



May 27, 2016

Mr. David R. Bean  
Director of Research and Technical Activities  
Governmental Accounting Standards Board  
401 Merritt 7  
P.O. Box 5116  
Norwalk, CT 06856-5116  
Via email: [director@gasb.org](mailto:director@gasb.org)

Re: Project No. 3-24E

Dear Mr. Bean:

The Healthcare Financial Management Association's (HFMA's) Principles and Practices (P&P) Board appreciates this opportunity to comment on the Governmental Accounting Standards Board's (GASB) proposed statement on *Leases*.

HFMA is a professional organization of more than 40,000 individuals involved in various aspects of healthcare financial management. In 1975, HFMA founded the P&P Board, a special group of experts to serve as the primary advisory group in the areas of accounting principles and financial reporting practices to meet the unique characteristics of health service organizations.

HFMA has been long standing in its recommendation to the GASB to avoid differences between private sector and public sector standards that cannot be justified by fundamental or environmental differences between the two sectors. Accordingly, we are pleased of the Board's efforts to reexamine public sector lease accounting in the light of recent private sector developments, both in the United States and internationally. In the case that the public and private sector standards do diverge, guidance specific to liability classification, an example discussed during our April 29, 2016 meeting, may mitigate potential debt ratio and covenant reporting issues. Additionally, it is imperative for the Board to clearly identify and justify any proposed disparities with the recently released FASB model in any forthcoming statement. An attachment is provided to detail some important points for the GASB to consider as to the impact on the healthcare sector.

Thank you for the opportunity to comment. We are always ready to provide additional comments, or meet with you or members of your board to discuss this matter further. If we can provide additional material or perspective on this issue, please contact Richard Gundling, Senior Vice President of HFMA's Washington, DC office, at (202) 296-2920 ext. 605 or [rgundling@hfma.org](mailto:rgundling@hfma.org).

Sincerely,

Brian P. Conner, CPA  
P&P Board Chair

**Points to consider as to the impact on the healthcare sector**

Some basic premises:

- Healthcare entities, particularly hospitals, are capital intensive and make extensive use of leased assets.
- Financial statement users compare against other tax-exempt healthcare entities, not against governments. While most analysts have a good understanding on FASB-GASB differences, we cannot assume that the same is true for all users of financial statements, such as bondholders, banks, lease financing companies.
- The majority of fee-for-service revenues earned by hospitals are based on government payment rules that differentiate lease-related expenses as financing or operating.
- The proposal could put economically disadvantaged governmental healthcare entities in terms of the costs (and exposures) of having to renegotiate debt covenants, the potential for adverse consequences of asking to renegotiate, the potential for violation of debt covenants if renegotiation is not possible, the costs and ongoing burden of needing to maintain two sets of accounting records

General Points:

- The proposal uses a “Foundational Principle” that “all leases are financings of the right to use an underlying asset” and therefore concludes that a single approach should be used for lease accounting. In a recent meeting with the HFMA P&P Board members, the GASB representatives indicated they believe the single model would better suit the needs of most of its constituents, which are primarily traditional tax-supported governments. The needs of HFMA’s constituents that operate in the governmental sector are closely aligned with those of private sector healthcare entities. Therefore, the needs of governmental healthcare entities and the needs of traditional governments conflict regarding these standards.
- The GASB proposes that lessees apply capital lease accounting to all leases to simplify lease accounting. For the capitalized operating leases, the P&L lease cost is front loaded as interest is imputed on the liability and the resulting liability is classified as debt. A significant concern is with the foundational principal that all leases should all be treated as the financing of a capital asset. We do not support the GASB’s model, as it does not contemplate the inherent differences between financing leases and other leases. We believe that the accounting should and must acknowledge that distinction. When a healthcare organization is a lessee for medical equipment under operating lease arrangements, the benefit received is level throughout the term, unlike purchased equipment that declines in value over its useful life. Applying a capital lease model which reflects the pattern of benefit as starting high and gradually decreasing over the term of the arrangement, does not faithfully represent the periodic costs for the use of the asset. This front-end loaded expense pattern would be at odds with the level expense pattern that would be reported by private sector counterparts acquiring the same asset financed by the same lease.

