aamc association of american medical colleges

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

September 13-14, 1978
Washington Hilton Hotel
Washington, D.C.

Wednesday, September 13

7:00 P.M.	Cocktails	Independence Room
8:00 P.M.	Dinner	Hamilton Room

Thursday, September 14

9:00 A.M.	COTH Administrative Board Business Meeting (Coffee and Danish)	Grant Room
1:00 P.M.	Joint COTH/COD/CAS/OSR Administrative Board Luncheon	Georgetown West Room
2:30 P.M.	Executive Council Business Meeting	Conservatory Room

Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 466-5100

Council of Teaching Hospitals
Administrative Board

September 14, 1978
Washington Hilton Hotel

9:00 a.m. - 1:00 p.m.

AGENDA

XIII.	Flexner and Borden Awards	Executive Council Agenda Page 30
XIV.	Report of the Task Force on Minority Student Opportunities in Medicine	Executive Council Agenda Page 31
XV.	Report of the Task Force on Student Financing	Executive Council Agenda Page 39
XVI.	FY 1979 CCME Budget	Executive Council Agenda Page 42
XVII.	FY 1979 LCCME Budget	Executive Council Agenda Page 43
XVIII.	Current Activities of the NBME Advisory Committee on Continuing Physician Evaluation	Executive Council Agenda Page 109
XIX.	1978 AAMC Officers' Retreat	Executive Council Agenda Page 112

INFORMATION ITEM

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XXI.	Other Business	
XXII.	Adjournment	

Association of American Medical Colleges
COTH Administrative Board Meeting

Washington Hilton Hotel
Washington, D.C.
June 22, 1978

MINUTES

PRESENT:

David L. Everhart, Chairman
Robert M. Heyssel, M.D., Chairman-Elect
David D. Thompson, M.D., Immediate Past Chairman
John Reinertsen, Secretary
John W. Colloton
Jerome R. Dolezal
James M. Ensign
Lawrence A. Hill
Stuart Marylander
Malcom Randall
Elliott C. Roberts
Robert E. Toomey

ABSENT:

Stanley R. Nelson
Mitchell T. Rabkin, M.D.
William T. Robinson, AHA Representative

GUESTS:

Paul R. Elliott, Ph.D.
John A. Gronvall, M.D.
Kevin Hickey

STAFF:

James D. Bentley, Ph.D.
Gail Gross
James I. Hudson, M.D.
Joseph C. Isaacs
Paul H. Jolly, Ph.D.
Thomas J. Kennedy, Jr., M.D.
Richard M. Knapp, Ph.D.
Dario Prieto

I. Call to Order

Mr. Everhart called the meeting to order at 9:15 A.M. in the Grant Room of the Washington Hilton Hotel.

Mr. Everhart announced to the Board that Malcom Randall had recently received the National Administrator's Award for Executive Leadership from the Veterans Administration. He congratulated Mr. Randall for receiving this honor to the applause of the Board.

II. Consideration of Minutes

ACTION: It was moved, seconded, and carried unanimously to approve without modification the minutes of the March 23, 1978 COTH Administrative Board meeting.

At this point, Mr. Everhart informed the Board that in early June a third session of the Management Advancement Program for hospital directors took place in Florida. He invited Mr. Ensign and Mr. Dolezal who had attended the session to share their reactions.

Mr. Ensign began by saying that he would characterize the session as a survey course in current trends in management styles and techniques. He indicated that while it may be difficult for some administrators to get away from their offices for five consecutive days, it is a "fantastic" program. He urged all Board members to take advantage of this concentrated package of management techniques and philosophy. Mr. Ensign emphasized that all who attended were chief executive officers of hospitals and briefly described the eleven topics that were covered during the program. Program techniques ranged from didactics to a case study approach, and included a role-playing session which dealt with "real guts" issues. Mr. Ensign said there were some minor things that could have been improved, but did not elaborate. Allowing that there were some minor negative aspects, Mr. Dolezal also contended that the program was excellent and most helpful overall. Mr. Everhart then introduced Dr. Gronvall, AAMC Chairman-Elect and Dean at the University of Michigan Medical School, as a fellow member of the MAP steering committee. Both Dr. Granvall and Mr. Everhart were pleased to hear the two Board members' enthusiastic reactions to the program.

Mr. Colloton asked whether the seminar had to be held in June. Mr. Everhart explained that there are a series of three sessions held at different times of the year aimed at various constituencies. The June session has traditionally been reserved for hospital directors. The group of consultants which staff these seminars are committed to a certain number of days per year, the dates of which have already been set. The June dates have been scheduled for the Phase I group of hospital chief executives and are relatively inflexible. Dr. Gronvall suggested that it might be possible to retain the same dates throughout the year, but rotate the constituency groups. Mr. Colloton asked if the June dates pose a problem for many chief executives. Dr. Knapp responded that for the most part, the June dates have not really presented a barrier in the past. He noted that the last session drew the largest attendance yet, despite a $300 tuition collected for the first time.

Given the foregoing discussion, Mr. Everhart assured that he and Dr. Gronvall would recommend to the MAP steering committee that it examine the possibility of rotating the three groups (medical school deans, teaching hospital directors and department chairmen) for the prescribed dates or changing the dates entirely. Mr. Roberts asked if there was a limit to the number of attendees to a MAP session. Mr. Everhart explained that there were usually 25 to 35 participants per session, but that 35 was the maximum workable number.

Mr. Everhart informed the Board that the three-member 1978 COTH Nominating Committee included himself, Daniel Capps of the University of Arizona Hospital and Dr. Thompson as chairman. He explained that the purpose of the Nominating Committee would be to select nominees to fill vacancies for COTH and AAMC officers, COTH Administrative Board members and COTH representatives to the AAMC Executive Council and Assembly. Based upon nominations from the membership the Nominating Committee would meet to determine and finalize the slate of nominees. This slate will be presented to the COTH membership for a final vote at the AAMC Annual Meeting. Mr. Everhart urged Board members with suggestions for nominees to contact any of the three committee members as soon as possible.

Mr. Everhart reminded the Board that at the March Board meeting, Mr. Colloton had some specific suggestions relative to the cost containment session with Paul Rettig, Staff Director, Subcommittee on Health of the House Ways and Means Committee. Dr. Bentley was asked to follow-up on this for the Board. Dr. Bentley proceeded by summarizing the two principle suggestions that Mr. Colloton made in reference to Mr. Rettig's description of the Rostenkowski cost containment legislation: (1) if a hospital during the voluntary period keeps its rate of increase below the goals of the voluntary program, then it should be allowed to carry forward that percentage difference between its actual rate of increase and that for which it was programmed; and (2) precision of the accounting estimates must be examined, given that the Rostenkowski bill provides a penalty for inaccurate reporting by requiring the use for reimbursement purposes of the lower numbers of what is inaccurately reported. Dr. Bentley reported that the document setting forth these positions had been sent to Paul Rettig, but that there had been little raction since the House Ways and Means Committee had yet to begin mark-up of the cost containment legislation. It was, however, timely for presentation to the House Interstate and Foreign Commerce Committee which was marking up the legislation at that time. Thus far, however, little progress had been made by either of the Committees. Dr. Bentley explained that one reason for this regarded the provision that would allow a hospital to carry-forward the amount by which its rate of increase in expenses during the voluntary program was below the allowed ceiling. The position developed by Mr. Colloton and advocated by the AAMC argues that maximum voluntary cost containment will be attained if individual hospitals are not penalized in future years for cost reductions below the voluntary effort ceiling.

Dr. Bentley pointed out that the legislators and staffers on Capitol Hill don't agree with this argument since they basically assume that the voluntary effort will fail. Some staff of the Interstate and Foreign Commerce Committee have argued that if the voluntary effort fails and mandatory containment is effected, permitting hospitals to carry forward the extra savings will drive future revenue increases that much higher. Dr. Bentley summarized that the best course of action would be to work with Rostenkowski's staff whose House Ways and Means Committee has yet to react to the legislation.

In terms of the accounting procedures, Dr. Bentley explained that the proposal would allot to hospitals a two percent variation on quarterly reporting. The Interstate and Foreign Commerce Committee is supportive of this idea, but does not want it in the language of the law. Instead, the Committee would encourage the Secretary to allow some lattitude in terms of the reporting requirements, leaving the bill general and being more specific in regulations. The AAMC is in a tough position to argue because the AAMC's previous cost containment testimony has argued that the Secretary needs some flexibility and shouldn't be too restricted by law. Dr. Bentley reiterated that the best course of action at this time would be to work with Rostenkowski. Mr. Colloton complimented Dr. Bentley for the thorough follow-up and agreed that the only thing to do would be to continue our involvement and see what happens.

Mr. Ensign reminded the Board that he had raised the quarterly report issue in St. Louis and saw it as a real threat because final costs per quarter can't be known until the end of the year when the books are closed. He expressed concern about the HEW form being used which indicates that if actual costs are more than reported costs, they will be disallowed under Medicare. This seemed to Mr. Ensign to be unreasonable since it's not known that quickly what the costs will be.

Mr. Everhart brought to the Board's attention a study report by Chevis Smyth and members of the AAMC staff entitled, "Departmental Review in Schools of Medicine." He pointed out that the report is getting good response and is worthwhile reading. Dr. Knapp reported that since the report was distributed to the COTH membership, he has received numerous requests for additional copies from member hospitals that seldom, if ever, contact COTH offices.

III. Membership

A. Eligibility for Continuing COTH Membership

Dr. Bentley explained that the material presented on pages 23-27 of the Executive Council agenda incorporated the position taken by the COTH Administrative Board at its March meeting when it reviewed current COTH members. Current COTH membership requirements stipulate that for corresponding membership an institution must have an affiliation agreement with a medical school

and letter of support from the dean of an LCME accredited medical school. In addition, for full teaching hospital membership, the institution must be a hospital and have four residency programs, at least two of which must be in the basic six fields of medicine -- medicine, surgery, pediatrics, obstetrics, gynecology, psychiatry or family practice. There would be an exception for specialty institutions. Dr. Bentley noted that at the March meeting, the Board agreed that those institutions already COTH members without an affiliation agreement should be "grandfathered" in and allowed to remain members; that those hospitals which are presently COTH teaching hospital members, but do not have the required number of types of residency programs, be reclassified as corresponding members effective next July; and lastly that the NIH Clinical Center, which doesn't have any of the basic programs but does have some of the more complex systems, be recognized as a specialty institution. These three determinations were set forth in the report and Dr. Bentley expressed staff's recommendation that the Executive Council approve this report and forward it to the AAMC Assembly for action at the Annual Meeting in October.

Mr. Toomey questioned the importance of a signed affiliation agreement as a requirement for membership when a hospital meets all the other requirements. Mr. Everhart explained that the AAMC is an organization that is committed to the teaching and learning of medicine at all levels, which includes graduate medical education along with its responsibility to the nation's medical schools. Therefore, as part of the AAMC's education orientation, COTH has a responsibility to require an affiliation agreement between its members and medical schools. He acknowledged that there are a number of institutions which have traditionally not been university-affiliated, but obviously have quality programs in graduate medical education. The Board agreed that those institutions should be allowed to remain members if they are currently so, but that all hospitals seeking membership in the future must have an affiliation agreement to meet membership requirements and conform to AAMC's general principles. A listing of the hospitals that will be "grandfathered" in appears on pages 25 and 26 of the Executive Council Agenda. Mr. Everhart also directed the Board's attention to the list of hospitals eligible for COTH membership, though they are not currently members (page 81 of the COTH Agenda). He stressed that this list is for informational purposes only and should not be considered for any marketing campaign for new members.

Mr. Colloton questioned whether the affiliation agreement must be with a medical school or if it could be with a medical school, hospital or clincial department. Dr. Bentley said that current membership rules state that it must be with a medical school. Mr. Everhart noted that COTH has not been concerned about how formal the agreements have been, as long as the hospital would apparently provide an appropriate environment for medical education and training. He added that agreements vary tremendously from hospital to hospital and there has thus far been no effort to establish guidelines for developing these agreements. Dr. Knapp concurred, saying that affiliation agreements, if anything, have been deliberately unrestrictive. He further stated that, in terms of the Council of Teaching Hospitals, the affiliation agreement merely defines the commitment to medical education beyond that of patient care and that this is what constitutes the common interest with the AAMC. Mr. Reinertsen allowed that although affiliation agreements are not perfect documents, they are still necessary aides to the planning and coordination of the graduate medical education balance.

ACTION: It was moved, seconded and carried to recommend that the Executive Council approve and forward to the AAMC Assembly the following revisions to the COTH membership requirements (as presented on page 24 of the Executive Council Agenda):

- That hospitals belonging to COTH prior to July 1, 1978 who do not have a signed affiliation agreement be retained as members provided they continue to maintain the required number of residencies;
- That teaching hospital members that either do not sponsor or participate in four approved residency programs or do not have two programs within the required basic six residencies be reclassified as corresponding members effective July 1, 1979; and
- That the NIH Clinical Center be retained as a full teaching hospital member recognizing its specialty care nature.

B. Membership Applications

Dr. Bentley reviewed the applications of five institutions and upon staff recommendation the following actions resulted:

ACTION: It was moved, seconded and carried to approve Charles F. Kettering Memorial Hospital, Kettering, Ohio for full COTH membership.

ACTION: It was moved, seconded and carried to approve Good Samaritan Hospital and Health Center, Dayton, Ohio for full COTH membership.

