responsibility in selecting a competent CEO. In *Reserve Life Insurance Company v. Salter* (1957), one of the first cases establishing this duty, the court was severe in its finding:

Failing to appreciate their duties and responsibilities led these Trustees to feel, according to their testimony, that they had discharged their duties by picking as Administrator, Salter, a former school teacher, apparently as ignorant of operating a hospital as they themselves were.

The governing body uses organized committees to monitor the CEO’s performance. Although committee structures vary from organization to organization, an executive committee of the governing body is typically responsible for routine monitoring of all committees and includes the chairs of all the committees as members. For financial management, the governing body uses a finance committee responsible for monitoring the CEO’s performance.
in financial affairs. The finance committee includes governing body members with a financial interest or occupation. In smaller organizations, the duties of the finance committee also include audit responsibilities; in larger organizations, audit responsibilities may be monitored by an audit committee. Generally, the CEO and/or the chief operating officer (COO) and chief financial officer (CFO) attend finance committee meetings ex officio, and also serve as staff support to those committees. Figure 2.1 identifies these relationships.

After the Enron bankruptcy, the federal government passed strict corporate accountability standards known as the Sarbanes-Oxley Act of 2002 (see Appendix 1.1 in Chapter 1). While the standards only apply to for-profit organizations, many not-for-profit organizations are attempting to comply with the standards. Some states like New York are considering passing Sarbanes-Oxley–like state legislation that also applies to not-for-profits.

In November of 2003, Richard Scrushy, founder and former chairman of for-profit HealthSouth, was indicted for 85 counts on conspiracy, fraud and money laundering. The indictment alleges that Scrushy was the mastermind of a wide-ranging scheme to inflate the rehabilitation and outpatient-care company’s earnings in order to meet Wall Street expectations. The indictment further alleges that Scrushy added at least $2.7 billion in fictitious income to HealthSouth’s books during a multiyear conspiracy dating back to 1996. Scrushy becomes the first CEO (and as a result, healthcare becomes the first industry) indicted under Sarbanes-Oxley which holds the CEO personally liable for financial misreporting. If convicted, Scrushy faces a possible maximum sen-
rence of 650 years in prison, the forfeiture of $279 million in ill-gotten gains, and more than $36 million in fines. While the impact of the Scully indictment on the healthcare industry is not yet clear, it seems reasonable to assume that both federal regulatory agencies and bond rating firms will be paying special attention to the healthcare industry in the future. It also seems reasonable to assume that the governing bodies of healthcare organizations will be holding the CEO more accountable for financial reporting (Piotrowski 2003).

**Chief Financial Officer**

In larger healthcare organizations, the CEO delegates the authority for accomplishing the duties related to financial management to the COO, who delegates authority for day-to-day financial operations to the CFO. In certain cases, the CFO reports directly to the CEO for financial matters. The Committee on Ethics and Eligibility Standards of the Financial Executives Institute has defined the CFO duties as follows (Berman, Kukla, and Weeks 1994):

1. To establish, coordinate, and maintain, through authorized management, an integrated plan for the control of operations. Such a plan would provide cost standards, expense budgets, sales forecasts, profit planning, and programs for capital investments/financing to the extent required in the business.

2. To measure performance against approved operating plans and standards, and to report and interpret the results of operations to all levels of management. This function includes the design, installation, and maintenance of accounting policy, and the compilation of statistical records as required.

3. To measure and report on the validity of the objectives of the business and on the effectiveness of its policies, organization structure, and procedures in attaining those objectives. This includes consulting with all segments of management responsible for policy or action concerning any phase of the operation of the business as it relates to the performance of this function.

4. To report to government agencies, as required, and to supervise all matters relating to taxes.

5. To interpret and report on the effect of external influences on the attainment of the objectives of the business. This function includes the continuous appraisal of economic and social forces and of government influences as they affect the operations of the business.

6. To provide protection for the assets of the business. This function includes establishing and maintaining adequate internal control and auditing, and ensuring proper insurance coverage.