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- Application of this model would be particularly detrimental for healthcare entities, where government payments for services to patients based (directly or indirectly) on costs constitute the majority of total revenues. The foundational principle is inconsistent with the principles of the government payment methodologies.
- A single model approach would result in less useful information being provided to users of the financial statements that are making resource allocation decisions among all tax-exempt healthcare entities, and puts governmental healthcare entities at a disadvantage. The significant divergence this would create between the reporting of leases between, for example, governmental hospitals and not-for-profit hospitals would result in less useful information being provided to users of the financial statements
- For healthcare entities, the proposed standards fall far short of passing the cost/benefit test and in fact, would create significant economic disadvantages for governmental healthcare entities. To avoid these negative consequences and the disadvantage at which they would place governmental entities relative to private sector entities, we strongly encourage the GASB to permit healthcare entities to use a dual model in which the asset will amortize at the same rate as the principal reduction of the liability (thus producing straight line rent expense each year), maintaining the ability to report expenses as always, permit classification of the expense as single line rent expense in the SRECNP (Statement of Revenues, Expenses and Changes in Net Position) and as operating cash flows in the Statement of Cash Flows), and where liabilities brought onto the balance sheet for operating leases are explicitly excluded from long-term debt classification. (In fact, we believe that use of a dual model should be permitted for all special purpose entities whose separately-issued financial statements are evaluated against private sector counterparts). If the GASB is unwilling to incorporate these concepts into its own model, we strongly encourage the GASB to provide these constituents with the option to apply the FASB's lease accounting rules as long as transparent disclosure of the difference is made. If the healthcare entity is part of a traditional government's reporting entity, we do not believe this would adversely impact the traditional government's reporting, because the healthcare entity's statements will normally be included by discrete presentation rather than blending.

**Specific Points:**

**Medicare/Medicaid payment system and other government contracts**

- In the U.S., the federal and state governments are the largest purchasers of healthcare services. In that regard, CMS (the Center for Medicare and Medicaid Services) and state Medicaid programs require healthcare entities to accumulate and report detailed information about their costs in a manner prescribed by those governments and submit detailed "cost reports" at the close of each year. CMS regulations for reporting of costs associated with leased property and equipment are based on FAS 13 concepts. Leases are classified either as "virtual

purchases” of capital assets or rental arrangements (where amounts are paid to “obtain use of an asset for the period of the lease”). Virtual purchases are treated as capital costs under the payment rules, while costs associated with “periodic use of assets” are treated as operating expenses. Costs reported can impact reported revenue and cash inflows either directly (for cost-reimbursed activities) or indirectly (where predetermined rates are based on historic costs reported).

- Irrespective of any changes in financial reporting rules, CMS will continue to require hospitals to accumulate and report information in this manner as part of their core revenue generating activities. The GASB’s proposed single model approach would negatively impact core operations by requiring us to maintain two sets of accounting records for operating leases: one set for government reporting and one set for financial reporting. This would be costly and inefficient, and would be a significant detriment relative to private sector counterparts (who will continue to report costs under the new FASB rules as they do today).
- While most healthcare government contracting is associated with generation of patient service revenue, other government contracting arrangements (e.g., sponsored research) may involve cost reimbursement based on GAAP expense reporting requirements. If expenses are ultimately reimbursable regardless of capital vs. operating lease classification, cash inflows (and reported revenues) would be artificially higher in the early years and lower in later years, when today, they reflect the pattern of lease payments made. If arrangements reimburse rent but not capital costs, the amount of revenues earned (and cash inflows received) by the entity would be directly impacted.
- Stakeholder concerns regarding implications for entities that have government payment arrangements were a significant factor in the FASB’s decision to retain a dual model system in lieu of going to a single model system as originally planned. Those stakeholder concerns are equally relevant and important for governmental health care entities. We urge GASB to permit healthcare entities (and other governmental enterprises with private sector comparability needs) to continue to utilize the dual model approach.

