Last Updated: May 11, 2007

Medical Remuneration Receivables[1]

I. Medical Remuneration Claims

1. Outline of Medical Remuneration Claims

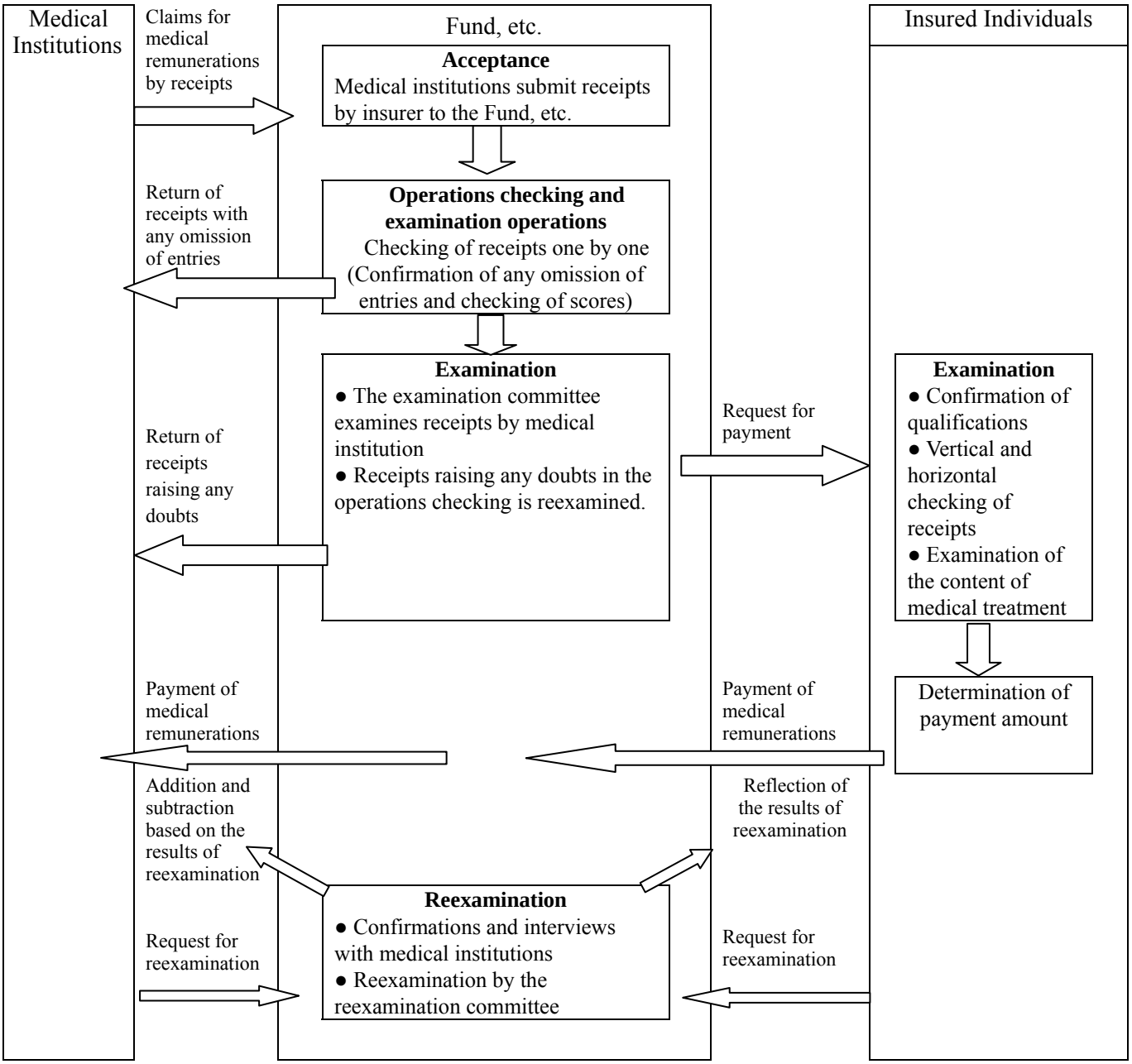
When an insurance medical institution gives medical cares to insured individuals and to their dependents, the medical institution has a claim on the Social Insurance Medical Fee Payment Fund or a National Health Insurance Organization (hereinafter collectively called "Fund, etc.") for payment of the medical remunerations from the Funds, etc. as compensation of the medical care services. This claim is referred to as a "medical remuneration claim".