A profile of the average hospital and system CFO in 2003, compared to a profile of the average hospital CFO in 2001 and 1995, according to information provided by the Healthcare Financial Management Association
<table>
<thead>
<tr>
<th></th>
<th>1995</th>
<th>2001</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual compensation</td>
<td>$99,900</td>
<td>$127,000</td>
<td>$151,000</td>
</tr>
<tr>
<td>Average age</td>
<td>42</td>
<td>46</td>
<td>47</td>
</tr>
<tr>
<td>Percent male</td>
<td>84</td>
<td>76</td>
<td>83</td>
</tr>
<tr>
<td>Percent with master's degree</td>
<td>53</td>
<td>49</td>
<td>45</td>
</tr>
<tr>
<td>Percent with CPA</td>
<td>83</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>Percent with HFMA certi</td>
<td>25</td>
<td>17</td>
<td>20</td>
</tr>
</tbody>
</table>

*Table 2.1 Hospital CFO Profile*

(HFMA), is shown in Table 2.1. The 1995 profile also included personal strengths, personal weaknesses, and future concerns about healthcare.

CFOs reported their strengths as attention to the bottom line and planning. Reported weaknesses included personnel matters and hospital politics. CFOs reported that their greatest future concerns included, in order of importance, capitation, managed care, integrated systems, and information systems. The 2001 and 2003 profiles include a comparison by gender. In 2003, the percentage of women CFOs responding to the survey was down from 24 percent in 2001 to 17 percent in 2003. These results were unexpected and may have more to do with the sample than with practices in the industry. In 2003, women earned an average of $56,700 less than men, up from a difference of $36,800 reported in 2001. However, after adjusting for other determining factors such as job tenure, total number of reporting employees, net patient revenue of the organization, the area’s wage index, CPA attainment, eligibility for bonus or profit sharing, and bed count, regression analysis finds that gender is still a significant determinant of compensation, accounting for $15,000 of the reported difference in 2003 and $14,000 of the reported difference in 2001.

At an average age of 47, hospital and system CFOs are relatively young. This means that organizations and associations like HFMA will need to find new ways to motivate CFOs who have reached the top of their career ladder at a young age (the 1995 CFO profile reported that only 8 percent of the surveyed CFOs aspired to be the CEO). Although only 16 percent of the CFOs were women in 1995, that percentage has increased steadily over the years and will continue to increase as women who graduated from business schools in the 1970s and 1980s gain the prerequisite experience to be CFOs. Forty-five percent of the CFOs have advanced degrees, usually in business administration. Most CFOs have undergraduate degrees in accounting and 45 percent are certified in public accounting.

Many CFOs with multiple certifications would argue that certification in HFMA is the most meaningful certification for CFOs in the healthcare
industry. However, many CFOs received their public accounting certification shortly after graduation and feel additional certification in HFMA is unnecessary. Currently only 20 percent of the CFOs in the 2003 survey are HFMA certified. Certification in HFMA requires the following:

- Be a member of HFMA for two years;
- Complete 60 college semester hours or the equivalent;
- Earn 60 Founders Awards points by participating in HFMA service opportunities or continuing education (40 of the 60 required points can be earned through participating in education opportunities in societies and organizations other than HFMA);
- Provide a reference from an immediate supervisor and from an HFMA chapter officer or director; and
- Pass a written core exam on the healthcare industry and pass one of four specialty exams in accounting and finance, financial management of physician practices, managed care, or patient financial services. (Exams are Internet-based and must be taken with an HFMA chapter proctor present.)

Several surveys conducted between 1996 and 2001 have identified expanded roles for CFOs requiring a broad range of new traits and skills. Surveys of healthcare CFOs conducted by Wirt/Kieffer (Doody 2000) have identified five intrinsic traits possessed by born leaders that CFOs must nurture:

1. Strategic thinking
2. Ability to adjust to change
3. Personal integrity
4. Vision
5. Ability to be a team player

The CFOs also identified six acquired leadership skills (Doody 2000):

1. Communicate clearly—the vast majority of the CFOs identified good communication as the most important leadership skill for CFOs;
2. Provide leadership in day-to-day operations—the CFOs recognized the importance of providing leadership in a practical, daily manner;
3. Manage resources and finances—the CFOs remembered the importance of this very traditional skill that includes planning, organizing, staffing, directing, and controlling;
4. Build coalitions—the CFOs recognized that cooperating with others and building coalitions will be imperative to success in the future;
5. Create a positive organizational culture—the CFOs realized that as they build coalitions, they must use their political skills to maintain and promote a positive organizational culture; and
6. **Maintain strong physician relationships**—the CFOs report that they are rapidly becoming key players in relationships between organizational providers and physicians due to the increasing importance of financial and regulatory expertise.