**Impact on debt arrangements and borrowing capability**

- Tax-exempt hospitals (government and not-for-profit) are heavily dependent on debt financing for their capital needs. We are troubled by the proposal’s characterization of operating lease obligations as financing liabilities that must be reported as long-term debt (giving the appearance that governmental hospitals have more debt-laden balance sheets than their FASB reporting counterparts), and by different amortization rates of that liability compared to the amortization of the right-of-use asset. If entities use straight-line amortization of the ROU asset (to be consistent with their policy for depreciation), the book value of the asset will amortize more quickly than the liability in the early years of the contract. The excess of the liability balance over the asset balance will have a negative impact on a lessee’s net position in the early years of a lease contract. The reduction in net position in conjunction with “underwater” leases would be magnified in the

- first few years of the new standard due to commencement of asset and liability amortization for all contracts as of the same date.
- If these changes are implemented, lessees' credit ratings and borrowing capability may be affected relative to their not-for-profit counterparts. Restrictive covenants comparable to those of our private sector counterparts are common features of debt-related instruments such as bond indentures, bank lending facilities, bank liquidity agreements, derivative agreements, bond insurance, and other agreements. We believe that grossing up the balance sheet with assets and liabilities that amortize at different rates, and categorizing the new liabilities as debt, will negatively impact the calculation of financial ratios included in many debt-related agreements (such as debt-to-total assets, debt to equity, debt to capitalization ratios, and cash coverage ratios) and in certain cases, trigger technical default.
  - The extent to which entities will encounter negative consequences will vary, depending on whether their legal agreements contain provisions permitting the parties to revisit contractual terms when there are changes in GAAP. Renegotiating covenants in agreements that do not have these provisions can have significant economic ramifications. A request to renegotiate covenants typically gives the debt holder the right to insist on changes to fees, rates, or covenants themselves. In addition, covenants waivers or amendments involving competitive tax exempt debt issues can involve contacting thousands of bondholders, and the requested waiver or amendment potentially may not occur. If a lender is unwilling to renegotiate, penalties for covenant violations are often severe and may allow the lender to accelerate repayment, increase fees, or require additional collateral. We can provide additional information about covenant renegotiations in the health care industry if needed.
  - Unlike traditional governments who will be making such changes all at once as a group (and thus, all are subject to these potential detriments), governmental health care entities are typically considered "nonprofit health care entities" for ratings and similar purposes. While tax-exempt bond rating analysts generally are familiar with the FASB-GASB differences, the same may not be true with regard to the wider group of users. In particular, users may not be aware that GASB health care entities are adopting new leasing rules that are different (and significantly more detrimental) than those being adopted by FASB not-for-profit entities. To avoid these negative consequences and the disadvantage at which they would place governmental entities relative to private sector entities, we strongly encourage the GASB to adopt or permit an approach that allows operating lease liabilities and assets to amortize at the same rate throughout the life of the agreement, and to classify the liabilities as non-debt obligations.

**Leases embedded in service agreements**

- The proposal defines a lease as "a contract that conveys the right to use a nonfinancial asset (the underlying asset)" and excludes contracts for services "except those that contain both a lease component and a service component."

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- While in some cases it is obvious that a service agreement contains a lease component, in others it is not so clear. For example, agreements that provide use of medical equipment along with related “disposables” (supplies to use on such equipment) often contain a unilateral option for the vendor to swap out or substitute the equipment at its discretion. In such situations, is a “right to use” asset present?
- As a result of the proposal’s lack of specificity, we believe that two entities could reach different conclusions regarding the same contract. One might conclude that the arrangement is a pure service agreement (because it does not have the unconditional right to use a specific asset during the lease term), while another might conclude that the use of any equipment under the arrangement indicates an embedded lease that should be capitalized (and thus, treated as a financed purchase).
- This was a contentious issue in the FASB and IASB projects, and we encourage the GASB to give consideration to the FASB and IASB’s deliberations and conclusions. We believe that the guidance must be clarified in order for this aspect of the proposal to be operational.