The medical institution sends certificates of medical remunerations (hereinafter called "receipt") to the Fund, etc. until the 10th day of the next month of having provided medical care services and then makes a claim on the Fund, etc. for the medical fees excluding those paid individually by insured individuals at their own cost. The Fund, etc. examine whether the receipts, by which the medical institution has made a claim for the medical fees, are valid and appropriate in compliance with the rules on insurance medical institutions and persons in charge of medical cares (hereinafter called "rules on insurance medical persons in charge of medical cares") as stipulated in Article 70 and 72 of the Health Insurance Law, and then requests the insurers to pay the medical fees. The insurers themselves also examine the receipts to determine the payment amount and then pay the medical remunerations to the Fund, etc. with insurance premiums as resources. The medical remunerations paid by the insurers to the Fund, etc. are transferred to the medical institution by the Fund, etc.

As described above, payments of medical remunerations by the Fund, etc. to medical institutions take form of medical remuneration revenues from the insurers as resources, thereby raising a problem on who is the debtor of medical remuneration claims. In this context, the Supreme Court made the following judgment on December 20, 1973: When an insurer entrusts the Social Insurance Medical Fee Payment Fund with payments of medical remunerations, the Fund undertakes the legal obligations to pay them to persons in charge of insurance medical cares in its own name and based on its own examinations; and when an insurer entrusts a National Health Insurance Organization with examinations and payments of medical remunerations, the National Health Insurance Organization also undertakes the obligations to pay them to medical institutions in charge of insurance medical cares. The judgment made it clear that the Fund, etc. are the debtors of medical remuneration claims and dispensing remuneration claims.

[1] The same concept basically applies to the credit rating of dispensing remuneration claims. For benefit claims for nursing-care costs, see the reference report under the title of "Problems of the Liquidation of Benefit Claims for Nursing-care Costs".

Figure1: Flows of medical remuneration claims, examinations, and payments



2. Creditworthiness of the medical remuneration examination and payment bodies and creditworthiness of medical remuneration claims

(1) Social Insurance Medical Fee Payment Fund

[Profile]

The Social Insurance Medical Fee Payment Fund (hereinafter called “Payment Fund”) is a special public corporation. It was established in 1948 following the enactment of the Law on Social Insurance Medical Fee Payment Fund. Based on the entrustment by individual insurers except for those of the

National Health Insurance, the Payment Fund makes examinations and payments of medical remunerations as applied for by insurance medical institutions. Since October 2003 at which time the law on the Payment Fund was partially revised, the Payment Fund has been changed to a private corporation.

[Organization and Examination System]

The Payment Fund has its Headquarters in Tokyo and establishes the executive board, the members of which include no more than 17 board members (twelve representatives from the insurers, insured individuals, and persons in charge of medical cares with four representative from each interest group, and five public-interest representatives). The Payment Fund also places its branches in all the prefectures. Each branch establishes the administration board to discuss its operations management. Like the executive board, the administration board is comprised of the representatives from the insurers, insured individuals, and persons in charge of medical cares, as well as the public-interest representatives with the same number of members from each interest group (two from each).

In order to examine the certificate of medical remunerations (receipt), a “special examination committee” is organized in the Headquarters, while the “examination committee” is established in each branch. The examination committee of each branch is composed of the representatives from three groups of the persons in charge of medical cares, insurers, and academic experts with the same number of members from each group. One representative’s term of office is two years. Under its control, the examination committee organizes the management committee as well as the examination specialized committee, reexamination committee, dispensing examination committee, etc. There is a scheme in which the receipts marking high scores equal to or more than certain scores, among others, are examined by the examination specialized committee. (The special examination committee of the Headquarters examines the receipts marking 420,000 scores or more and those of dental treatment fees marking 200,000 scores.) For reference’s sake, the (fixed) number of examination members was 4,536 at the end of 2003, of which the number of full-time examination members was 671.