At the 2003 CFO Exchange sponsored by HFMA’s CFO Forum, HFMA President Dick Clarke introduced a healthcare financial competency model that demands new, more complex roles for healthcare CFOs in addition to more traditional roles as identified in Figure 2.2.

In addition to CFO’s, certified public accountants (CPAs) are being asked to take on additional roles by the American Institute of Certified Public Accountants in their 1997 publication, *CPA Vision Project—2011 and Beyond*, which identifies needed changes in the nature of being an accountant: greater emphasis on professional demeanor, leadership, and interpersonal communications.

Do CFOs and accountants have the personalities conducive to these expanded roles demanding new competencies? Using Myers-Briggs personality typing, several studies have identified that the predominant personality types of accountants are introversion (I) (versus extroversion), sensing (S) (versus intuitive), thinking (T) (versus feeling), and judging (J) (versus perceiving). Larabee (1994) reported that 37.3 percent of the study sample were STJs (significant compared to 20.5 percent found in the general population) and 56.0 percent were IS (significant compared to 40.1 percent found in the general population). The consistency among the findings of the personality studies on accountants is remarkable considering when the studies were conducted (1980 to 1997) and where the studies were conducted (United States, United Kingdom, and the Netherlands).

ISTJs represent 7 to 10 percent of the American population and are serious, responsible, sensible, trustworthy, and honor their commitments. Practical and realistic, they are matter-of-fact and thorough. They are painstakingly accurate and methodical, with great powers of concentration. They value and use logical and impersonal analysis and are organized and systematic in getting things done on time (Tieger and Barron-Tieger 2001).

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Past</th>
<th>Present</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roles</td>
<td>Financial Expert</td>
<td>Business Advisor</td>
<td>Enterprise Leader</td>
</tr>
<tr>
<td>Competencies</td>
<td>technical expertise</td>
<td>decision support</td>
<td>strategic leadership</td>
</tr>
<tr>
<td></td>
<td>results oriented supervisor</td>
<td>compliance oversight</td>
<td>system influence</td>
</tr>
<tr>
<td></td>
<td>internal focus</td>
<td>coach/teacher</td>
<td>mentor</td>
</tr>
<tr>
<td></td>
<td>risk minimizer</td>
<td>internal/external</td>
<td>external focus</td>
</tr>
<tr>
<td></td>
<td>risk quantifier</td>
<td>risk accepter</td>
<td></td>
</tr>
</tbody>
</table>

**FIGURE 2.2**
Healthcare Financial Competency Model
Do CFOs have the same personalities as accountants, or do only the extroverted accountants become CFOs? In a survey of healthcare senior financial executives (which includes not only CFOs but also vice presidents of finance) conducted by the Healthcare Financial Management Association and Texas State University, it was reported that 37.8 percent of the sample was STJs (compared to 37.3 percent found in the accountant sample and 20.5 percent found in the general population) and 57.0 were Is (compared to 56.0 found in the accountant sample and 20.5 percent found in the general population), confirming that healthcare CFOs have personalities similar to accountants (Nowicki 2003).

**Controller and Treasurer**

Reporting to the CFO are the controller and the treasurer. The controller is the chief accounting officer of the healthcare organization and is usually responsible for financial accounting, managerial accounting, tax accounting, patient accounting, and internal auditing. The treasurer is responsible for managing working capital, the healthcare organization’s investment portfolio, and the financing of capital expenditures. In smaller organizations, the controller function and the treasurer function may be combined into one position, or may be integrated with the CFO’s responsibilities.

**Corporate Compliance Officer**

Many organizations are adding a corporate compliance officer (CCO) to their senior management teams in response to industrywide fraud and abuse concerns. The final compliance program guidelines for hospitals recently issued by the Department of Health and Human Services (HHS) Office of Inspector General (OIG) list the appointment of a CCO as a critical element of any corporate compliance plan (HHS 2000). A 1998 national survey by Wirtz/Kieffer (Doody 1998) reported that healthcare compliance officers usually report directly to the CEO or board and are seen as peers of the CFO. CCOs are typically responsible for conducting compliance reviews (to assess how well the organization complies with fraud and abuse laws), investigating potential fraud and abuse problems, and examining relationships and contracts for possible illegal provisions. In organizations that have not added a CCO, COOs, staff or retained attorneys, or CFOs are performing these functions. Because no education, certification, or licensure is required for CCOs, CEOs seek individuals that understand the legal issues involved with compliance and exhibit the following personal characteristics that might support the compliance functions (Doody 1998):

- Analytical, inquisitive, persistent;
- Detail-minded;
- Skilled in dealing with people;
- Dispassionate, objective;
- Courageous;
- Discreet; and
- A strong moral sense.

