FEATURE STORY

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depreciating and stating the value of hospital buildings what you need to know

Hospital financial statements should accurately reflect the depreciated cost of their building's structure.

AT A GLANCE

- Healthcare financial executives of not-for-profit hospitals may be overdepreciating and understating the value of the hospital building on their financial statements.
- Changing the remaining lives of assets and their depreciation will help enhance the bottom line for many organizations.
- Ensuring that they are correctly stating the investment value of their assets is one way CFOs can have a positive impact on their organization's bottom line in a tough economy.

Are not-for-profit hospital financial executives overdepreciating their facilities? Are they understating the value of their facilities?

These are not intended to be trick questions. The answer to both questions is the same: Yes, they are overdepreciating their buildings and, as a consequence, are understating their investment value. Yet changing the lives of assets and their depreciation could help healthcare organizations improve their margins, which is particularly important in a troubled economy. Understating a building's investment value is contrary to the reporting requirements under the Sarbanes Oxley Act of 2002 and Financial Accounting Standards Board (FASB) Statement of Accounting Standards
No. 15, *Accounting by Debtors and Creditors for Troubled Debt Restructuring*.

How did this situation arise? Why is the situation continuing? And more important, can this situation be corrected and prevented?

How This Situation Arose

The advent of Medicare in 1966 put greater emphasis on depreciation of hospital buildings. Medicare started as a "cost-based" program. Therefore, for hospitals to be reimbursed for the allowable expense, their financial executives needed to be able to compute depreciation.

Computing depreciation requires two types of information:
> A record that reflects the cost or value of the hospital's assets
> A life over which financial executives expect the asset to be useful

Many hospitals in the 1960s did not have this information, so it needed to be developed. Medicare auditors accepted a number of different approaches to developing the cost basis of the assets. They also accepted the life recommendations detailed in the American Hospital Association's (AHA) *Chart of Accounts*, which recommended a 50-year life for hospital buildings in 1965. This recommended life was revised to 40 years in 1966. Currently, AHA's publication *Estimated Useful Lives of Depreciable Hospital Assets* shows a 40-year building structural component life. Depreciation is no longer a directly reimbursable expense for most hospitals.

From 1966 through 1991, both not-for-profit and for-profit hospitals did their utmost to maximize their depreciation expense for Medicare cost reporting purposes. As cost reimbursement was phased out during the 10 years (1991-2001) subsequent to the introduction of diagnosis-related groups, less attention was paid to depreciation. Subsequently, for-profit hospitals began using the same life for buildings in their financial statements as they did for tax reporting: 39.5 years.

Why 39.5 years? Over time, the IRS realized that if a hospital assigned a 40-year life to building structural components and even shorter lives—20 years—for building service components (such as electrical, plumbing, and HVAC), the hospital was effectively writing off the property in less than 30 years. The IRS correctly contended that there was too much existing evidence of actual hospital buildings lasting considerably longer than 30, 40, or 50 years. In fact, many hospital buildings today are more than 100 years old.

The 39.5 years is a composite life that encompasses structural elements with 80-, 90-, and 100-year lives and building service asset lives of 15, 20, and 30 years. When the building component is weighted by component dollars and assigned a life, the composite life for high-quality hospital construction will be equal to or greater than 40 years. A study of more than 400 hospital buildings and their components in which members of our firm took part found that most hospitals have composite lives in excess of 45 years.

Perpetuating the Situation

So the situation arose because not-for-profit hospitals were depreciating their building assets too quickly and thereby understating their investment value. Why did it continue?

A 40-year building structural life seems reasonable to people who are not construction experts and who see the life is backed up by data published by the AHA. Additionally, auditors tend to view the assignment of a longer life to an existing asset as a potential error when in fact it is not. The new remaining life is the factual reflection of a new assessment of the present status and expected future benefits associated with the asset. This is in accordance with FASB Statement of Accounting Standards No. 154, *Accounting Changes and Error Corrections*.

Many commercial and residential buildings are more than 50, 60, and even 70 years old. How does this happen? The simple answer is repair and maintenance with some remodeling and/or renovations. Over time, well-constructed buildings will have floors recarpeted, walls repainted, windows replaced, new wiring installed, and plumbing fixtures upgraded. The list of repairs and renovations will eventually include many or all of the short-lived building components. This is the normal expected life cycle of a building.

No one really believes a hospital building will be gone in less than 40 years. Hospitals do not normally relocate. Instead, they renovate existing facilities or acquire adjacent land for new construction. Remodeling and renovating are an accepted way of life. Although interior building components change and over time, the functions conducted within the building may change, the building structural components will remain the same.