[Examination Results]

The payment Fund achieved the following examination results for fiscal 2004 (period from March 2004 to February 2005) on a definite basis: The total number of examinations was 799,840,000 (up 1.7 % from a year ago) and the total amount of medical remunerations was ¥10,052,700 million (down 0.3% from a year earlier). Out of ¥10,052,700 million the amount of medical treatment remunerations was ¥7,467,400 million (a year-on-year decrease of 1.1%). Out of 799,840,000 examinations, the number of examinations of medical treatment remunerations was 480,710,000 (a year-on-year increase of 0.3%). The payment Fund examines no less than 8,000 high-value receipts marking 420,000 scores or more on a yearly basis.

The Payment Fund has been making efforts to make these enormous examination operations more

efficient by means of OCR processing of receipts. In addition, it is required to i) make operations processing more efficient by organizational review, etc. and to ii) streamline the organization including decrease in the fixed number of employees. To fulfill these requirements, the Payment Fund left the operations cost unchanged during the fiscal years 1999, 2000, and 2001. In the fiscal years 2002 and 2003, the operations cost for one examination/payment was decreased by ¥2. As a result, the fiscal year 2003 showed the following results: The operations cost for one examination/payment of medical remuneration was ¥114.20; and the operations cost for one examination/payment of dispensing remuneration was ¥57.20.

[Evaluation of Creditworthiness of Medical Remuneration Claims]

The Payment Fund pays medical remunerations to each medical institution with the medical remunerations from the insurers as resources, and so the solvency of the Payment Fund entirely depends on the conditions of medical remunerations received from the insurers. The receipt percentage of medical remunerations from the mutual aid associations during a receipt period is 99% or more staying at a high level. On the other hand, the receipt percentage of medical remunerations from the health insurance associations, etc. involving many small health insurance associations hovers around 85%. In terms of the receipt percentage of medical remunerations, there is a big difference between the insurers. The payment Fund takes responses to any delay of payment of medical remunerations by an insurer in such a manner that the Payment Fund makes a withdrawal from the trust money as received preliminarily from the insurer and from the basic fund. In response to recently increasing dissolutions of health insurance associations, there is a scheme in which their obligations to pay medical remunerations are taken over by the government-managed health insurance.

(2) National Health Insurance Organizations

[Profile]

A National Health Insurance Organization (hereinafter called “National Health Insurance Organization”) is a public corporation jointly established by the insurers (cities, towns and villages as well as national health insurance associations) based on the provisions of Article 83 of the National Health Insurance Law. There is one national health insurance organization in each prefecture. Each national health insurance organization is obliged to obtain the approval of its establishment from the governor of each prefecture and to submit its budgets, account settlements, etc. to the governor that has the supervisory authority on the national health insurance organization.

If two thirds or more of the member insurers in a district (city, town, or village) participate in the national health insurance organization, all the rest of the insurers also become the members of the national health insurance organization in that district. The medical remuneration examination committee is to be organized under the national health insurance organization. Based on the contract with each insurer, the national health insurance organization can examine receipts submitted by

insurance medical institutions, etc. and can pay medical remunerations to them, so all the national health insurers currently entrust the relevant national health insurance organization with examinations and payments of medical remunerations.

[Examination Procedures and Financial Resources]

Each prefecture independently manages the national health insurance organization. Just like the Payment Fund, also in the case of the national health insurance organization, the examination committee composed of the three groups (the persons in charge of medical cares, insurers, and academic experts) is required to hold discussions on examinations of receipts. The Payment Fund and the national health insurance organization of each prefecture have many other common points. The number of definite payments of medical remunerations by the national insurance organizations has constantly been increasing. The fiscal year 2003 recorded the following results: there were 742,000,000 payments, which increased by 80 percent over the previous ten years.