The Health Care Compliance Association (HCCA) surveyed healthcare organizations in 2000 and found the results recorded in Table 2.2 (HCCA 2000). See Table 2.3 for recent compensation trends.

**Chief Information Officer**

Historically, managing information resources in healthcare organizations has been the responsibility of the CFO, a practice that reflected the need for accurate and timely financial information. However, given the increasing importance of clinical information systems like medical records as well as the

<table>
<thead>
<tr>
<th><strong>Maturity of Compliance Programs</strong></th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizations with active compliance programs</td>
<td>71%</td>
</tr>
<tr>
<td>Organizations with appointed CCO</td>
<td>98%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Reporting Relationships</strong></th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>To board of directors</td>
<td>15%</td>
</tr>
<tr>
<td>To CEO/president</td>
<td>58%</td>
</tr>
<tr>
<td>Executive vice president</td>
<td>6%</td>
</tr>
<tr>
<td>Chief financial officer (CFO)</td>
<td>5%</td>
</tr>
<tr>
<td>Legal counsel</td>
<td>4%</td>
</tr>
<tr>
<td>Chief operating officer (COO)</td>
<td>4%</td>
</tr>
<tr>
<td>Compliance committee</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>CCO Demographics</strong></th>
<th>2000</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>46 years</td>
<td>46 years</td>
</tr>
<tr>
<td>Female</td>
<td>56%</td>
<td>56%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Highest degree/certification received</strong></th>
<th>2000</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bachelor's</td>
<td>26%</td>
<td>26%</td>
</tr>
<tr>
<td>Master's</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Ph.D.</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>J.D.</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>CPA</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>Health Care Certification</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td>Nursing</td>
<td>10%</td>
<td>10%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Average salary</strong></th>
<th>2000</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred background in order of preference</td>
<td>$90,000</td>
<td>$90,000</td>
</tr>
<tr>
<td>1. Hospital administration</td>
<td>1. Hospital administration</td>
<td></td>
</tr>
<tr>
<td>2. Auditing</td>
<td>2. Auditing</td>
<td></td>
</tr>
<tr>
<td>3. Law</td>
<td>3. Law</td>
<td></td>
</tr>
<tr>
<td>4. Regulatory affairs</td>
<td>4. Regulatory affairs</td>
<td></td>
</tr>
</tbody>
</table>
Y2K scare, many healthcare organizations have assigned the responsibilities for managing information resources to a chief information officer (CIO). Typically reporting directly to the CEO, the CIO is responsible for not only providing management oversight to all information processing and telecommunications systems in the organization, but also for assisting senior management in using information in management decision making (Austin and Boxerman 1998). The responsibilities of CIOs are rapidly evolving to include e-commerce, e-health and other web-based and multimedia technologies; business-service formats to respond tactically to strategic business initiatives; and outsourcing of all or a portion of the information technology departments. As CIOs become an accepted part of the executive team, leadership skills will become more important and technology skills will become less important. In fact, CIOs will delegate many of their technology responsibilities to chief technology officers (Hagland 2000).

**Privacy Officer**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated privacy and security regulations for the healthcare industry. The HHS's final rule on privacy issued in 2002 and effective in 2003 requires that the “entity must designate a privacy official who is responsible for the development and implementation of the privacy policies and procedures of the entity” (CMS 2004). The HHS's final rule on security, issued in 2003 and effective in 2005 requires that the “security responsibility be assigned to a specific individual or organization . . . for the management and supervision of the use of security measures to protect data and of the conduct of personnel in relation to the protection of data” (CMS 2004). It is unclear whether the same position could, or should, be responsible for both privacy and security of information. It is clear that specific education, certification, or licensure does not currently exist. The American Health Information Management Association (AHIMA) makes a good case that HIM professionals should have the training and experience to handle most of the skills required for privacy officers. HIM professionals should have (Dennis 2001)

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**TABLE 2.3**  
Healthcare Compensation Trends