Therefore, the building structural life of 40 years is inaccurate, as shown by the history of existing facilities, which prove a 45-year composite life is the norm. The building service lives are reasonably accurate.

As a result, a building structural life of 40 years continues to be accepted, causing an ongoing problem of not accurately representing hospital buildings' depreciated value on financial statements. Admittedly, depreciation is not the hottest topic in the accounting world of not-for-profits. Today's not-for-profit hospital property accounting is being conducted in the same aggressive fashion as it was when depreciation was a reimbursable cost: not because it is correct, but because it is self-perpetuating.

The Remedies

Two issues need to be addressed:

> How do we support a hospital building life that differs from what is published by the AHA?

> How do we get that life accepted by the hospitals and their outside auditors?

The life issue is the easiest to address. For more than 60 years, the appraisal industry has used Marshall & Swift, a Los Angeles-based firm that provides building cost data, as one of its major sources when assigning asset lives. Marshall & Swift's manual *Marshall Valuation Service* shows a 50-year composite life for hospital buildings. The manual also provides lives for some building components. A number of years ago, members of our firm undertook an effort to compile historical data on hospital lives throughout the country. We are continuing to add data to this study. This initiative was easily accomplished because quite often in the appraisal process, a detailed engineering analysis is required of the buildings. This analysis provides a wealth of data, including dates of construction, maintenance history of the facilities, effective age, and estimated remaining life of the building and its components. These data are all of the ingredients necessary to determine the actual building component lives and the corresponding actual composite life. The Hospital Building Life Analysis study now includes the life history of more than 400 hospitals and their associated buildings.

This historical information provides support for 70-, 80-, 90-, and 100-year lives for the structural components of a hospital building. This translates to 40-, 45-, and, in some cases, 50-year or more composite lives.

Reaching the outside auditors is the major issue. Correcting the overdepreciation and asset value understatement involves the development of new remaining lives for existing building assets. This effort is not actually correcting an error, but rather, changing an estimate. It involves conducting an engineering review of existing property and, based on this information, setting a remaining life. The American Institute of Certified Public Accountants recommends changing life estimates when new information becomes available through a review of the assets, how they have been used and maintained, and what history shows. This was established in FASB Accounting Principle Bulletin Opinion No. 20, *Accounting Changes*, which has been superseded by FASB Statement No. 154. FASB Statement No. 154 states, "A change in accounting estimate is a necessary consequence of the assessment, in conjunction with the periodic presentation of financial statements, of the present status and expected future benefits and obligations associated with assets and liabilities. Change in accounting estimates result from new information."

We know how to set a correct life on building assets, in particular their structural components. We know how to handle the balance sheet presentation. We have the necessary documentation to support these lives. The AHA has no supporting documentation for its 40-year life on building structural components, and the firms it cites as its source use a 50-year composite life for hospital buildings when determining their fair value.

Some not-for-profit hospitals, where we have conducted studies of existing facilities, have issued financial statements with an acknowledgement of the decrease in depreciation where it was material. Yet in general, the situation of not-for-profit hospital buildings being overdepreciated and their asset value being understated is still the norm rather than the exception.

As yet, Sarbanes Oxley does not apply to not-for-profit hospitals; therefore, their understatement of asset value is not perceived as a real problem. However, a correct reading of FASB Statement No. 154 requires the proper measuring of loss in value in a servicing asset from reporting period to reporting period and the reflection of the loss in value in both the income statement and balance sheet.

Some accounting firms are gently encouraging their not-for-profit hospital clients to start to bring their financial statements into compliance with Sarbanes Oxley, but most are not. Additionally, although the outside auditors know estimates in useful lives should be addressed and are easily handled in accordance with FASB Statement No. 154, they still appear to be reluctant to do so. They are far more willing to accept longer structural lives on new construction than they are on existing buildings. A change in lives on existing facilities could result in a footnote. No footnote would be required for new construction.

Financial Executive Responsibility

We have addressed how and why overdepreciation of hospital buildings developed, why it continues, and some remedies, and have acknowledged the fact that some not-for-profits have taken action to correct the inaccuracies of their financial statements. What we have not done is address responsibility.

We are in an era of unusual skepticism of financial statements of both public and private entities. Seeing the resulting worldwide economic impact that incorrect financial statements have had, those who have the opportunity and responsibility to provide more accurate financial statements should do so. Do so and enhance and protect their access to the credit markets in a time of financial difficulty while moving to comply with FASB Statement No. 154. ●

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