ACTION: It was moved, seconded and carried to approve Jerry L. Pettis Memorial Veterans Hospital, Loma Linda, California for full COTH membership.

ACTION: It was moved, seconded and carried to approve the Southwestern Michigan Area Health Education Center, Kalamazoo, Michigan for COTH corresponding membership.

ACTION: It was moved, seconded and carried to approve the University of Massachusetts Hospital, Worcester, Massachusetts for COTH full membership.

C. Non-COTH Hospitals Which Meet Membership Requirements

Mr. Everhart noted that this item had already been reviewed and reiterated that it was for the Board's information and interest only.

IV. Distinguished Service Member Nomination

Dr. Knapp reviewed this agenda item for the Board and recommended approval of the recommendation as set forth in the COTH Board Agenda.

ACTION: It was moved, seconded and carried that Leonard W. Cronkhite, Jr., M.D., President, The Medical College of Wisconsin, be recommended for Distinguished Service Membership in the AAMC (as recommended on page 92 of the COTH Administrative Board Agenda).

V. JCAH Survey of Capital Expenditures

Dr. Bentley reviewed for the Board that at last year's September meeting, in response to some concerns about our cost containment testimony, it was suggested that staff undertake a study of what COTH members were spending on capital and other physical plant expenditures as a result of JCAH surveys; moreover, it was desirable to learn this in terms of the Life and Health Safety Codes. Staff proceeded to develop a questionnaire which the Board approved last January. It was sent to the COTH membership and slightly more than 200 responses (approximately 50% of the membership) were received. He indicated that within that 50% response rate there were some fairly significant variations. Some hospital groupings by ownership and COTH region responded very heavily, while other groupings responded very lightly as indicated on Table I (of hand-out attachment). Dr. Bentley pointed out that there was a need to be very cautious with regard to generalizations made from this data because of the probability of sampling error. Mr. Hill corrected the title of the first column on Table I from Northwest to Northeast. Dr. Bentley reported that staff had decided to delete some of the data compiled. It was felt that if the report was to have credibility beyond COTH, it must not be perceived as identifying every conceivable expenditure as JCAH required. Removed were those expenditures where the JCAH may have recommended a needed expenditure to an institution, but the hospital had opted to undertake other necessary expenditures. Staff also deleted data from institutions that had built an entirely new physical plant or had mandatory expenditures in excess of $10 million.

Dr. Bentley went on to say that the 195 hospitals that provided data on past year expenditures, excluding those that he had just indicated were removed, spent a little over $71 million collectively on JCAH expenditures in the fiscal year preceeding last September. As shown in Tables III and IV (of hand-out attachments), the average institution spent $365,000. Taking a closer look along regional lines, the midwestern institutions spent substantially more than the average among all the respondents, the government hosptials spent more than the overall average,

and the non-government hospitals spent less than the overall average (as shown in Table IV). Tables V and VI (of hand-out attachments) show what remains to be done at the responding institutions in future fiscal years. The estimate in terms of 1976 dollars is $217.5 million for 175 hospitals. Those states which have relatively small populations are going to get a relatively small share of the proposed capital ceiling and yet, if this data is accurate of a broader picture, they have needs that are somewhat disproportionate. It appears that the VA and state-owned institutions will continue to have an atypical amount of work that needs to be done to bring them into compliance with JCAH standards. Dr. Bentley summarized that this constituted staff's report to the Board and asked for guidance on what should be done with the report. Dr. Knapp added that staff had taken the conservative route and wanted to know how the Board felt about possibly integrating or adding those things that were taken out, cautioning readers regarding the generalizability of their use.

Mr. Marylander felt it would be a good idea to include the data that had been omitted and thought that the report should be circulated to decision-makers in government, as well as COTH membership. Mr. Hill agreed. Mr. Colloton wondered if the expenditures examined in the report could be more appropriately identified as renovation expenditures, thereby crystallizing that all capital expenditures that call for total or large scale replacement had been eliminated. Dr. Heyssel asked if the staff had considered resurveying the hospitals that didn't respond, giving them a copy of this report to dramatize the results in an effort to get a better response rate. Dr. Bentley pointed out that this data is almost a year old. Mr. Toomey asked whether the survey results have been conveyed to the JCAH. Dr. Knapp stated that the JCAH knows it's been done, but has yet to see the data. He felt that with the addition of the improvements discussed, the survey report could be given to the JCAH, and used with Congress and the Executive Branch as well. Dr. Knapp suggested that this report be used in its present form as an interim document to initiate another survey to update this information. Regarding distribution of the report, Mr. Roberts felt that the data could possibly be used against COTH and that the Board would have to be clear in terms of what it hoped to accomplish with the report and its accuracy. Mr. Everhart summarized the discussion, suggesting that staff should update the report to gain a more complete sample and that the report, incorporating Mr. Colloton's recommendation, be refined as quickly as possible. At a subsequent meeting, strategy could be developed regarding the most effective distribution of this information. There was general agreement and it was decided that the preliminary report should be minimally distributed until a more complete report is available.

Dr. Gronvall suggested that at the beginning of the report there be some kind of explanation describing which portion of overall capital expenditure plant costs the report is addressing. In terms of planning at the national level, these data may identify areas to achieve cost savings through elimination of unnecessary expenditures. Several board members shared the concern that the JCAH was forcing hospitals into difficult situations regarding the question of whether completely new construction should be undertaken or large expenditures should be made to conform to the codes within existing structures. Dr. Heyssel believed that the report must look at the question of how the expenditure requirements affect the quality of the hospital's plant because you can make renovations and still have a sub-standard plant. Mr. Hickey felt that the current document was only half of the report because the benefits from the expenditures had not been shown.

VII. Election of Academic Society Members

ACTION: It was moved, seconded and carried to recommend to the AAMC Executive Council the election of the Association of Academic Departments of Otolaryngology and Thoracic Surgery Program Directors to AAMC Membership, pending approval by the CAS Administrative Board, the full Council of Academic Societies and the AAMC Assembly (as set forth on page 21 of the Executive Council Agenda).

VIII. AAMC Affiliate Institutional Membership

ACTION: It was moved, seconded and carried to recommend that the Executive Council require accreditation by the Liaison Committee on Medical Education as a prerequisite for election to Affiliate Institutional membership (as provided on page 22 of the Executive Council Agenda).

IX. AAMC Biomedical and Behavioral Research Policy

Mr. Everhart reminded the Board that there had been a fair amount of discussion of this item at the last Board meeting. As a result of that discussion, the Executive Council representatives were instructed to convey the concerns of the Board and take appropriate action at the Executive Council meeting. The Board identified a number of problems with the policy statement, particularly with the relationship of consumers in the decision-making process and public involvement in the formulation of research policy. Dr. Bentley recalled for the Board that the previous draft of this document called for citizen involvement in terms of the process of directing and selecting research projects. The Board was concerned about this language and recommendation that public participation would be appropriate and desirable at the institute level of NIH or other major governmental entities. In addition, the Board intended that NIH should not have dual responsibility to both implement technology and for review of transfer of low-cost research to patient care (as discussed in Goal #5 on page 45 of the Executive Council Agenda). Dr. Bentley felt that these concerns had been taken into consideration and properly addressed in the revision of the position paper. For Goal #5, a general objective was expressed and was followed by supporting recommendations to help achieve the objective.

Subsequent to the Board's vote on this issue and aware of the Board's unanimity on approval of the recommendation, Mr. Toomey asked to go on record with a concern about Goal #6 on page 55 of the Executive Council Agenda. He felt that the goal should read, "Assure full and adequate support for all aspects of the research process that can show direction and potential results," because there is too much waste without such direction. Dr. Thompson stated that it would be unwise to highlight the fact that some research doesn't pay off and creates some waste. He emphasized that this will always be a part of the research process because it's the nature of the art. Mr. Toomey stated that he respected that view, but felt the goal was too simple for such a complex issue.

ACTION: It was moved, seconded and carried to recommend that the Executive Council adopt the policy statement on biomedical and behavioral research as stated in the Executive Council Agenda on pages 29-69.

X. Discharge in Bankruptcy of Student Loans

Mr. Everhart stated that this issue had been raised because there were a number of students that were defaulting on loans in pursuit of their medical education. In an effort to deal with this problem, the staff developed the recommendation as set forth on p. 62 of the Executive Council Agenda.

Dr. Gronvall noted that the default and bankruptcy rate among medical students is not high, but that the dramatics surrounding one such bankruptcy could have a marked effect on other students. He felt it would be appropriate to take a moral stand on this ethical issue and that it would be beneficial for the AAMC to go on public record disapproving of the practice. Dr. Gronvall personally felt that legislation resulting from this would not be likely.

Dr. Bentley reported the reactions of the OSR Administrative Board to the recommendation. First, they wanted some assurance of consideration for the amount of indebtedness that students were allowed to incur during medical school. Secondly, they didn't want it presented by the AAMC that a major contributor to the problem of defaulting of student loans is the medical school graduate. They would suggest alternative language in the second paragraph of the recommendation which makes this inference. Dr. Thompson suggested that the inference would be softened by taking out the words "increasing numbers of." Dr. Heyssel voiced objection to the idea that the AAMC should appear overly concerned about how much indebtedness a student incurs, since there should be a sense of individual responsibility on the part of the student. He felt that the AAMC should not go beyond declaring its disapproval. Mr. Marylander speculated that the loan approach to financing medical education may not be the best solution, but students taking loans should be obligated to repay them. He felt that AAMC could take a good position, but should not try to pass judgement on the right or wrong of what may be a societal problem in general or on an individual's personal decisions on how he or she handles his or her own financial situation.

Mr. Everhart summarized that the Board supported the first and second paragraph of the recommendation but that the third and fifth paragraphs should be taken out.

ACTION: It was moved, seconded, and carried to approve the first two of the three courses of action proposed on page 61 of the Executive Council Agenda and approve, as AAMC policy, the statement on discharge in bankruptcy of student loans as presented on page 62 of the Executive Council Agenda, deleting the third and fifth paragraphs and the words "increasing numbers of" from the second line of the second paragraph.

XII. Recent Manpower Reports from GAO, National Academy of Sciences and CCME

ACTION: It was moved, seconded and carried to recommend that an AAMC Committee be constituted immediately to analyze these three documents and to develop an official AAMC position with respect to their recommendations, as well as the strategy for the most effective use of that position (as recommended on page 73 of the Executive Council Agenda). In addition to these three documents, the Board recommended that the committee constituted review and develop an Association position on an American Society for Internal Medicine Board of Trustees Report as presented in the COTH Agenda on pages 129-136.

XIII. Financial Considerations for Admission to Medical School

Dr. Heyssel felt that since the medical profession was not doing anything to resolve this problem, legislation to address the problem would ensue. He felt that it may be the time for censure of institutions taking payment for admissions to medical schools. Mr. Everhart stated that he would discuss the possible need for censure before the Executive Council.

ACTION: It was moved, seconded and carried to recommend that the Executive Council adopt the policy statement as set forth on page 81 of the Executive Council Agenda.

XIV. Recommendations of the CCME Committee on the Opportunities of Women in Medicine

Dr. Knapp reviewed this item for the Board. Several Board members expressed confusion about how this was presented. Dr. Kennedy clarified that the staff recommendation was that the recommendations of the report be accepted but that the report itself be revised. He explained further that the first staff recommendation on page 82 of the Executive Council Agenda is that the recommendations of the CCME Committee be approved by the parent organizations. The second recommendation on page 88 of the Executive Council Agenda is for action to amend the report itself. Dr. Bentley pointed out that in the recommendations, residents were referred to as workers rather than students. It was also pointed out that recommendations 4 and 5 are exactly alike. Dr. Kennedy further clarified that the CCME transmits back to the parent organization a set of recommendations from a full report and requests that the parent organizations simply approve the recommendations--at the same time the full report will be sent along for review and comment, but not for action as a CCME document. Dr. Kennedy explained that there is still a question of what the CCME will do with this report when it is returned. He stated that he would appreciate any guidance from the Board on this. Dr. Heyssel commented that he had been initially involved in the development of this report, but withdrew his participation because of numerous problems he had with the recommendations.

Upon the motion made by Mr. Ensign, the Board took the following action;

ACTION: It was moved, seconded and carried to take no action with regard to the recommendation to approve the Report of the CCME Committee on the Opportunities for Women in Medicine and express the COTH Administrative Board's concerns to the Executive Council through its representatives to the Council.

Mr. Marylander moved to amend this action, which was approved by the Board as follows:

ACTION: It was moved, seconded and carried to amend the foregoing motion to allow the COTH Executive Council Representatives full latitude to use their judgment to determine what necessary actions should be taken during the Executive Council meeting regarding the Report of the CCME Committee on the Opportunities for Women in Medicine.

XI. Report of the Task Force on Minority Student Opportunities in Medicine

Mr. Everhart introduced Paul R. Elliott, M.D., Chairman of the AAMC Task Force on Minority Student Opportunities in Medicine and Director of Program in Medical Sciences at Florida State University.