High-value receipts are examined by the special examination committee as organized by the All-Japan Federation of National Health Insurance Organizations (hereinafter called "National Health Insurance Federation"), which is comprised of the national health insurance organizations as its members. Like the Payment Fund, high-value receipts of medical treatment remunerations marking 420,000 scores are to be examined by this committee. The fiscal year 2004 posted the following results: the total number of examinations of high-value receipts was 10,492 (up 1.2% form a year ago); and the number of examinations of medical treatment remunerations for heart diseases constituted about 30% of 10,492. There is a scheme in which a contracting insurer incurs the full amount of national health insurance medical remunerations. Government subsidies for operations costs in part are provided to the national health insurance organizations to expedite their examinations and payments of medical remunerations.

[Evaluation of Creditworthiness of Medical Remuneration Claims]

Like the Payment Fund, in the case of each national health insurance organization, there is also a scheme in which payments of medical remunerations to each medical institution entirely depends on the conditions of medical remunerations received from the insurers, so to speak, national health insurances of cities, towns, and villages as well as national health insurance associations. Each national health insurance organization maintains a high-level receipt percentage of medical remunerations received from the insurers, which generally marks nearly 100%. If any insurer delays its payment of medical remunerations, each national health insurance organization gets a loan from financial institutions in response to that case.

[Overall Evaluation]

There are requests to the deregulation committee, etc. for enhancement of the insurers' functions

including permission of their examinations of receipts. However, it is not easy to construct an organizational system that ensures smooth and efficient processing of more than 1,500 million examinations and payments of medical remunerations on a yearly basis by the two examination bodies (Payment Fund and National Health Insurance Organizations) as described above.

The drastic reform plan of the current medical insurance system to be discussed in this autumn and thereafter is premised on the universal health insurance system, and so it is expected that the medical remuneration scheme based on the current social insurance system will be maintained.

Judging from these points in a comprehensive manner, the Payment Fund and the National Health Insurance Organizations being two medical remunerations examination and payment bodies are deemed to have quasi-creditworthiness of the Japanese government.

II. Risks of Medical Remuneration Claims

1. Current Claim and Future Claim

With attention focused on the process of medical treatment/care(a) claim for medical remuneration, medical remuneration claims are classified into the following three types.