<table>
<thead>
<tr>
<th>Position</th>
<th>1999</th>
<th>2001</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director/Manager of Finance</td>
<td>$78,800</td>
<td>$83,900</td>
<td>$91,700</td>
</tr>
<tr>
<td>Director/Manager of Managed Care</td>
<td>$73,700</td>
<td>$80,000</td>
<td>$87,800</td>
</tr>
<tr>
<td>Controller</td>
<td>$72,600</td>
<td>$78,300</td>
<td>$85,600</td>
</tr>
<tr>
<td>Compliance Officer</td>
<td>$70,400</td>
<td>$79,000</td>
<td>$89,300</td>
</tr>
<tr>
<td>Director/Manager of Patient Accounting</td>
<td>$60,800</td>
<td>$71,200</td>
<td>$77,000</td>
</tr>
<tr>
<td>Director/Manager of Accounting</td>
<td>$55,800</td>
<td>$62,500</td>
<td>$70,800</td>
</tr>
</tbody>
</table>

• HIPAA competency;
• Knowledge of how confidential information is used;
• Knowledge of how confidential information is disclosed;
• Knowledge of information technology;
• Knowledge of state and federal laws on information; and
• The ability to promote unpopular positions.

**Internal Auditor**

As described in Berman, Kukla, and Weeks (1994), independent auditors are quite different from internal auditors. The independent auditor is typically a large accounting firm with a contract with the healthcare organization. The internal auditor is an employee of the organization who usually reports to the controller. The independent auditor's primary concern is the financial reporting needs of external entities, and the internal auditor's primary concern is protecting the organization's assets from fraud, error, and loss. The independent auditor's responsibilities are limited primarily to financial matters; the internal auditor's responsibilities include both financial and operational matters. The independent auditor is only incidentally concerned with identifying fraud (i.e., the independent auditor is not looking for fraud, but is duty-bound to report any fraud found in the organization to the party that engaged the auditor's services); the internal auditor is directly concerned with identifying fraud.

In a comparison of surveys of directors of internal audit completed in 1990 and 1998, researchers found that internal auditors are spending significantly more time on management and operational improvement activities and less time on traditional accounting and compliance activities (Edwards, Kusel, and Oxner 2000).

**Independent Auditor**

Independent auditors are typically large accounting firms retained by the healthcare organization to ensure that the financial reports sent to external agencies are correct as to accounting format. Examples of external agencies include the state and federal government, commercial insurance companies, and lenders. Correct as to accounting format means that the healthcare organization used generally accepted accounting principles (GAAP) in preparing the report. This does not guarantee that the healthcare organization is financially sound. The American Institute of Certified Public Accountants (AICPA) recently issued Statement on Auditing Standards (SAS) No. 82, Consideration of Fraud in a Financial Statement Audit, which requires independent auditors to obtain reasonable assurance that financial statements are free of material misstatements caused by error or fraud. While SAS No. 82 provides guidelines for independent auditors to use to help detect and document risk factors related to potential fraud, SAS No. 82 does not expand their detection
responsibility. Therefore, healthcare organizations and independent auditors
should discuss thoroughly the scope and focus of the audit as it relates to the
organization’s compliance efforts (Reinstein and Dery 1999).

Independent auditors typically audit the healthcare organization once
each year. The duration of the audit is partially dependent on the size of the
organization. At the end of the audit, the independent auditor produces an
audit report comprised of three paragraphs:

1. The introductory paragraph identifies the financial statements audited;
management’s responsibilities in preparing the financial statements; and
the auditor’s responsibilities in expressing the audit opinion.
2. The scope paragraph describes the criteria used in the audit (for instance,
GAAP).
3. The opinion paragraph includes the auditor’s statement about whether
the financial statements are correct as to accounting format.

A fourth paragraph, the explanatory paragraph, is included only if GAAP
was not used in preparing the financial statements or if any uncertainty exists
regarding how the financial statements were prepared. The AICPA Audit and
Accounting Guide for Health Care Organizations (1996) provides examples
of audit reports, including the four different opinions referenced next.

The opinion paragraph is the heart of the audit report and deserves
special emphasis. Independent auditors use four types of opinions in rendering
their reports:

1. An unqualified opinion means that, in all material respects, the financial
statements fairly present the financial position, results of operations, and
cash flows of the organization in conformance with GAAP. An unqualified
opinion may have an additional explanatory paragraph, but an explanatory
paragraph does not affect the opinion. Auditors use an explanatory
paragraph when they are basing their opinion in part on the work of a
different external auditor, or when they need additional information to
prevent the audit report from being misleading when uncertainties exist
that they cannot reasonably resolve by the publication date of the audit
report.