Dr. Elliott began his review of the task force report by describing the history of the task force itself. He then briefly related several summary statements from the report and expressed his willingness to discuss any of these with the board in terms of their direct relationship to COTH. Dr. Elliott drew attention to the seven goals that the task force had developed. He said that the first goal -- within a certain length of time, represented minority groups should achieve within the practice and the education of medicine at least their level of population in the nation -- had perhaps the most import. The task force proposed that the only way to accomplish the goal of increased racial minority representation would be to increase the pool of qualified racial minority applicants to medical school. The task force did not address how these proposed efforts would be funded; however, legislation was introduced at the federal level, and in several cases at the state level, to specifically support programs for racial minority students at the high school/college interface.

Dr. Elliott further explained that the task force visited 12 medical schools with a variety of minority affairs programs and had examined these programs in-depth for two days of extensive research. It was concluded that several good programs were in operation and that, collectively, they resulted in a highly successful endeavor. It was found that all of the goals developed by the task force with the exception of #5, were being implemented. He indicated that the task force attempted to go to schools with reputations for having very good programs, so that it could be determined what constitutes a workable program.

Mr. Colloton wondered what the quantitative factors were in meeting goal #1. Dr. Elliott responded that the pool size would have to be doubled and that the single most important focal point of that potential doubling is at the interface between high school and college, particularly in the traditionally white unviersities.

ACTION: It was moved, seconded and carried to accept the report of the Task Force on Minority Student Opportunities in Medicine.

Board discussion resulted in the following amendment:

ACTION: It was moved, seconded and carried to amend the foregoing action to add "and urge the AAMC to move with conviction and enthusiasm on this issue."

Dr. Heyssel felt that some other language be used in the report rather than the word "recommendation." Dr. Elliott said he would relay this to the Executive Council, which will decide what is to be done with the report.

XVI. Statement Submitted for Consideration by Council of Deans at its 1978 Spring Meeting

Mr. Everhart reported that this item was merely for the Board's information and required no action.

XVII. American Society of Internal Medicine Resolution

Mr. Everhart reminded the Board that in a previous action it recommended that this report be included among those to be reviewed by a special AAMC committee and that no further action was necessary at this time.

XIX. AAMC Testimony on AICPA Exposure Draft

Mr. Everhart asked Dr. Bentley to brief the Board on the testimony that the AAMC presented at the AICPA hearing and reminded the Board that this issue had been discussed at some length at the last meeting. Mr. Everhart passed out copies of the testimony and said he understood that the testimony had gone very well and COTH/AAMC had been well-represented. Dr. Bentley extended thanks to Mr. Marylander and Jim Ludlam for articulating well some of the positions in which the Ad Hoc Committee had expressed interest. Irwin Birnbaum, Deputy Director at Montefiore Medical Center in New York, presented the testimony, accompanied by Jack Myers (AAMC counsel) who has specialized in nonprofit organizations and foundations. Dr. Bentley complimented them for their performance. Dr. Bentley informed the Board that there would be a meeting in New York during the week following the Board meeting, at which time an AICPA Ad Hoc Committee would redraft the position paper. The AAMC would then have another opportunity for comment.

XX. Other Information Items

Mr. Everhart informed the Board that as of July 15, 1978, Dr. Knapp will have completed ten years of service at the AAMC. On behalf of the Board, Mr. Everhart conveyed appreciation and respect for Dr. Knapp's efforts on behalf of teaching hospitals. The Board agreed enthusiastically.

Dr. Knapp brought to the attention of the Board the completion of the annual University-Owned Hospital Survey and welcomed any observations. He indicated that Joe Isaacs is responsible for the survey and complimented him for once again doing a fine job on it.

VI. COTH Spring Meeting Evaluation Report

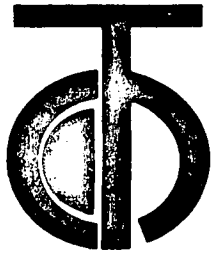
Mr. Everhart asked the Board to recall that they had decided to initiate a Spring Meeting, since a meeting of this kind had not been held for awhile, and to determine if there was interest for such in the field. An evaluation form had been developed in order to help determine the success of the program. Responses have been tabulated, indicating that the program was well-received, generally viewed as being very good, and should definitely be repeated. Dr. Heyssel added that he too thought it was a good meeting and strongly urged the appointment of a planning committee for the next meeting.

Mr. Everhart felt that it would be appropriate for Dr. Heyssel, as COTH Chairman-Elect, to appoint the Chairman of the planning committee and work with him on committee composition. He also suggested that a central, non-resort location would be most desirable for the next meeting, while Dr. Thompson favored a resort location for less formal interaction among the CEO's.

ACTION: It was moved, seconded and carried that the COTH Chairman-Elect appoint a 1979 COTH Spring Meeting planning committee as soon as possible, to evaluate the comments on the 1978 meeting and begin to structure the program for the next meeting.

XXI. Adjournment

The meeting was adjourned at 1:00 p.m.



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to not-for-profit -- IRS 501(C)(3) -- and publicly owned hospitals having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTIONS: Complete all Sections (I-V) of this application.

Return the completed application, supplementary information (Section IV), and the supporting documents (Section V) to the:

Association of American Medical Colleges
Council of Teaching Hospitals
Suite 200
One Dupont Circle, N.W.
Washington, D.C. 20036

I. HOSPITAL IDENTIFICATION

Hospital Name: Baroness Erlanger - T.C. Thompson Children's Hospitals

Hospital Address: (Street) 975 East Third Street

(City) Chattanooga (State) Tennessee (Zip) 37403

(Area Code)/Telephone Number: (615) 755-7811

Name of Hospital's Chief Executive Officer: James A. Lamb

Title of Hospital's Chief Executive Officer: President

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year)

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	754	Admissions:	29,478
Average Daily Census:	616	Visits: Emergency Room:	81,281
Total Live Births:	3,281	Visits: Outpatient or Clinic:	52,255

B. Financial Data

Total Operating Expenses: $ 43,468,000.00

Total Payroll Expenses: $ 26,716,000.00

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 1,320,000.00
Supervising Faculty: $ 285,500.00

C. Staffing Data

Number of Personnel: Full-Time: 2,305
Part-Time: 190

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 153
With Medical School Faculty Appointments: 103

Clinical Services with Full-Time Salaried Chiefs of Service (list services):

Pathology	Anesthesiology	General Surgery	Pediatrics
Radiology	Internal Medicine	OB/GYN	Family Practice

Does the hospital have a full-time salaried Director of Medical Education?: Yes G. E. Livanec

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

Please complete the following information on your hospital's participation in undergraduate medical education during the most recently completed academic year:

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	- / 6	- / 13	
Surgery	1 / 5	12 / 1	
Ob-Gyn	1 / 3	7 / 1	
Pediatrics	- / 4	- / -	
Family Practice	- / 1	- / -	
Radiology	- / 1	- / 4	
Other: Anesthesiology	- / 1	- / 1	
Ophthalmology	- / 1	- / -	
Orthopaedic Surgery	- / 1	- / 1	
Pathology	- / 3	- / 1	
Plastic Surgery	- / 1	- / -	

B. Graduate Medical Education

Please complete the following information on your hospital's participation in graduate medical education reporting only full-time equivalent positions offered and filled. If the hospital participates in combined programs, indicate only FTE positions and individuals assigned to applicant hospital.

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible	8 / 0	6	2	
Medicine	6 / 14	19	1	
Surgery	4 / 12	12	1	
Ob-Gyn	0 / 10	9	1	
Pediatrics	4 / 6	8	2	
Family Practice	6 / 12	2	1	
Psychiatry				
Other:				
Ortho.Surgery	0 / 10	5	3	
Ophthamology	0 / 4	4	0	
Pathology	0 / 4	0	2	
Plastic Surg.	0 / 4	4	0	

[1]As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical* and Categorical programs should be reported under the clinical service of the supervising program director.

[2]As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.

IV. SUPPLEMENTARY INFORMATION

To assist the COTH Administrative Board in its evaluation of whether the hospital fulfills present membership criteria, you are invited to submit a brief statement which supplements the data provided in Section I-III of this application. When combined, the supplementary statement and required data should provide a comprehensive summary of the hospital's organized medical education and research programs. Specific reference should be given to unique hospital characteristics and educational program features.

V. SUPPORTING DOCUMENTS

A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement.

B. A letter of recommendation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs.

Name of Affiliated Medical School: University of Tennessee Center for Health Sciences

Dean of Affiliated Medical School: William E. Rosenberg,M.D.(Acting)

Information Submitted by: (Name) G.E. Livanec

(Title) Director of Medical Education

Signature of Hospital's Chief Executive Officer:

(Date) 7/18/78

APPLICATION SUPPLEMENT

The following information is submitted as a supplement to the application:

HISTORICAL PERSPECTIVE

The Baroness Erlanger Hospital was founded in 1891. Postgraduate medical training began in 1915 with an intern program. Subsequently, in 1928, the T. C. Thompson Children's Hospital was established for the pediatric population. The Hospitals continued their growth to the present bed complement of 654 for the Erlanger Hospital and 100 beds for the Children's Hospital. Postgraduate medical programs expanded with the Hospitals and ten A.M.A. approved resident programs are currently offered.

In 1974, the state legislature passed enabling legislation creating two branch campuses of the University of Tennessee College of Medicine in Memphis. These two Clinical Education Centers were established in Knoxville and Chattanooga. During this year, the Clinical Education Center at Chattanooga signed an affiliation agreement with the Board of Trustees of the Hospitals whereby the Clinical Education Center assumed the educational responsibility for all the existing medical education programs at Erlanger and Children's Hospitals.

By an overwhelming majority of voters, a referendum was passed 1975 which transferred ownership of the Hospitals from the City and County to an independent Hospital Authority.

CURRENT EDUCATION PROGRAMS

Medical students may now choose to take electives or clerkships here in Chattanooga. Currently, students may choose from twenty-seven electives and two clerkships. All electives and clerkships are approved by the respective committees of the College of Medicine, University of Tennessee.

In addition to medical education, the Center has Pharmacy and Allied Health components staffed by full-time individuals.

The Center has a full-time Director of Continuing Medical Education. This unit offered fifteen programs last year involving sixty-five speakers. Some nine-hundred physicians, nurses and allied health professionals attended these programs.

In addition to the capital outlay of $285,500.00 by the Hospital for supervising faculty, the Clinical Education Center currently supports full-time and part-time faculty with an annual expenditure of $309,000.00.

FUTURE PLANS/EXPANSION

Construction is now underway on a cancer treatment center and the Willie D. Miller Eye Center. Planning includes a new Professional Building, complete renovation of the existing Hospital and a new building for the Family Medicine model unit.

XPLANATION OF ITEMS CONTAINED IN APPLICATION FORM

1. Item III A.

   The column "Number of Clerkships" is divided into two parts as clerkships are defined as mandatory rotations whereas electives are free choice; therefore, the first numbers represent clerkships only and the second numbers reflect electives.

2. Item III B.

   Instruction indicated by your superscript[1] instructs one to report categorical numbers under clinical services. Unfortunately, this is not provided for in clear fashion on the form. Therefore, the "Positions offered" column is split into two columns: the first numbers represent only the first year (PGY-1) positions available by department and the second column represents the sum total of all years for that department excluding first-year positions.

THE UNIVERSITY OF TENNESSEE
COLLEGE OF MEDICINE
MEMPHIS, TENNESSEE 38163

OFFICE OF THE DEAN

As Dean of the College of Medicine for the University of Tennessee Center for the Health Sciences, I would like to recommend the admission of the Baroness Erlanger and T. C. Thompson Children's Hospitals located in Chattanooga, Tennessee, for membership in the Council of Teaching Hospitals. Both hospitals are physically attached to and administratively controlled by the Chattanooga-Hamilton County Hospital Authority under the administration of Mr. James Lamb, President.

In 1974, the State legislature created two satellite Clinical Education Centers for the University of Tennessee located in Chattanooga and Knoxville. Both Centers are administratively controlled by the University of Tennessee System through the University of Tennessee Center for Health Sciences located in Memphis. During the same year, an affiliation agreement between the University of Tennessee and the Hospitals was signed. The University of Tennessee College of Medicine, through the U. T. Clinical Education Center in Chattanooga, assumed all medical education responsibilities at the Hospitals which included medical students and intern/resident training programs.

All clerkships and electives offered through the Chattanooga campus are approved by the College of Medicine. Currently, two clerkships are approved, together with some twenty-seven electives approved or in the final stages of approval.

The importance and contribution of this 754-bed complex to both medical students and interns and resident education in our State have increased yearly.

In summation, I would hope that you look favorably on the admission of the Baroness Erlanger/T. C. Thompson Children's Hospitals.

Sincerely,

E. William Rosenberg
Acting Dean
University of Tennessee
College of Medicine

AFFILIATION AGREEMENT

THIS AGREEMENT, Made this 16th day of January, 1974 by and between the University of Tennessee, an educational corporation of the State of Tennessee, sometimes hereinafter referred to as Medical Units, and the Baroness Erlanger Hospital, sometimes hereinafter referred to as Hospital, in cooperation with the Southeast Tennessee Area Health Education Center, sometimes hereinafter referred to as SETAHEC.