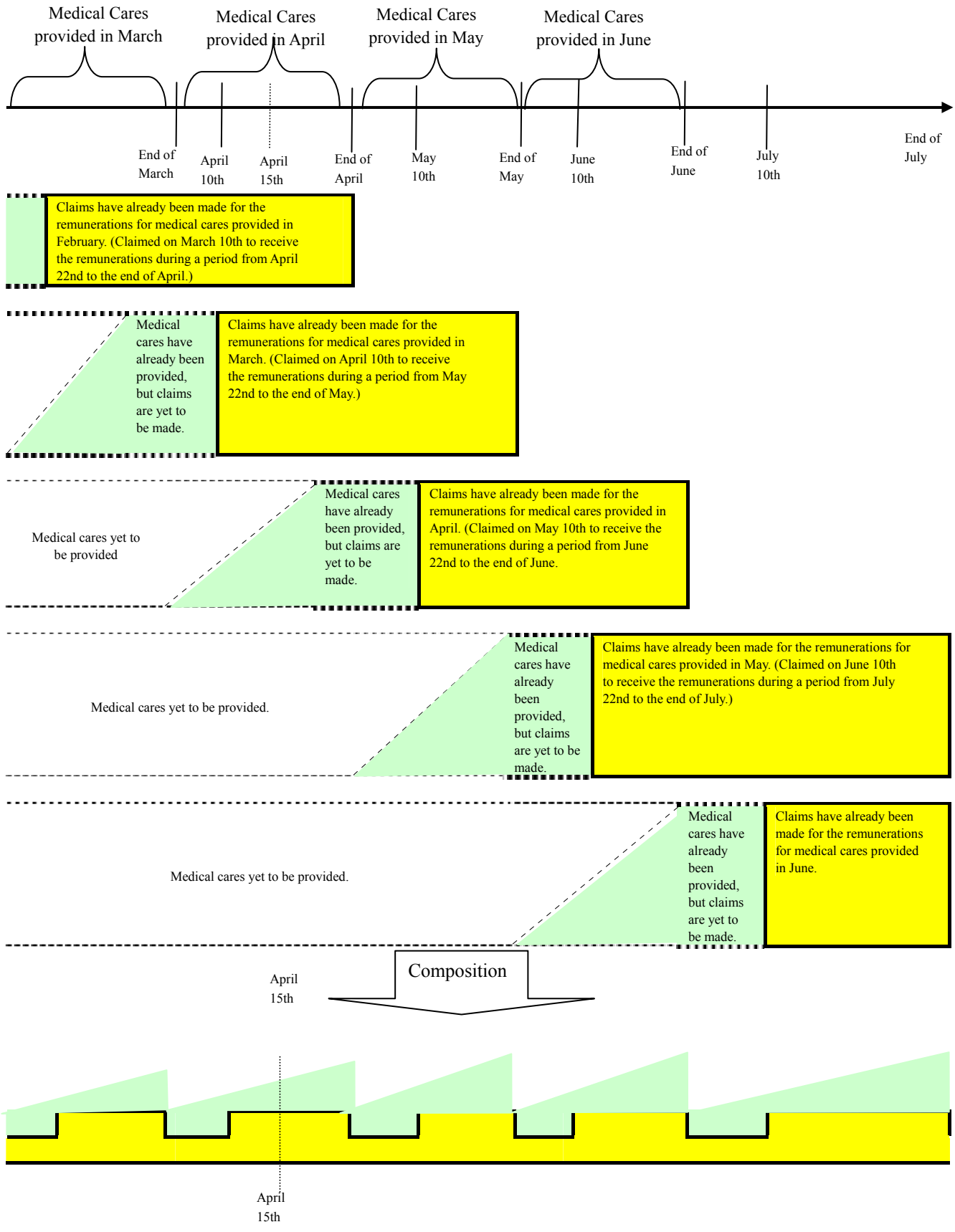
A current claim of Type (b) produces a cash flow to the highest degree of certainty and a future claim of Type (c) produces a cash flow to the lowest degree of certainty.

(a) Current claims (in the case where medical cares have already been provided and claims for the medical remunerations have already been made) (the yellow-colored part of the table below)

(b) Claims yet to be made in the case where medical cares have already been provided (the light-green-colored part of the table below)

(c) Future claims (in the case where medical cares are yet to be provided) (the white-colored part of the table below)

Figure 2: Relation between “Elapse of Time” and “Medical Remuneration Claims”



2. Risks of Medical Remuneration Claims (Current Claims)

(1) False Claims

If any false claims including claims for medical remunerations in excess of the actual medical fees are detected in any medical institution being the originator, there is a risk that the Fund, etc. may decrease the payment amount of medical remunerations as a setoff for the overpaid amount due to the false claim. Regardless of whether or not the medical remuneration claims transferred to the liquidation vehicle are based on false claims, it is impossible to completely avoid the risk that the payment amount of medical remunerations may decrease, unless the Fund, etc. give their consent with no objection to the transfer of the claims.

The enforcement regulations of the Medical Care Law stipulate a standard number of medical doctors and that of nurses corresponding to an average number of patients for one day and a number of allowable hospital beds. However, many hospitals are unable to secure the standard number of medical doctors as required. Some of them pretend that they secure the standard number of medical doctors by borrowing the names of medical doctors of university hospitals against the background that they cannot continue to exist as a hospital and their status will be downgraded from a hospital to a clinic, if they are no longer able to secure the standard number of medical doctors. The medical remuneration unit price is determined according to the number of medical doctors as notified by a hospital. If the number of medical doctors on the active list is less than 60% of the standard number of medical doctors, any hospital should reduce medical remunerations and should make a claim for the balance amount of medical remunerations after the reduction. Any hospital that has notified a number of medical doctors in excess of those on the active list has accordingly made a false claim for medial remunerations (even though such notification was not intended to make a claim for medical remunerations in excess of the actual medical fees).