2. A qualified opinion means that the financial statements fairly present,
in all material respects, the financial position, results of operations, and
cash flows of the organization in conformance with GAAP, except for
matters identified in additional paragraphs of the report. Auditors use a
qualified opinion when there is insufficient evidential matter, when the
organization has placed restrictions on the scope of the audit, or when the
financial statements depart in a material, though not substantial, manner
from GAAP.
3. An adverse opinion means that the financial statements do not fairly present the financial position, results of operations, and/or cash flows of the organization in conformance with GAAP. Auditors use additional paragraphs after the opinion to describe the reasons for an adverse opinion.

4. A disclaimer of opinion means that the auditor does not express an opinion on the financial statements, usually because the scope of the audit was insufficient for the auditor to render an opinion.

**Alternative Corporate Structures**

As previously mentioned, healthcare organizations are chartered as corporations by the state. Prior to the late 1970s, most healthcare corporations consisted of one corporation or a limited number of corporations. Beginning in the late 1970s, a legal strategy called corporate restructuring became popular in response to increasing economic pressures on healthcare organizations. The purpose of corporate restructuring was to maximize the economic position of the healthcare organization by developing new corporations (see Stromberg 1982). Typically, healthcare organizations restructure for one or more of the following four reasons, which dictate the corporate restructuring model.

Healthcare organizations that need to facilitate the development of a new service may develop a wholly controlled subsidiary corporation. For example, a for-profit healthcare organization may develop a wholly controlled subsidiary not-for-profit corporation called a foundation to facilitate education and research. In addition to facilitating education and research, the for-profit healthcare organization shelters some income from taxes by using the income for purposes that are tax-exempt.

Healthcare organizations that need to protect present and future assets may develop a parent holding corporation. For example, for-profit healthcare organizations may develop several parent corporations to layer their liability in the event of malpractice suits. Courts allow only the assets of the organization, and not the assets of the parent corporation, to be introduced during deliberations regarding damage awards.

Healthcare organizations that need to maximize patient care and other operating revenues and even nonoperating revenues may develop a quasi-independent sister corporation. In this model, the healthcare organization can control no more than 49 percent of the governing body of the sister corporation. For example, a healthcare organization, either for-profit or not-for-profit, may develop a gift shop whose governing body usually uses the income to benefit the healthcare organization. The healthcare organization believes that the perception of independence on the part of customers, both in terms of who controls the governing body and who controls the employees or volunteers, gives the gift shop an additional advantage in generating revenue.
Customers are more likely to donate funds to an “independent” corporation than to the healthcare organization that sends them a bill.

Healthcare organizations that need to attract additional funds through philanthropy may develop a wholly independent corporation. In this model, the healthcare organization cannot control any of the governing body. For example, a healthcare organization may develop a foundation whose governing body raises money using relationships established by the healthcare organization. The governing body of the foundation usually uses the income to benefit the healthcare organization, much in the same way that university alumni associations, which are independent from the universities, use their income to benefit universities.

Although corporate restructuring was popular in the late 1970s and 1980s, both Medicare and the Internal Revenue Service (IRS) have increased their interest in the resulting corporations (see Squiers 1986). Medicare’s position has been that a portion of the income generated by quasi-independent corporations like gift shops should be deducted from the amount Medicare owes the healthcare organization under cost-based reimbursement. Medicare reasons that a portion of the gift shop sales are attributable to Medicare patients and their visitors.

The IRS’s position is that corporate restructuring that allows a corporation to avoid paying taxes should be reviewed to ensure that the primary purpose of the corporate restructuring is legitimate. Areas of concern include the unrelated business income (UBI) generated by not-for-profit healthcare organizations through the formations of their wholly controlled subsidiary corporations (e.g., parking garages, adjacent hotels, catering services, and so on). Healthcare organizations that have restructured their corporations are encouraged to seek specialized legal and tax advice (see the recommended reading list for more information), and organizations contemplating such corporate restructuring are also encouraged to seek such advice. Chapter 3 will provide an overview of the tax status of corporations and review in detail the tax-exempt organization.

References

American Hospital Association. 1990. Role and Functions of the Hospital Governing Board. Chicago: AHA.