WITNESSETH:

WHEREAS, the 1973 General Assembly of the State of Tennessee appropriated state funds to the University of Tennessee Medical Units for the establishment of a University of Tennessee Clinical Education Center in the Chattanooga, Tennessee, area during the 1973-74 fiscal year to provide undergraduate, graduate, and post graduate medical education in cooperation with hospitals, the SETAHEC, practicing physicians, and other health care providers in the Chattanooga area; and

WHEREAS, representatives of the Medical Units, the SETAHEC, and the Hospital have engaged in negotiations for the development of a clinical education center;[1] and

WHEREAS, the Medical Units, the Hospital, and the SETAHEC look to utilization of the Hospital as one important base for the Medical Units'

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[1] As described in Attachment A

Clinical Education Center in the Chattanooga area and as a location for training of medical students with involvement of the professional staff of the Hospital and faculty members of the Medical Units' Clinical Education Center; and

WHEREAS, there is mutual interest in conducting quality educational programs for students of medicine at the undergraduate, graduate, and post-graduate levels; and

WHEREAS, the above mentioned mutual interest can be developed more effectively and efficiently by each party in joint, cooperative efforts; and

WHEREAS, these negotiations have resulted in the following affiliation agreement for medical research, education, and clinical training that is a part of the University of Tennessee Clinical Education Center.

NOW, THEREFORE, in consideration of the mutual covenants and agreements herein contained, the Medical Units and Baroness Erlanger Hospital hereto agree as follows:

1. The Hospital agrees to provide such space as is available, facilities and equipment within the Hospital or in related clinics or other facilities to enable a successful conjoint program of medical research, education, and clinical training subject to the provision that certain purely educational space may be secured by the Clinical Education Center through its own resources or through cooperative agreements with other health care providers in the Chattanooga area.

2. The Hospital agrees to provide an adequate clinical instructional setting including inpatient care, ambulatory care, data and clinical records, necessary supporting services and other programs agreed upon for the education of students. Students as used herein will include any of the students enrolled in the UT Medical Units house staff (trainees and residents), and trainees or fellows of the Medical Units' Clinical Education Center in Chattanooga.

3. The Medical Units agree to use state appropriated and other specially secured funds to finance the full-time and part-time faculty salaries and other basic operating expenses for education with the Clinical Education Center. Included in the staff of the Clinical Education Center will be an Associate Dean of the UT College of Medicine, who will be principally responsible for administration of the Center under direction of the Dean of the UT College of Medicine. A Dean's Committee will be appointed to provide advice and counsel regarding the educational content of the program at the Clinical Education Center in Chattanooga.

4. The full-time and part-time and volunteer (unpaid private practicing physicians) who participate in educational programs of the Clinical Education Center will be appointed by the Associate Dean of the Center, the Dean of the College of Medicine, and the Chancellor of the UT Medical Units in accordance with University of Tennessee policies on faculty appointments.

University titles of the Hospital full-time, part-time, or volunteer staff involved in the educational programs of the University shall be determined by the University. The Hospital retains the right to appoint all

of its physician staff through established Hospital procedures, but no staff members shall participate in student teaching programs without prior University approval with criteria for appointment set by the University in accordance with the faculty, the Clinical Education Center, Hospital Administration, and UT Board of Trustees procedure and policies. Due consideration shall be given by the Medical Units to faculty appointments for Hospital staff who have been participating in pre-existing training programs of the Hospital. Pre-existing contracts with current Erlanger and Children's Hospitals with the Clinical Chief of Medicine, Clinical Chief of Surgery, Clinical Chief of Ob-Gyn and Clinical Chief of Pediatrics will be honored by the University until such contracts expire or are renegotiated or until the contracts can be legally terminated.

5. The Clinical Education Center will assign undergraduate medical students to the Hospital for educational experiences in such numbers and for such periods as may be mutually agreed upon.

6. The Hospital will pay the stipends for graduate medical students (interns and residents) in number and specialties mutually agreed upon. The Clinical Education Center and SETAHEC will cooperate with the Hospital in attracting and recruiting students for internships and residencies with final selections approved by the Clinical Education Center.

7. The University of Tennessee Clinical Education Center will be responsible for the design, maintenance, and operation of the curriculum

and clinical training for all students in cooperation with the Hospital for greatest possible mutual benefit.

The quality and content of all educational programs embraced in this agreement will be determined by the Clinical Education Center in accordance with the needs of students of the Center and by the objectives and capabilities of the Hospital and will be subject to review and approval of appropriate University and Hospital officials.

8. Consistent with maintaining the highest standards of patient care all non-private patients in the Hospital are considered to be teaching patients with Medical Units' students involved in their care under appropriate supervision of the professional staff of the Hospital and Center who remain responsible for patient care. Private physicians on the Center teaching staff will be encouraged to allow their private patients to become teaching patients. House Staff (interns and residents) will assume progressively increasing responsibilities for patient care, including writing of orders for such care. The details of the educational programs which involve the University will be developed by the Chairman of the appropriate Center program.

9. Any individuals who participate in Center education and training programs in the Hospital will be approved by both parties to this agreement. The Hospital agrees that any education and training program for interns, residents, and trainees will be administratively a part of the UT Medical Units Clinical Education Center with maximum effort made by both parties

to retain full accreditation. Any certificate awarded as a result of these educational programs will bear the names of the University of Tennessee and the Hospital.

10. All Faculty appointments for volunteer faculty will terminate upon termination of staff appointment at the Hospital or upon termination of this agreement.

11. The parties to this agreement agree to the establishment of a Dean's Committee. This Committee will consist of five (5) members of the Clinical Education Center's faculty, three of whom shall be from the volunteer faculty; five (5) members of the UTMU faculty including the Clinical Education Center's Associate Dean. Members of this Committee will be appointed by the Dean of the College of Medicine who will Chair this Committee. The Dean's Committee will have as its only function the academic and curriculum considerations of the Clinical Education Center.

12. The parties to this agreement agree to the establishment of an Administrative Coordination Committee. Members of this Committee shall be the Administrator of each participating hospital; the Executive Director of the Southeast Tennessee Area Health Education Center; and the Associate Dean of the Clinical Education Center. This Committee will serve the Clinical Education Center by consideration on such points as coordination of rotation; balance of intern and resident stipends; proration of recruiting costs and other pertinent administrative details.

13. This agreement shall become effective January 16, 1974, and will continue in full force and effect until terminated as hereinafter

provided. This agreement may be modified upon request of either party and with the agreement of the other at any time, or it may be terminated at the end of any academic year by either party upon one year's written notice to the other. However, in the event of such termination of the agreement and at the request of the Medical Units, students then committed to a program of specialty training at the Hospital shall be permitted to complete that educational program at Hospital, subject to satisfactory performance.

14. Grant applications submitted for financial support by Baroness Erlanger Hospital or by members of its staff where University sponsorship is implied, or where the investigator indicates University affiliation, shall be submitted through the Clinical Education Center and appropriate University departmental chairmen, who will then route the grant application through the appropriate dean to the Chancellor for the Medical Units for their review and approval. Grant applications submitted by the University which indicate participation or sponsorship by the Hospital will be subject to prior approval by the Hospital.

15. The parties agree to recognize that in the performance of this contract the greatest benefits will be derived by promoting the interests of both parties, and each of the parties does, therefore, enter into this contract with the intention of loyally cooperating with the other in carrying out the terms of this contract and each party agrees to interpret its provisions insofar as it may legally do so in such manner as will best promote the interest of both and render the highest service to the public.

16. The parties mutually agree in relation to any aspect of the agreement to comply with the following provisions:

a. So far as concerns the obligations of the University of Tennessee and Baroness Erlanger Hospital, hereunder, this agreement shall be deemed executory only to the extent of monies available to the University of Tennessee Clinical Education Center and no liability shall be incurred by the University of Tennessee or the State of Tennessee and Baroness Erlanger Hospital beyond the monies available for the purpose hereof.

b. Neither party hereto shall assign, transfer or convey this agreement, or any part thereof, or any interest therein, without the consent in writing of the other.

c. Hospital and University agree not to discriminate against any employee or applicant for employment because of race, creed, color, sex, or national origin, as required by Executive Order No. 11246.

17. In the event House Staff at Baroness Erlanger are deemed to need to rotate to other hospitals in the Chattanooga are, the Clinical Education Center will develop rotation and financial arrangements subject to mutual approval of the Hospital and the Clinical Education Center.

18. The Hospital, Medical Units, and SETAHEC agree that roles and responsibilities defined in Attachment A of this document are in fact part of this affiliation agreement.

IN WITNESS WHEREOF, the parties hereto have executed this agreement the day and year first above written.

THE UNIVERSITY OF TENNESSEE

BY: _____
Chancellor of the Medical Units

BY: _____
W. H. Read, Vice President
Business and Finance

BARONESS ERLANGER HOSPITAL

BY: _____
John P. Gaither, Chairman
Board of Trustees

BY: _____
Harold L. Peterson
Administrator

I. Institutional and Program Relationships and Responsibilities

The overall objectives of a clinical training center in Southeast Tennessee are to attract more physicians to the area, to help improve the quality of health services and education programs in the area, and to promote an increase in the number and kind of educational experiences for medical students, interns and residents in Tennessee. At the present time Baroness Erlanger Hospital is essentially alone in providing internship and residency programs in the area. It is recognized that the more successful clinical training programs today require a major commitment from and relationship to a medical school in addition to commitments from practicing physicians and resources of hospitals. Under a state mandate, the University of Tennessee College of Medicine will provide this commitment and other physicians and hospitals in the Chattanooga area have qualifications and interests in supporting an expanded clinical training center. Considerable cooperation will be required among these parties and new resources will need to be developed. The Southeast Tennessee Area Health Education Center (SETAHEC) is ideally suited to expedite cooperation and development of resources.

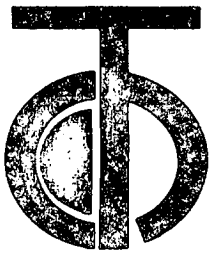
The roles and responsibilities of the organizations supporting the clinical training center are summarized in Exhibit I following this page. These roles and responsibilities are based on the premises that:

1) Educational programs must be controlled by the medical school and teachers in the program according to requirements and expectations of medical students, interns and residents.

2) Hospitals, the state and communities must provide the resources and administrative services (i.e. funds, facilities, and other services).

3) SETAHEC should promote new resources for clinical training to serve as a catalyst among participating organizations and to foster equitable commitments of resources and administrative services from the state, medical school and hospitals.

	1 DEAN'S COMMITTEE	2 CLINICAL EDUCATION CENTER	3 HOSPITALS	4 SETAHEC
MEMBERS	Dean 3 Faculty from UTMU 5 Faculty from UTCEC at Chattanooga Assistant Dean for UTCEC	Dean Assistant Dean Teaching Physicians from area hospitals Program Directors Local Training Committee Staff shared with SETAHEC	Board of Trustees Medical Staff Administration	Staff
ROLES AND RESPONSIBILITIES ASSIGNED	Approve educational objectives Review curriculum for interns and residents Approve curriculum for medical students at CEC within overall objectives of UT College of Medicine Program review and CEC evaluations Approve faculty appointments and promotions Provide assistance with research proposals initiated by CEC when appropriate	Develop and recommend program objectives Develop curriculum and programs for residents and interns Develop local medical student curriculum (with UT guidelines) Conduct training programs Evaluate training programs Recruit faculty Recommend faculty appointments at the program level and deal with promotions Prepare and manage budgets (approved by the Dean) Work with SETAHEC in the development of affiliation agreements with hospitals Recruit residents and interns Assign students and house staff Aid other education programs (including continuing education) in using a team approach to education and practice ~~Consult with hospitals on appointments of service chiefs~~ Develop post-graduate education program and continuing education in collaboration with SETAHEC and other agencies	Provide patient care Manage quality of care Approve staff appointments Determine staff privileges Review education programs as they relate to hospital commitments Provide house staff stipends and program support Share facilities Provide teaching patients Make affiliation agreements with CEC Elect chiefs of services Elect chiefs of staff Support continuing education programs developed by SETAHEC	Promote hospital and physician participation in CEC (expedite affiliation agreements) Assistance in recruitment of faculty and house staff Promote good relations among organizations in program by fostering communications Identify potential problems and resolve them before they become major Assist in raising funds for facilities and operations Conduct feasibility studies of new programs Propose and promote new education and delivery models (e.g., Family Practice Program) Provide administrative and educational assistance to CEC and hospitals Develop, promote and provide administrative support for medical and allied health education
ROLES AND RESPONSIBILITIES NOT ASSIGNED	Control over patient care Control over research submitted by SETAHEC and		Control over quality or contents of educational programs	Control over teaching and patient care



COUNCIL OF TEACHING HOSPITALS ⊖ ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to not-for-profit -- IRS 501(C)(3) -- and publicly owned hospitals having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTIONS: Complete all Sections (I-V) of this application.