As the result of an on-site inspection (audit) of a hospital conducted by the social insurance office established in each prefecture, if a fact of any false claim is confirmed, a claim for the return of dishonestly received medical remunerations will be made against the hospital. If a malicious claim is made, its designation as an insurance medical institution will be cancelled and so the hospital will be taken over by a new management body or it does nothing but close down[2].

Even when a fact of any false claim is confirmed, the Fund, etc. will not suddenly decrease the amount of medical remunerations payable to the liquidation vehicle in the next month as a setoff for the overpaid amount due to the false claim in a usual case. First of all, a claim for the return of dishonestly claimed and received medical remunerations will be made against the hospital. Even when a decision is made to cancel its designation as an insurance medical institution, a grace period of one

[2] In an over-bed region where the number of actual hospital beds exceeds the number of necessary hospital beds as stipulated in the Medical Care Law, it is prohibited for a different business manager to take over the management of any medical institution whose designation as an insurance medical institution has been cancelled as a general rule, and so the medical institution will close down after the transfer of hospitalized patients to any other hospital(s).

month is often set before actual cancellation of its designation as an insurance medical hospital and before finding of any hospital(s) to which the hospitalized patients will be transferred and finding of a new business manager. A medical corporation will not become bankrupt immediately after the decision is made to cancel its designation as an insurance medical institution. In the case where a medical corporation becomes bankrupt and the medical institution has no financial resources to refund the falsely claimed and received medical remunerations, there remains the possibility that the amount of medical remunerations payable to the liquidation vehicle may be reduced as a setoff for the overpaid amount due to the false claim. If the amount of falsely claimed medical remunerations is not covered by the reduction of medical remunerations to be paid later as a setoff for that amount of money, there is a possibility that the Fund, etc. may claim against the liquidation vehicle a restitution of undue profits on the medical remunerations, which the Fund, etc. have already paid to it, based on the civil code (theoretically speaking).

There is also an argument that some hospitals have borrowed the names of medical doctors from outside, partly because the enforcement regulations of the Medical Care Law stipulate a standard number of medical doctors according the number of patients without sufficient considerations given to the conditions of individual regions. The Ministry of Health, Labor, and Welfare is reported to implement a policy of reviewing the current system in such a direction that if it is difficult for any hospital to secure the standard number of medical doctors in an outlying region, the governor of each prefecture can ease the criteria at his/her own discretion[3].

(2) Dilution

Regarding medical remunerations, the following cases occur constantly: Medical remunerations are returned, if there are any clerical errors in the content of receipts including omissions of entries, errors in the entries (different insurer, different insurance card number, etc.) and if there are any descriptive errors in the content of medical cares; and the payment amount (score) of medical remunerations is reduced as the result of their examination by the Fund, etc. in compliance with the rules on insurance medical persons in charge of medical cares. Besides, if the examination results of some receipts are not notified before the end of the next month of having claimed medical remunerations (the medial remunerations will be paid in the month after the next month or even later), the medical remunerations will be diluted because the previous payment amount of medical remunerations to be decreased due to the insurer's request for the reexamination will be set off against the payment amount of medical remunerations, etc. for the current month. (The insurer can later make a request for the reexamination of receipts, the payment of which the insurer has already completed, if they have any doubts. If the reduction of the payment amount of medical remunerations is approved, the payment amount to be decreased will be set off against the payment amount of medical