**Lessor accounting**

- Hospitals often own medical office real estate on and around hospital campuses in order to encourage physicians and other health care professionals to practice in close proximity to the hospital. Tenant agreements typically are considered operating leases.
- We disagree with the proposed requirement for lessors with operating leases to reflect receivables for the future rent payments along with a deferred inflow of resources. Reporting both a lease receivable and the underlying asset for a given contract is counterintuitive and gives the appearance of inflating the lessor’s assets. In the medical office building scenario, for example (where there are multiple suites leased to different users for different terms that have different start and end dates), we believe that calculating and reporting lease receivables would be an accounting exercise that does not provide decision-useful information. In fact, we believe that financial statements will be more difficult for readers and users to understand, particularly when compared to those of our private sector counterparts.
- The primary concerns expressed regarding off-balance-sheet accounting have been on the lessee side. In general, we believe the existing lessor accounting model works well. Both the FASB and IASB decided to leave their lessor accounting requirements largely intact. We strongly encourage the GASB to follow their lead and retain the existing GAS 62 requirements for lessors. If the desire for lessor/lessee symmetry is driven primarily by concern over leases with or between component units, we suggest that the proposed lessor requirements be limited solely to those situations.

**Sale-leaseback transactions**

- The healthcare industry has become especially active in the sale-leaseback market, as hospital real estate in particular has proven to be particularly inviting

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- to investors. Sale-leasebacks involve core operating properties (e.g. hospital buildings) as well as ancillary properties (e.g. medical office buildings).
- When a transaction meets the criteria for a sale, we encourage the Board to reconsider the proposal's requirement to defer and amortize gains and losses resulting from the sale. This appears to be inconsistent with the view that the sale and leaseback portions should be accounted for separately as a sale transaction and a lease transaction. The rationale and conceptual basis for deferring gains and losses from transactions that are recognized as sales is not apparent from the exposure draft. We note that this deferral will create another inconsistency between governmental hospitals similar transactions in the private sector. We believe this treatment result in underreporting the net position of a governmental health care entity, and making these entities appear to be financially weaker than our private sector counterparts when financial ratios are compared. If a GASB reporting hospital and a FASB reporting hospital of similar financial strength enter into an identical sale-leaseback transaction that results in a gain, the private sector entity's financial ratios will appear stronger due to its ability to recognize the gains in the period they occur.

**Additional background information:**

Based on the most recent survey conducted by the American Hospital Association, governmental entities comprise 20% of community hospitals.

AHA Hospital Statistics, 2016 edition

|  |              |
|--|--------------|
| Nongovernmental not-for-profit community hospitals | 2,870        |
| Investor-owned (for-profit) community hospitals    | 1,053        |
| State and local government community hospitals     | <u>1,003</u> |
|  | 4,926        |

Based on those statistics, we could estimate that overall, 80% of healthcare entities report using the FASB standards and 20% apply GASB standards. If we consider only tax-exempt hospitals (the group included in "not for profit hospital" rating methodologies) 74% apply FASB and 26% would apply GASB.

Convergence is particularly important in those capital markets where governmental entities and private sector non-for-profit entities compete for capital (e.g. the tax-exempt debt market). Both types of entities share certain defining characteristics—absence of a profit motive, no owners to whom a return on investment must be provided—and enter into leasing agreements under similar commercial terms with similar motives.

As a group, traditional governments (GASB's primary constituency) are followed by municipal analysts and in essence compete with each other for capital. On the other hand, healthcare entities' financial statements are compared against those of other healthcare entities by healthcare industry analysts. For purposes of bond ratings, these are rated based using specialized criteria developed for not-for-profit hospitals.

Today, governmental and private sector entities apply essentially the same rules for lease accounting.