Return the completed application, supplementary information (Section IV), and the supporting documents (Section V) to the:

Association of American Medical Colleges
Council of Teaching Hospitals
Suite 200
One Dupont Circle, N.W.
Washington, D.C. 20036

I. HOSPITAL IDENTIFICATION

Hospital Name: MERCY HOSPITAL

Hospital Address: (Street) 1400 West Park Avenue

(City) Urbana (State) Illinois (Zip) 61801

(Area Code)/Telephone Number: (217) 337-2141

Name of Hospital's Chief Executive Officer: Ronald R. Aldrich

Title of Hospital's Chief Executive Officer: President

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year)

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn): 260

Average Daily Census: 197

Total Live Births: 856

Admissions: 9,672

Visits: Emergency Room: 11,131

Visits: Outpatient or Clinic: 13,440

B. Financial Data

Total Operating Expenses: $ 15,978,036

Total Payroll Expenses: $ 7,627,672

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ --
Supervising Faculty: $ --

C. Staffing Data

Number of Personnel: Full-Time: 659
Part-Time: 295

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 79
With Medical School Faculty Appointments: 115

Clinical Services with Full-Time Salaried Chiefs of Service (list services):

Pulmonary Medicine & Anesthesiology	Pathology	Neonatology	Rehabilitation
Radiology	Radiation Therapy	Emergency Room	Hemodialysis

Does the hospital have a full-time salaried Director of Medical Education?: yes

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

Please complete the following information on your hospital's participation in undergraduate medical education during the most recently completed academic year:

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	We have been a one year basic medical sciences school;		
Surgery	we are beginning a full curriculum and will have our		
Ob-Gyn	first 13 second year students starting July 5, 1978.		
Pediatrics	Clerkships will not begin until July 1979.		
Family Practice			
Psychiatry			
Other:			

B. Graduate Medical Education

Please complete the following information on your hospital's participation in graduate medical education reporting only full-time equivalent positions offered and filled. If the hospital participates in combined programs, indicate only FTE positions and individuals assigned to applicant hospital.

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible	We are completing application now to the Liaison			
Medicine	Committee on Graduate Medical Education for a combined			
Surgery	internal medicine residency progam, hopefully, for			
Ob-Gyn	June 24, 1979; if not, for June 24, 1980. Application			
Pediatrics	for pathology residency is also forthcoming.			
Family Practice				
Psychiatry				
Other:				

[1]As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical* and Categorical programs should be reported under the clinical service of the supervising program director.

[2]As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.

IV. SUPPLEMENTARY INFORMATION

To assist the COTH Administrative Board in its evaluation of whether the hospital fulfills present membership criteria, you are invited to submit a brief statement which supplements the data provided in Section I-III of this application. When combined, the supplementary statement and required data should provide a comprehensive summary of the hospital's organized medical education and research programs. Specific reference should be given to unique hospital characteristics and educational program features.

V. SUPPORTING DOCUMENTS

A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement.

B. A letter of recommendation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs.

Name of Affiliated Medical School: University of Illinois School of Basic Medical Sciences and Clinical Medicine, Urbana-Champaign Campus

Dean of Affiliated Medical School: Daniel K. Bloomfield, M.D.

Information Submitted by: (Name) Ronald R. Aldrich

(Title) President

Signature of Hospital's Chief Executive Officer:

Ronald R Aldrich (Date) July 5, 1978

UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE
SCHOOLS OF BASIC MEDICAL SCIENCES AND CLINICAL MEDICINE
MEDICAL SCIENCES BUILDING
URBANA, ILLINOIS 61801

(217) 333-9284

June 29, 1978

Chairman, Council of Teaching Hospitals
Association of American Medical Colleges
Suite 200
One Dupont Circle, N.W.
Washington, DC 20036

Dear Sir:

This is to confirm that Mercy Hospital is a major affiliated teaching hospital of the University of Illinois College of Medicine, School of Clinical Medicine, Urbana-Champaign. It is one of the three hospitals where our school will carry on the bulk of its undergraduate medical education and where we plan to develop, in concert with the hospital, residencies in general internal medicine, family practice, pediatrics, surgery, and pathology. While all of these residencies have not yet been established, the hospital is actively planning with us and I recommend that they be admitted to the Council of Teaching Hospitals at the earliest possible date.

Yours sincerely,

Daniel K. Bloomfield mls

Daniel K. Bloomfield, M.D.
Dean

DKB:mls
cc: Ronald Aldrich, President
Mercy Hospital

AFFILIATION AGREEMENT BETWEEN MERCY HOSPITAL OF URBANA
AND THE BOARD OF TRUSTEES OF THE UNIVERSITY OF ILLINOIS

PROLOGUE

THE BOARD OF TRUSTEES OF THE UNIVERSITY OF ILLINOIS (hereinafter referred to as the University), through its College of Medicine, intends to develop selected existing clinical facilities in a supportive role for any or all components of the College of Medicine.

This Affiliation Agreement, while complete in itself, is designed to provide the basis for cooperative educational programs between the Affiliated Hospital and the University's Schools of Basic Medical Sciences and Clinical Medicine at the Urbana-Champaign campus of the University of Illinois. A hospital which will accept responsibility for the delivery of clinical curriculum in a relationship to the University to be described below will be designated as a "Clinical Education Center."

THIS AGREEMENT made this day of May 25, 1978 between MERCY HOSPITAL OF URBANA, a corporation duly organized under the laws of the State of Illinois, hereinafter called "the Hospital," THE BOARD OF TRUSTEES OF THE UNIVERSITY OF ILLINOIS, a corporation duly organized under the laws of the State of Illinois, hereinafter called "the University," and within the University the Schools of Basic Medical Sciences and Clinical Medicine, hereinafter called "the Schools," WITNESSETH:

WHEREAS, the Hospital is a general hospital for the care and treatment of the sick.

WHEREAS, the University operates a school of medicine for instruction in the care and treatment of the sick.

WHEREAS, the Hospital and the University have over a period of years had a tradition of medical achievement and the common goal of improving the health of the citizens in their community and adding to the body of medical knowledge: and

WHEREAS, the Parties desire to extend further the scope of their cooperation.

NOW, THEREFORE, in consideration of the mutual promises contained herein, it is agreed between the Hospital and the University, hereinafter sometimes called "the Parties," as follows:

OBJECTIVES

The University and the Hospital acknowledge the following common objectives: to develop new health professional education programs; to pursue improvement in the quality and delivery of health care; to conduct research in the health and health-related fields; and to respond to the health care needs of the community. The Parties of this Agreement believe these goals may be achieved more effectively and efficiently through the combination of the resources of the Parties.

The Parties agree as a basic principle of their relationship that they shall continue to exist and function as independent institutions. The Hospital shall remain autonomous, and its affairs shall be managed by such executives, officers, directors, and managers as, from time to time, may be chosen for this purpose. It is agreed, however, that the University and no other shall have primary rights and responsibilities with respect to teaching and that the Hospital shall have primary responsibility with respect to patient care in the areas of activity governed by this Agreement.

This Agreement is designed to provide the basis for fulfillment of the objectives of the Schools and their affiliated Clinical Education Centers while preserving the prerogatives and integrity of each, and supersedes any previously existing agreement now operational between the Hospital and the University.

TERMS OF THIS AGREEMENT

I. Faculty and Hospital Staff Appointments

A. The Board of Directors of Mercy Hospital shall control the appointments to the staff of the Hospital. The University shall control the appointments to the faculty of the Schools and the College of Medicine. Nothing in this Agreement changes the basic powers of the respective Parties to make such appointments.

B. For certain responsibilities, the Schools may wish to appoint salaried faculty to the Clinical Education Center. In such cases, the Schools must have the concurrence of the Hospital in the decision and the Hospital must be represented in the procedure of search, selection and appointment.

C. Included among the faculty assigned to the Hospital will be a Director of the Clinical Education Center responsible to the Dean of the Schools and to the Hospital's Chief Executive Officer. The Director's responsibilities will be listed in a job description mutually agreed to by the Parties hereto.

D. All such appointments shall be made and shall continue subject to the By-Laws of the Hospital or faculty regulations of the University, whichever is applicable, as amended from time to time, including provisions relating to pensions and retirements. Neither the Hospital nor the University shall incur obligation for the other with respect to any appointee except as stated in the Agreement or hereafter agreed between the Parties, nor incur any obligation contrary to their separate By-Laws.

In each case, sub-contracts and job descriptions will define the responsibilities and requirements of the position referred to in B and C immediately above. To be eligible for such positions, candidates shall meet eligibility requirements for staff appointment to the Hospital and have the approval for staff membership by the Board of Directors.

E. If such individuals are to provide reimbursable services to the Hospital, appropriate income sharing arrangements may be developed in the form of affiliation sub-contracts.

F. The Affiliated Hospital retains the right to appoint candidates to its staff without University approval. Such persons shall not be formally engaged in the University educational programs unless first given a faculty appointment. If such persons are salaried by the Hospital and provide reimbursable educational services to the School, appropriate cost and/or salary sharing arrangements will be developed in the form of affiliation sub-contracts.

G. Physicians currently on the staff of the Hospital who hold faculty appointments in medical schools other than the University of Illinois may be offered appointments to the faculty of the Schools and the College of Medicine if approved for such appointments by the University. Participation by such physicians in the College of Medicine program is encouraged. Such physicians who wish to maintain their faculty appointment at an institution other than the University of Illinois will be allowed to do so by the University.

H. All classes of faculty referred to in B, C and G above, as well as others who may be appointed by the University and approved by the hospital, will constitute the faculty of the Clinical Education Center.

II. Patients and Teaching Programs

All patients under the care of the medical staff of the Hospital will be included in the educational programs, and the Hospital will solicit the cooperation and the signed consent of all patients in this endeavor. It is contemplated that the educational programs developed between the Parties will involve hospitalized patients and non-hospitalized patients. If in the opinion of the attending physicians inclusion of a patient in the educational program will jeopardize the welfare of the patient, or if the patient refuses consent, the patient will not be included in the educational programs - such fact will be recorded by the attending physician in the medical record.

III. Students

A. The Parties recognize health professional students at all levels to be integral members of the health care team. Students will be permitted appropriate degrees of supervised responsibility according to their level of education and demonstrated individual competency.

B. Although decisions concerning numbers of students in various categories assigned to the Clinical Education Center will be mutually agreed upon in advance, the individual student assignment to the Clinical Education Center is a School responsibility.

C. Students may not receive cash payments or other perquisites while assigned to the Hospital unless specific agreements to the contrary approved by the Dean of the Schools and the Chief Executive Officer of the Hospital are set out.

D. Resident physicians, although still considered as students, should be recognized as approaching the point for independent responsibility.

E. The fiscal arrangments governing Residency will be individually defined in separate affiliation sub-contracts.

IV. Curriculum

The organization, establishment of and decision concerning curriculum will be the responsibility and the right of the University, acting through the faculty of the Schools in the College of Medicine. (The faculty of the Schools includes the faculties of all components.)

V. Space

A. The Schools will support financially the space within the Clinical Education Center which is necessary and appropriate to accomplishment of the Schools' teaching and research objectives.

B. The space assigned as Director's Office and any other space used primarily for School activities shall bear the conspicuous designation Mercy

Hospital Clinical Educational Center, University of Illinois College of Medicine, Schools of Basic Medical Sciences and Clinical Medicine, Urbana-Champaign.

C. To the extent that the facilities of the Hospital are used by the University, the teaching programs for medical students shall be the primary responsibility of the University. The University shall cooperate in providing instructional resources for medical education, and the Hospital will, in turn, cooperate in providing the clinical setting for clinical instruction.

VI. Costs

Costs related to patient care and community service are the responsibility of the Hospital. Costs related to the University of Illinois approved and sponsored education programs are the responsibility of the University. Costs which cannot be clearly assigned to one activity or the other shall be allocated between the Parties by written agreement, prior to a commitment for any expenditures to be made.

VII. Exclusivity

Members of the faculty of the University who are appointed to the staff of the Hospital will have primary responsibility for the teaching of interns, residents and medical students. The Hospital shall not affiliate with or provide teaching facilities for any instruction of higher learning for medical students other than those of the University of Illinois, except by agreement between the Parties.

Likewise, the University shall not designate any other affiliated volunteer hospital in Region 3-B as having a higher level of teaching affiliation or responsibility than Mercy Hospital, except by agreement between the Parties.

VIII. Initiation and Termination

A. This Agreement shall become effective on signing, and may be terminated upon one year's notice in writing by either Party to the other. It may be amended at any time by mutual agreement. Nothing in the Agreement is intended to be contrary to State or Federal laws or regulations, and in the event of conflict, the State and Federal laws supersede this Agreement.

B. Coordination and implementation of the provision of this Agreement shall be effected through regular and frequent conferences and consultations between the Dean of the Schools or his Designee and the Chief Executive Officer of the Hospital or his Designee. In addition, an Ad Hoc Advisory Committee may be convened from time to time by either the Dean of the Schools or the Chief Executive Officer of the Hospital for discussion and review of any subject of joint concern between the University and the Hospital. This Committee may be composed of, but not necessarily limited to, the following: the Dean of the Schools, one faculty member from the Schools, the President of the Hospital's Board of Directors, the Chief Executive Officer of the Hospital, and a member of the medical staff of the Hospital.

C. As set forth in the opening paragraphs of this Agreement, many areas of cooperation will be required between the Parties and it is therefore agreed that in the arrangement of their physical facilities, administrative functions and other activities in which both have an interest, they will, to the extent feasible, work in close harmony in order to achieve the most economical and efficient utilization of their available resources.

D. This Agreement does not abrogate any existing agreements between the Hospital and other hospitals or schools nor between the University and other hospitals.

E. The President (or Designee) of the University and the President (or Designee) of the Board of Directors of the Hospital shall confer as necessary to review operations under this Agreement, discuss potential problem areas, and plan cooperative measures including the appointment of such committees as may be required to achieve in practice the maximum mutual benefit from the joint undertaking of their institutions.

IX. Benefits

Nothing contained herein shall be construed as conferring any benefits, rights, entitlements, or privileges on any person, organization or corporation not a Party hereto.

IN WITNESS WHEREOF, the Parties hereto have duly executed this Agreement, and caused their seals to be affixed hereto, the day and year first above written.

(SEAL)

ATTEST:

_____

MERCY HOSPITAL OF URBANA

Donald K. Aldrich, President

(4/14/78)

(SEAL)

_____

THE TRUSTEES OF THE
UNIVERSITY OF ILLINOIS

R. W. Brady

Comptroller

Earl W Porter

Secretary of the Board

The Jewish Hospital and Medical Center of Brooklyn

555 PROSPECT PLACE
BROOKLYN, N. Y. 11238

August 17, 1978

Mr. Richard M. Knapp
Director, Department of Teaching Hospital
Association of American Medical Colleges
One Dupont Circle, N.W.
Suite 200
Washington, D.C. 20036

Dear Dick:

In response to your letter of August 9, and as we discussed on the telephone yesterday, the Jewish Hospital wishes to remain a member of the Association of Medical Colleges but because of its poor financial condition, is unable to meet its dues obligations. The hospital is operating under the supervision of the State of New York as indicated in the attached letter from Richard Berman to Howard Miller dated May 3, 1978. The State of New York has extended the interim emergency rate beyond the July 31, expiration date with similar conditions. While the hospital has not entered court to arrange protection from its creditors, we are operating as if we were in a bankruptcy proceeding. Hopefully, the Association will be able to continue our membership because of the circumstances I have outlined above and I formally request that consideration be given to our dire financial circumstances.

Any other information which you need will be made available to you or any other appropriate official of the Association.

Sincerely,

JAY OKUN YEDVAB
Executive Vice President

JOY/ac

STATE OF NEW YORK
DEPARTMENT OF HEALTH OFFICE OF HEALTH SYSTEMS MANAGEMENT
TOWER BUILDING • EMPIRE STATE PLAZA • ALBANY, N.Y. 12237

ROBERT P. WHALEN, M.D.
Commissioner

RICHARD A. BERMAN
Director

May 3, 1978

Honorable Howard F. Miller
Division of the Budget
State Capitol
Albany, New York

Dear Dr. Miller:

Whereas section 2800 of the Public Health Law mandates the Commissioner of Health to provide for the protection and promotion of the health of the people of the State, and section 1396 (a) (10) (A) of Title 42 of the United States Code provides that a state plan for medical assistance shall provide for making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under various chapters of said Title 42;

Whereas the Jewish Hospital and Medical Center of Brooklyn (JHMCB) is located in a medically underserved area and currently serves large numbers of Medicaid eligible individuals who rely on JHMCB to meet their medical needs;

Whereas the State Hospital Review and Planning Council has adopted a resolution urging that assistance be provided to JHMCB to the extent possible under law to enable the hospital to continue to meet the needs of the community it serves;

Whereas closure would adversely affect the health and welfare of the residents of the community served by JHMCB;

Whereas JHMCB has accumulated considerable debt and is unable to meet current obligations, and unless immediate action is taken, bankruptcy and closure may be imminent;

Whereas examination of the records of JHMCB by the Office of Health Systems Management (OHSM) since promulgation of the 1978 inpatient rate has indicated that, because of weaknesses in the hospital's financial systems, statistical and financial information previously submitted in support of certain rates and appeals do not give adequate data upon which to adjudicate appeals and certify a revised medicaid rate on a timely basis pursuant to section 2807 of the Public Health Law;

Whereas JHMCB has agreed to install a system of management and financial controls which will insure, to the maximum extent possible, future financial stability.

Therefore, I certify that it is necessary, and in the public interest, to promulgate the proposed interim rates on the attached schedule for medical services rendered at JHMCB for the period January 1 through July 31, 1978, subject to adjustment

pursuant to applicable laws and regulations, and further subject to written acceptant by the hospital of the following understanding:

1. JHHCB shall on or before June 30, 1978 make application pursuant to Article 28 of the Public Health Law for approval of those services currently being provided without such approval.

2. The hospital shall not use Medicaid revenues attributable to patient care rendered on or after January 1, 1978 to pay for expenses incurred prior to January 1, 1978.

3. While it is the obligation of the hospital's board to manage its own affairs, the hospital's operations and management shall be subject to continuing review by OHSM. The hospital shall take such action as OHSM may require as a result of such review.

4. JHHCB shall submit to OHSM on or before June 30, 1978: (a) a financial and management plan which demonstrates the ability to meet current obligations with current revenues, (b) a financial and management plan which provides for the orderly payment of past-due obligations. The hospital's plan will indicate steps to be taken to reduce bad debts, improve productivity, and generate new sources of revenue. The plan will include proposals to restructure its management and board to provide increased accountability and more active oversight, to install improved cost contr and budgeting, and to establish more accurate and timely financial and managerial reports.

5. The hospital will act immediately to reduce costs so as to begin to bring its operating budget in approximate balance.

Implementation of such plan and any modification thereof shall take place only after the approval of OHSM. JHHCB shall provide such regular reports and information as OHSM shall request with respect to proposed expenditures and revenues and shall promptly inform OHSM of any significant deviations from plan and any material changes in its financial condition.

Sincerely yours,

Richard A. Berman
Director
Office of Health
Systems Management

The rates established are hereby approved.

Howard F. Miller
Director of the Budget

Attachment

SCHEDULE OF PROPOSED INTERIM RATES

FACILITY: Jewish Hospital and Medical Center of Brooklyn

COUNTY: Kings County

SERVICE	FROM	TO	EFFECTIVE PERIOD
Inpatient	$186.47	$210.00	1/1/78 - 7/31/78

COTH SPRING MEETING PLANNING COMMITTEE

Following is a list of committee members. The committee met on August 24, and Mr. Marylander will provide a summary of the group's recommendations.

Stuart Marylander - Chairman
Executive Vice President
Cedars-Sinai Medical Center
Los Angeles, California

Dennis R. Barry
General Director
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Robert E. Frank
President
Barnes Hospital
St. Louis, Missouri

A.A. Gavazzi
Hospital Director
Veterans Administration Hospital
Washington, D.C.

Bruce M. Perry
Executive Director
The University Hospital & Clinics
Oklahoma City, Oklahoma

David S. Weiner
President
The Children's Hospital Medical Center
Boston, Massachusetts

ANNUAL MEETING SCHEDULE

		Room
Sunday, October 22		
5:30 - 9:00 p.m.	Invitation Seminar for COTH Members Who Have Attended the Management Advancement Program	Marlboro A
Monday, October 23		
7:30 - 9:00 a.m.	COTH Administrative Board Breakfast	Newberry
9:00 a.m. - Noon	AAMC Plenary Session	Grand Ballroom
Noon - 4:30 p.m.	COTH Luncheon and Business Meeting	Salon 1
	"Multiple Hospital Systems and the Teaching Hospital"	
	"The Opportunities"	
	Ed J. Connors President Mercy Health Corporation Farmington Hills, Michigan	
	"The Problems"	
	Mark S. Levitan Executive Director Hospital of the University of Pennsylvania	
Tuesday, October 24		
9:00 - 10:30 a.m.	AAMC Plenary Session	Grand Ballroom
11:00 a.m. - 1:00 p.m.	AAMC Assembly	Ballroom A
12:30 - 2:00 p.m.	COTH Past Chairmen's Luncheon	Norwich

		Room
Tuesday, October 24		
1:30 - 4:00 p.m.	COD/CAS/COTH Joint Program	Ballroom D

Session I

"The Interplay of Governmental Regulation, Professional Responsibility and Market Forces in the Field of Health"

Alfred F. Dougherty, Jr.
Director, Bureau of Competition
Federal Trade Commission

Julius R. Krevans
Dean, University of California,
San Francisco
School of Medicine

Session II

"Biomedical Research and the Public Interest: The Role of Public Sector Regulation"

Laura Nader
Professor of Anthropology
University of California, Berkeley

Joshua Lederberg
President
Rockefeller University

faculty will include:

Don L. Arnwine
President
Charleston Area Medical Center
Charleston, WV

James A. Campbell, M.D.
President
Rush Presbyterian St. Lukes Medical Center
Chicago, IL

Edward J. Connors
President
Sisters of Mercy Health Corporation
Farmington Hills, MI

Jacques Cousin
President
Detroit Medical Center
Detroit, MI

Richard M. Knapp, Ph.D.
Director
Department of Teaching Hospitals
American Association of Medical Colleges
Washington, DC

Mark Levitan
Executive Director
Hospital of the University of Pennsylvania
Philadelphia, PA

Glenn R. Mitchell
Executive Director
Medical Center Hospitals
Norfolk, VA

Merlin L. Olson
Executive Director
University of Colorado Medical Center
Denver, CO

Hiram C. Polk, Jr., M.D.
Professor and Chairman of Surgery
University of Louisville Medical School
Louisville, KY

C. Thomas Smith
President
Yale-New Haven Hospital
New Haven, CT

Samuel O. Thier, M.D.
Chairman of Medicine
Yale-New Haven Hospital
New Haven, CT

Gail L. Warden
Executive Vice President
American Hospital Association
Chicago, IL

Donald C. Wegmiller
President
Health Central, Inc.
Minneapolis, MN

John H. Westerman
General Director and Associate Professor
University of Minnesota Hospitals and Clinics
Minneapolis, MN

MULTIHOSPITAL SYSTEM UNIVERSITY TEACHING HOSPITAL CONFERENCE

AUGUST 21 – 22, 1978
Rush Presbyterian St. Luke's Medical Center Academic Facility
Chicago, IL

Sponsored By

The Center for Multihospital Systems and
Shared Services Organizations
American Hospital Association
Chicago, IL

Department of Teaching Hospitals
Association of American Medical Colleges
Washington, DC

Rush Presbyterian St. Luke's Medical Center
Chicago, IL

conference objectives

- to inform academic health science centers and their teaching hospitals of the changing configuration in the structure of the hospital industry.
- to evaluate the potential impact of this evolving configuration on the medical schools and their teaching hospitals.
- to explore the dimensions of the interface, both in the public and private sectors, on the programs of the medical schools and their teaching hospitals in the areas of levels of care of patients and in the development of medical manpower.

monday, august 21, 1978

8:00 - 8:45 a.m.	Registration	
8:45 - 9:00	Welcome Address	James A. Campbell, M.D.
9:00 - 9:30	Keynote Address Conference Rationale	Gail L. Warden
9:30 - 10:00	Coffee	
10:00 - 11:00	University Teaching Hospitals and Multihospital Systems	Mark Levitan Hiram C. Polk, Jr. M.D. Samuel O. Thier, M.D.
11:00 - 12:00	Reactors Panel	Richard M. Knapp, Ph. D.
12:00 - 1:00	Lunch	
1:00 - 2:30	Multihospital System Implications	Don L. Arnwine Donald C. Wegmiller
2:30 - 3:00	Coffee	
3:00 - 4:00	Reactors Panel	C. Thomas Smith
4:15 - 7:00 p.m.	Cocktails/Dinner Speaker	

tuesday, august 22, 1978

9:00 - 10:30 a.m.	Multihospital Systems Models	James A. Campbell, M.D. Jacques Cousin Glenn R. Mitchell John H. Westerman
10:30 - 11:00	Coffee	
11:00 - 12:00	Reactors Panel	Merlin L. Olson
12:00 - 2:00	Lunch Summary and Discussion Adjournment	Edward J. Connors

PROGRAM

Multihospital Systems/University Teaching Hospital Conference
Chicago, Illinois
August 21 - 22, 1978

Monday, August 21, 1978

Time	Activity	Location
	Moderator: Dr. Samuel Levey	
9:00 - 9:30 A.M.	General Session Keynote Address - Gail L. Warden	Room 434A Academic Facility
9:30 - 10:00	Coffee	Room 600
10:00 - 11:00	General Session Mark Levitan Hiram C. Polk, Jr., M.D. Samuel O. Thier, M.D. Joseph M. White, M.D.	Room 434A Academic Facility
11:00 - 12:00	Reactors Panel Red Group Blue Group Green Group	 Room 434A Room 435A Room 438 Academic Facility
12:00 - 1:00 P.M.	Lunch	Room 600
	Moderator: David G. Dickenson, M.D.	
1:00 - 2:30	General Session Don L. Arnwine Robert E. Toomey Donald C. Wegmiller	Room 434 A Academic Facility
2:30 - 3:00	Coffee	Room 600
3:00 - 4:30	Reactors Panel Red Group Blue Group Green Group	 Room 434A Room 434A Room 438 Academic Facility
5:00 - 7:00	Reception/Dinner Speaker - Robert M. Sigmond	Room 600

Tuesday, August 22, 1978

Time	Activity	Location
	Moderator: David L. Everhard	
8:30 - 10:00 A.M.	General Session James A. Campbell Jacques Cousin Glenn R. Mitchell John H. Westerman	Room 434A Academic Facility
10:00 - 10:30	Coffee	Room 600
10:30 - 12:00	Reactors Panel	
	Red Group	Room 434A
	Glue Group	Room 435A
	Green Group	Room 438 Academic Facility
12:00 - 2:00 P.M.	Lunch Summary and Discussion: Richard M. Knapp, Ph.D.	Room 600

FASB DISCUSSION MEMORANDUM

an analysis of issues related to

Conceptual Framework for Financial Accounting and Reporting: Objectives of Financial Reporting by Nonbusiness Organizations

June 15, 1978

Financial Accounting Standards Board
HIGH RIDGE PARK, STAMFORD, CONNECTICUT 06905

Page Number

CONTENTS

OBJECTIVES OF THIS PROJECT

On May 11, 1978, the Financial Accounting Standards Board (FASB) added to its technical agenda a project to determine the objectives of financial reporting by organizations other than business enterprises. This project is part of the Board's effort to develop a conceptual framework for financial accounting and reporting and, as such, will deal with broad conceptual issues rather than specific standards. The project is intended to result in an FASB Statement of Financial Accounting Concepts setting forth the objectives of financial reporting for organizations other than business enterprises. Implicit in that broad goal are two narrower objectives, namely, (1) to determine whether the objectives of financial reporting by nonbusiness organizations (governmental units and private nonprofit organizations) are the same as or different from those of business enterprises and (2) to determine whether the objectives of financial reporting are the same for all nonbusiness organizations or are different for various classes of nonbusiness organizations, such as governmental units and private nonprofit organizations.

On December 29, 1977, the FASB issued an Exposure Draft of the first *Statement of Financial Accounting Concepts*, "Objectives of Financial Reporting and Elements of Financial Statements of Business Enterprises." The purpose and standing of the series was explained in that Exposure Draft as follows:

> . . . The purpose of the series is to set forth fundamentals on which financial accounting and reporting standards will be based. More specifically, Statements of Financial Accounting Concepts are intended:
>
> - To establish the objectives and concepts that the Financial Accounting Standards Board will use in developing standards of financial accounting and reporting.
> - To provide guidance in resolving problems of financial accounting and reporting that are not addressed in authoritative pronouncements.
> - To enhance the assessment by users of the content and limitations of information provided by financial accounting and reporting and thereby further their ability to use that information effectively.
>
> Unlike a Statement of Financial Accounting Standards, a Statement of Financial Accounting Concepts does not establish accounting principles within the meaning of Rule 203 of the Rules of Conduct of the AICPA (or any successor rule or arrangement of similar scope and intent). Like other pronouncements of the Board, a Statement of Financial Accounting Concepts may be amended, superseded, or withdrawn by appropriate action under the Board's Rules of Procedure.[1]

The Statement resulting from this project is expected to have a similar standing.

Coincident with its decision to add this project to its technical agenda, the FASB decided to defer, pending further study, adding projects involving specific accounting standards for nonbusiness entities, either private or governmental.

This project will consider four broad questions abou the objectives of financial reporting of nonbusiness organizations:

- Who uses their financial reports?
- For what purposes is the information in those reports used?
- What types of financial information help satisfy those needs?
- What, if any, criteria should be employed to differentiate various kinds of organizations in establishing objectives of financial reporting?

Those matters, along with others, are considered in an *FASB Research Report*, "Financial Accounting in Nonbusiness Organizations, An Exploratory Study of Conceptual Issues" (the Research Report) prepared by Professor Robert N. Anthony of the Harvard Business School. That report was published by the FASB on May 15, 1978. The inside cover of this Discussion Memorandum gives details on how copies of the Research Report may be obtained.

PURPOSE OF THIS DISCUSSION MEMORANDUM

The purpose of this Discussion Memorandum is to:

- Focus on certain specific issues in the Research Report upon which the FASB desires public comment.
- Identify relevant sections of the Research Report containing arguments on both sides of each issue.
- Amplify certain aspects of those issues.
- Provide specific information about dates and places of public hearings.

The Discussion Memorandum considers all of the issues raised in the Research Report except those raised in Chapter 4 (Issues 9 - 13) which deal more with questions of specific accounting standards than with objectives. Since this project does not involve standards, this Discussion Memorandum does not explicitly consider those issues. Nonetheless, respondents should study those issues as practical aids in framing objectives and as specific implementation issues that must fit within the underlying conceptual framework. In addition, respondents should feel free to comment on those issues and relate them to the specific issues included in this Discussion Memorandum.

RELATIONSHIP OF THE DISCUSSION MEMORANDUM TO THE RESEARCH REPORT

This Discussion Memorandum does not stand alone. It is intended to be used with the Research Report, and respondents should read the entire Research Report before re-

sponding to the issues in the Discussion Memorandum. Respondents should particularly note that:

1. Dr. Anthony has taken pains to use a uniform terminology in his discussion of the issues. He gives his reasons in the preface to the Research Report:

> Of the many problems that had to be dealt with, one of the most perplexing, from a practical standpoint, was to decide on terminology. Among various nonbusiness organizations, different terms are used for the same ideas, and the same term for different ideas. For the purpose of communicating in this study, it was necessary to develop a standard set of terms. These changed with each successive draft because of unintended inferences that advisors pointed out. The terms in the final report are intended to be both understandable and also free from an implicit bias in favor of one point of view. Readers may find it difficult to adjust to terms with which they are unfamiliar, but I trust they will appreciate the necessity for a standard nomenclature.[2]

2. This Discussion Memorandum adopts the terminology of the Research Report. Respondents, accordingly, should bear in mind the definitions given to terms in the Research Report, which are listed below. In certain cases, these definitions differ from ones currently employed in certain nonbusiness organizations. Use of the Research Report definitions in this Discussion Memorandum does not imply that the FASB agrees or disagrees with these definitions.

   a) *Financial Resource Inflows.* All financial resources made available during an accounting period that increase the organization's equity. They consist of (1) operating inflows and (2) capital inflows.

   b) *Operating Inflows.* Financial resource inflows that are related to operating activities of the current period. They include (1) revenues and (2) other operating inflows. (Gains and losses are excluded from the discussion in the interests of simplicity.)

   c) *Revenues.* Amounts realized in exchange for goods and services during the current period. More technically, "gross increases in assets or gross decreases in liabilities (or a combination of both) from delivering or producing goods, rendering services, or other earning activities of an enterprise during a period."

   d) *Other Operating Inflows.* (Or nonrevenue inflows.) All operating inflows other than revenues. Examples are contributions, appropriations made by another entity, grants, and taxes, to the extent that these inflows are related to the operating activities of the current period.

   e) *Capital Inflows.* All financial resource inflows other than operating inflows. Examples are contributions, appropriations made by another entity, grants, and taxes, to the extent that these inflows are intended for the benefit of activities of future periods, rather than those of the current period.

   f) *Asset Conversions.* Transactions that convert an asset or liability into another asset or liability but that do not result in a change in the organization's equity.

g) *Expenses.* A monetary measure of the amounts of goods and services used for operating activities of the current period.

h) *Expenditures.* A monetary measure of the amounts of goods and services acquired during the current period, whether or not used in operating activities of that period.

i) *Operating Statement.* A financial statement that reports operating inflows, expenses, and the difference between them during the current period.

j) *Financial Flow Statement.* A financial statement that reports some or all of the financial resource inflows, expenditures, and/or asset conversions during the current period.[3]

k) *Spending* has to do with the resources used in an accounting period. It is an intentionally vague term, broad enough to encompass the alternative specific concepts of encumbrance, expense, expenditure, or cash disbursement. Its only purpose is to permit statements to be made that do not imply a preference for one of these specific concepts. It is *not* recommended for use in a concepts statement; a concepts statement should use one or more of the specific terms, depending on the approach that is finally decided upon.[4]

3. Dr. Anthony uses a specific methodology in discussing issues which is explained in Chapter 1 of the Research Report.

a) Background material is given that describes the nature of the problem and various alternative approaches that have been proposed for resolving it. This material is intended to be entirely descriptive; if any value judgments are inferred, their inclusion is unintentional.

b) Based on this background, the issue itself is stated briefly. This brief statement provides a convenient way of referring to the issue, but the reader should recognize that in the interest of brevity, nuances described in the background material may have been slighted or overlooked.

c) Relevant considerations relating to the issue are listed. Essentially, these are pros and cons for each of the alternative ways of resolving the issue.[5]

4. Dr. Anthony also adopts certain limitations on the scope of the Research Report and certain premises that underlie it. Those matters are discussed on pages 7 - 27 of the Research Report. Respondents should review that section of the Research Report carefully because the limitations on scope and premises are important in understanding how Dr. Anthony has framed the issues. For example, the overriding scope limitation is that:

> This study is limited to objectives and concepts for *general purpose financial reporting* by nonbusiness organizations. [Emphasis added.] [6]

Because of that focus, the following matters, among others, are excluded from the Research Report (and from this Discussion Memorandum): internal accounting, special purpose reports, and human resource and social accounting.

5. Dr. Anthony, in the interests of concreteness and clear exposition, also uses in Chapter 3 of the Research Report several schematic financial statements, and poses certain issues in terms of them. This project is concerned with the general type of information included in financial statements and not with format or details of the statements. Accordingly, the project does not involve questions about which financial statements should be required or their specific format.

The format of the Discussion Memorandum, in listing and discussing the issues raised in the Research Report, is as follows: First, the issues are grouped under four headings which are similar to the broad questions about the objectives of financial reporting of nonbusiness organizations described on page 2 of the Discussion Memorandum. Next, for some issues, a brief discussion of the background of the issue is included. Then, the issue is stated (as it appears in the Research Report), and relevant discussion in the Research Report is cited. Finally, for most issues, certain parts of the issue are amplified to encourage comments by respondents on particular aspects of Dr. Anthony's issues.

SUGGESTIONS TO RESPONDENTS

The issues presented in this Discussion Memorandum have been designed to elicit answers to questions about the objectives of financial reporting of nonbusiness organizations. However, the structure of the issues is not intended to inhibit discussion, and respondents may address other matters they believe to be relevant. Respondents are urged to reply to all of the issues presented. Evaluation of responses will be facilitated if respondents set forth not only their conclusions on each issue, but also their reasons for those conclusions. It will be particularly helpful if, in presenting their reasons for those conclusions, respondents refer, where appropriate, to:

1. Any empirical evidence that supports their conclusions or shows why alternative conclusions should be rejected.
2. The qualities of useful financial information referred to on page 27 of the Research Report, e.g., relevance, reliability, comparability, and understandability.
3. The potential economic and other consequences of adoption of the financial reporting objectives they advocate and the objectives they reject. In reflecting on potential economic and other consequences, respondents are urged to consider the potential relative impacts of alternative objectives on their own organization, organizational group, or other organizational groups, and on the U.S. economy and society as a whole, and to submit any evidence of those potential impacts that is available to them.
4. The probable accounting and administrative costs of implementing the objectives they advocate, compared with the costs of implementing alternative objectives.

ISSUES TO BE ADDRESSED BY RESPONDENTS

Users of Financial Statements of Nonbusiness Organizations

ISSUE ONE: Is the following list of primary users of financial report information adequate for the purpose of identifying needs for such information: governing bodies, investors and creditors, resource providers, oversight bodies, and constituents? (Research Report – Chapter 2, pages 39 - 46.)

The FASB also encourages respondents to set forth their views on:

a. The importance of classes of users (i) in general and (ii) for particular types of organizations.
b. Differences in importance of various classes of users among different types of organizations. For example, are investors and creditors (as a class) equally important users of financial reports of philanthropic organizations and governmental units?

User Needs – Purposes for Which Information Is Used

ISSUE TWO: Is the following list of the types of financial report information needed by users adequate as a basis for deciding how best to meet these needs: financial viability, fiscal compliance, management performance, and cost of services provided? (Chapter 2, pages 47 - 53.)

The FASB also encourages respondents to comment on:

a. The importance of each of the needs.
b. Whether those needs differ in importance for different organizations or classes of organizations.

Types of Financial Information to Satisfy User Needs

This general topic includes all the issues (numbers 3 - 8) raised by Dr. Anthony in Chapter 3 of the Research Report. In that Chapter, Dr. Anthony sets up various types of financial statements with rigorously defined content, and arranges issues relating to those statements in an order that is intended to facilitate the discussion of various arguments pertaining to the kinds of financial information needed by users. Respondents should keep that use of financial statements in mind in responding to Issues Three through Eight. That is, respondents should not address questions of financial statement format, but rather should address the usefulness of the different kinds of information contained in the different types of financial statements. Respondents should relate their views on the desirability of providing certain types of information to users with their views on how that information is useful to various kinds of users and for various purposes.

ISSUE THREE: **Do users need a report of operating flows that is separate from a report of capital flows?** (Chapter 3, pages 71 - 76.)

The FASB also encourages respondents to comment, both for this issue and for later issues, on various aspects of this "separation" issue, namely:

a. The relevance and significance of separating operating and capital flows in reporting *financial resource inflows* of nonbusiness organizations. Respondents should specifically consider and comment on Dr. Anthony's definitions of "operating inflows" and "capital inflows" in answering that question (page 3 of this Discussion Memorandum). Examples of capital inflows under those definitions are inflows of financial resources restricted to use as endowment or plant funds and capital grants in enterprise funds of governmental units.

    1) Respondents should describe how the separation or lack of separation in reporting resource inflows relates to their views on users and their needs.
    2) Respondents should indicate whether this problem is the same for private nonprofit organizations and governmental units.

b. The relevance and significance of separating operating and capital flows in reporting *spending* (see definition of that term on page 4 of this Discussion Memorandum). This aspect of the "separation" issue is considered in greater detail in Issues Four, Five, and Six of this Discussion Memorandum.

ISSUE FOUR: **Do users need an operating statement?** (Chapter 5, pages 76 - 93.)

The FASB also encourages respondents to review carefully Dr. Anthony's definition of an operating statement (page 4 of this Discussion Memorandum) before commenting on this question. The statement reports operating inflows and expenses and has a "bottom line" (the difference between operating inflows and expenses). The FASB is especially interested in and specifically requests respondents' views on how, if at all, the above information, taken together or displayed individually, helps satisfy the user needs enumerated in previous issues or raised independently by respondents. In that regard, Dr. Anthony notes on page 82 of the Research Report:

> The question of whether spending should be measured in terms of expenditures or in terms of expenses is often stated as a controversy between the "flow of resources approach" and the "cost determination approach."

Respondents should review carefully the arguments on pages 82 - 85 of the Research Report and address the controversy referred to in the above quotation. Thus, views on the following matters would be helpful.

a. Is the nature of this controversy similar for all parts of the nonbusiness sector, or does it differ for different organizations or classes of organizations? Is the

controversy principally limited to aspects of financial reporting for governmental units? If so, why?

b. How do budgetary considerations (the need to report fiscal compliance) impact on this issue?

ISSUE FIVE: **Do users need a report of cost of services performed?** (Chapter 3, pages 93 and 94.)

ISSUE SIX: **Should financial flow statements report encumbrances as well as, or instead of, expenditures?** (Chapter 3, pages 94 - 98.)

The FASB also requests that respondents comment on:

a. The way in which reporting on encumbrances (defined on page 95 of the Research Report) helps satisfy the user needs discussed in previous issues.

b. Whether this Issue is significantly more important for governmental units than for nongovernmental organizations. Is it a significant Issue in private nonprofit organizations?

ISSUE SEVEN: **Do users need a single, aggregated set of financial statements for the organization rather than separate financial statements for each fund group? If the latter, what criteria should determine the composition of fund groups?** (Chapter 3, pages 98 - 114.)

The FASB also requests that respondents relate their answer to this Issue to their previous views on users and their needs. In this regard, respondents are reminded that the Research Report on pages 18 - 21 excludes issues about defining the organization from its scope. This Discussion Memorandum has a similar exclusion. Accordingly, a Statement of Financial Accounting Concepts issuing from this project will not speak directly to that topic.

ISSUE EIGHT: **Are there conceptual issues related to the balance sheet?** (Chapter 3, pages 114 and 115.)

The FASB also requests that respondents consider the ways that issues relating to the balance sheet affect the formulation of objectives of financial reporting of nonbusiness organizations. In this regard, respondents may wish to review the tentative definitions of assets and liabilities which are presented in paragraphs 47 - 50 of the FASB Exposure Draft of a *Statement of Financial Accounting Concepts*, "Objectives of Financial Reporting and Elements of Financial Statements of Business Enterprises" and consider in what respects those definitions should be the same or different for nonbusiness organizations. Alternatively, respondents may wish to address this Issue independent of the Exposure Draft. In either case, respondents should address the following questions:

a. What types of information do balance sheets of nonbusiness organizations convey to users that is important in helping to satisfy their information needs?
b. Is that information different from information conveyed in the balance sheets of business enterprises?
c. Is that information different for different types of nonbusiness organizations?
d. Respondents are also encouraged to relate their comments on the balance sheet to their comments on the flow concepts of expense, expenditure, and encumbrances covered in Issues Three through Seven. In what ways do differing flow and stock concepts interact in conveying information to users of financial reports of nonbusiness organizations?

Criteria to Set Boundaries for Objectives of Financial Reporting

ISSUE FOURTEEN: How, if at all, should business organizations be distinguished from other organizations for the purpose of developing accounting concepts? (Chapter 5, pages 159 - 175.)

The FASB also encourages respondents to:

a. Relate the discussion in the Research Report to the questions of users and their information needs and show whether the profit/nonprofit approach or the source of resources approach coincides with differences in users and their needs.
b. Indicate other possible criteria that should be employed to differentiate various kinds of organizations in establishing objectives of financial reporting.

ISSUE FIFTEEN: Should the federal government and/or the state governments be excluded from the applicability of financial accounting concepts for nonbusiness organizations? (Chapter 5, pages 175 - 179.)

ISSUE SIXTEEN: Should a single set of concepts apply to all types of nonbusiness organizations, or should there be one set for governmental organizations and one or more additional sets for nongovernmental nonbusiness organizations? (Chapter 5, pages 180 - 194.)

The FASB also encourages respondents to relate their answer to this question to their previous views on users and information needs.

NOTES

[1]Financial Accounting Standards Board, *Proposed Statement of Financial Accounting Concepts*, "Objectives of Financial Reporting and Elements of Financial Statements of Business Enterprises" (Stamford, Conn.: FASB, December 1977), p. i.

[2]Anthony, Robert N., *Research Report*, "Financial Accounting in Nonbusiness Organizations, An Exploratory Study of Conceptual Issues" (Stamford, Conn.: FASB, May 1978), p. vi.

[3]Ibid., pp. 60 and 61.

[4]Ibid., p. 30.

[5]Ibid., p. 29.

[6]Ibid., p. 7.

Financial Accounting Standards Board

Financial Accounting in Nonbusiness Organizations

An Overview of the Research Report by Robert N. Anthony

This summary document is provided for persons interested in a capsulized view of the Research Report on Financial Accounting in Nonbusiness Organizations issued by the Board in May 1978.

INTRODUCTION

This overview has been prepared by the staff of the FASB for those who wish to be generally informed of the purpose and broad thrust of Dr. Anthony's study but do not wish to read the full study. Some of the issues from the study are repeated verbatim in this overview. To minimize perceived bias and disputes about semantics, Dr. Anthony has rigorously defined for purposes of the study many of the terms used in stating those issues. It is doubtful whether a reader can adequately interpret those issues without reading them in the context of the definitions and limitations which are spelled out in the study, and the serious reader is advised to read the full study before considering a response to the issues.

BACKGROUND

The decade of the 1970's has witnessed growing concern over the accountability of "nonbusiness organizations" — private nonprofit institutions and governmental units. Against the backdrop of the New York City fiscal crisis, the escalating costs of higher education, medical care, and social welfare programs, and widely publicized assertions of mismanagement in some governmental and philanthropic organizations, a growing number of private citizens and public officials have questioned the reliability and the relevance of the financial accounting and reporting by those organizations.

Public concern has been expressed through several avenues. Legislative initiatives have included proposals calling for uniform accounting principles for some organizations, such as charities, municipalities, and hospitals. Much has been written questioning the accounting and reporting practices of nonbusiness organizations. Others have defended the traditional practices and a general, albeit somewhat unfocused, debate has ensued. Finally, persons representing diverse interests have called upon the Financial Accounting Standards Board

(FASB) to play a role. In its April 1977 report, the Structure Committee of the Financial Accounting Foundation said "the Board must deal with municipal accounting." Others have suggested that the FASB expand its "conceptual framework" project to include a consideration of organizations other than business enterprises.

Those concerns led the FASB in August of 1977 to commission Professor Robert N. Anthony of Harvard University to undertake an exploratory study of the objectives and concepts underlying financial accounting and reporting for organizations other than business enterprises. The FASB also invited 53 advisors drawn from the broad universe of private and governmental organizations and groups to assist Dr. Anthony. Working with the advisors, in the relatively brief time span of nine months, Professor Anthony has produced the study *Financial Accounting in Nonbusiness Organizations, An Exploratory Study of Conceptual Issues* published in May 1978 by the FASB.

PURPOSE AND CONTENT OF THE STUDY

The aim of the study is to identify and define the issues in order to stimulate and focus public discussion. As such, the study is intended to assist the FASB to evaluate whether it is feasible and desirable for it to become involved in specific projects relating to accounting for nonprofit organizations and, if so, the nature and scope of the projects. With this purpose in mind, the study is organized to raise substantive issues and give arguments on each side, with no attempt to resolve the issues. The study broadly covers the following topics:

- It explores the current state of financial accounting and reporting by nonbusiness organizations.

- It attempts to identify the users of external financial statements of nonbusiness organizations and their information needs.

- It relates those user needs to information supplied by different types of financial statements.

- It explores certain specific financial accounting and reporting areas that are controversial and non-uniform, such as pensions and depreciation.

- It concludes by exploring the appropriate boundaries for a set of accounting concepts for nonbusiness organizations, including the question of whether separate accounting concepts are needed for nonbusiness organizations, and whether separate concepts may be needed for the governmental, nongovernmental, or other categories of the nonbusiness spectrum.

Current State of Nonbusiness Accounting

Accounting principles have developed differently for nonbusiness organizations and business enterprises. For the latter group, accounting principles have, since the 1930's, been established primarily by one authoritative body. Today it is the FASB. The force of the accounting profession's rules of ethics and the regulations of the Securities and Exchange Commission stand behind these principles of accounting and reporting for business.

For nonbusiness organizations, however, accounting principles have evolved along institutional lines. Therefore, different, and sometimes contradictory, accounting principles have developed for federal, state, and local governments, universities, hospitals, social welfare organizations, churches, museums, and others. These principles have been recommended by industry accounting groups, committees of the American Institute of Certified Public Accountants, and others, notably the National Council on Governmental Accounting (NCGA) and its predecessors. In government, the diversity is accentuated by the fact that some state legislatures have established accounting rules and practices that are different from those recommended by NCGA. Moreover, in general, the recommendations of these standards groups have not had the force of the accounting profession's rules of ethics, or an

institution comparable to the SEC to stand behind their application in practice.

Currently, major projects are underway by the NCGA, The Council of State Governments, and various AICPA committees, among others, to improve and make more uniform the accounting principles followed in various nonbusiness spheres. Some of those involved in these projects acknowledge that the lack of an agreement on basic objectives and concepts hampers their efforts.

Users and Uses of Nonbusiness Financial Statements

In exploring the users of financial statements, Dr. Anthony identifies five groups who use financial statements of nonbusiness organizations. These groups, as fully defined in the study, include governing bodies, investors and creditors, resource providers, oversight bodies, and constituents. As the first issue of the study, Dr. Anthony asks if there are other significant users of financial reports.

The study then asks what information about nonbusiness organizations the users need that financial statements might furnish. It considers four broad categories of information:

1. Financial viability — "information that indicates the organization's ability to continue to provide the services for which it exists."

2. Fiscal compliance — "The management of a nonbusiness organization ordinarily must comply with a number of spending mandates, such as budgetary constraints in government. Users want assurance that these mandates have been complied with and that resources have been used for the intended purpose."

3. Management performance — "Management's responsibility is greater than merely complying with the rules. Management is fundamentally responsible for spending money wisely. Thus, users are interested in how well the money was spent, to the extent that accounting can shed light on this."

4. Cost of services provided — "In most organizations the amount of spending for various programs is important information to users. Citizens are interested in how much their government spends for recreational facilities as compared with roads; prospective donors may be interested in the amount a college spends for its library as compared with its athletic programs."

Relating User Needs to Financial Statements

In this discussion, Dr. Anthony sets up various types of financial statements (rigorously defined as to content) and arranges issues relating to these statements in an order that is intended to facilitate the discussion of the arguments that have been raised about financial information to satisfy user needs. The reader is asked to consider six issues relating to the most meaningful information about financial resource flows, including arguments for and against a conventional "operating statement" similar to the income statement in a business enterprise. Here Dr. Anthony also discusses the aggregation issue—do users need a single, aggregated set of financial statements for the organization rather than separate financial statements for each fund group?

Selected Issues

The study considers five selected issues of financial accounting and reporting in nonbusiness organizations. As Dr. Anthony indicates, the issues selected are not intended to be a complete list. "Rather they were selected as indicative of the type of problems that should be addressed in arriving at accounting concepts and standards for nonbusiness organizations." These issues include:

1. How should the nonrevenue operating inflows (such as taxes and contributions) of an accounting period be measured?

2. How should endowment earnings be measured?

3. Under what circumstances, if any, should depreciation be recorded?

4. Should pension costs be accounted for in the period in which the related services were rendered?

5. Under what circumstances, if any, should donated or contributed services be recorded?

Boundaries for Nonbusiness Accounting Concepts

Certain fundamental issues are discussed in the last chapter of the study. Herein, Dr. Anthony notes that the conceptual framework currently being developed by the FASB relates specifically to business enterprises, though the term "business enterprises" is not defined. His study points up the difficulties in drawing a sharp line between business enterprises and other organizations so that each entity will be seen clearly to belong in one group or the other. He explores the advantages and disadvantages of two approaches: one based on legal definition — profit versus nonprofit — and the other based on sources of financial resource inflows — revenues from the sale of goods and services versus taxes, contributions, and the like. He asks for suggestions on other possible approaches. He also explores the premise that a single set of accounting concepts should apply to all enterprises, whether business or nonbusiness.

Resolution of those issues is fundamental to a definition, or stratification, of a universe of enterprises that share enough common economic characteristics that they may properly share a common conceptual framework for financial accounting and reporting.

The boundary issues are stated as:

- How, if at all, should business organizations be distinguished from other organizations for the purpose of developing accounting concepts?

- Should the federal and/or the state governments be ex-

cluded from the applicability of financial accounting concepts for nonbusiness organizations?

- Should a single set of concepts apply to all types of nonbusiness organizations, or should there be one set for governmental organizations and one or more additional sets for nongovernmental nonbusiness organizations?

CONCLUSION

The FASB hopes that all who are involved or interested in improving financial accounting and reporting — whether as users, issuers, attestors, or educators — will take the time to study Dr. Anthony's important work and give the Board the benefit of their views on the issues. The Board expects in the near future to solicit formal responses and announce dates and places for public hearings on at least some of the issues.