[3] The Hokkaido Shimbun Press of June 27, 2005

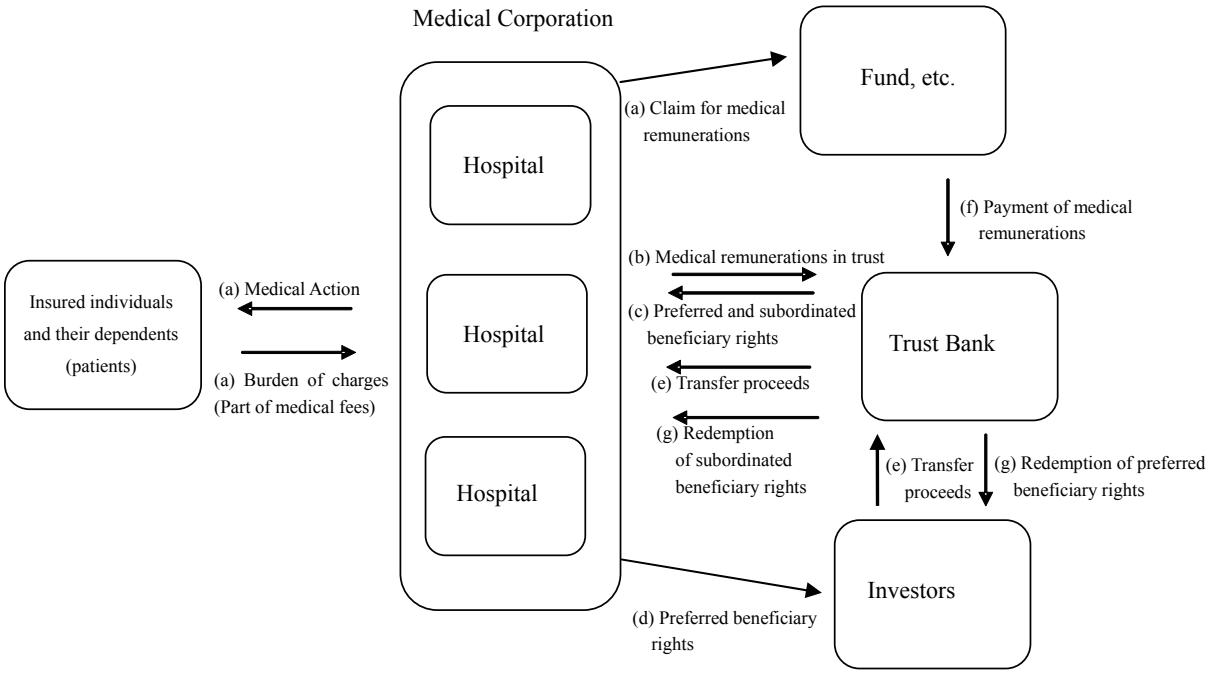
remunerations for the current month.)

III. Framework of Credit Rating

1. Liquidation Scheme on which this thesis is premised:

The following figure illustrates the liquidation scheme on which this thesis is premised. The simplest trust method is taken as an example.

Figure3: Scheme Chart of Trust Method



(a) A medical corporation (hospital) provides insurance medical cares to insured individuals and their dependants. It collects their burden charges (part of the medical fees) at the window. It sends the receipt to the Fund, etc. to make a claim for the balance amount of the medical remunerations subject to the insurance.

(b) The medical corporation transfers its holding medical remuneration claims in trust to a trust bank.

(c) Each time the medical corporation makes a claim on the Fund, etc. for medical remunerations every month, the trust bank issues preferred beneficiary rights and subordinated beneficiary rights for that month[4].

[4] Medical remuneration claims for one to three years are collectively transferred to the trust bank for convenience of fulfilling the opposing requirements. Transfer of preferred beneficiary rights often takes form as follows: Each time the medical corporation (hospital) makes a claim on the Fund, etc. for medical remunerations for the current month and the amount of the medical remuneration claim is determined, the preferred beneficiary rights are transferred to investors on a monthly basis. Normally, a credit rating is given to the medical remuneration claim at the time of the transfer of preferred beneficiary rights every month.

(d) The preferred beneficiary rights are transferred to investors and the subordinated beneficiary rights are retained by the medical corporation.

(e) The medical corporation receives the transfer proceeds of the preferred beneficiary rights paid by the investors.

(f) On the due date of a medical remuneration claim, the Fund, etc. pay directly to the trust bank the amount of medical remunerations (after deduction of the amount of medical remunerations to be returned due to the examination).

(g) The principals of preferred beneficiary rights are delivered to the investors and the balance amount is appropriated for the redemption of subordinated beneficiary rights.

2. Framework of Credit Rating of Claims yet to be made for remunerations for medical cares that have already been provided

(1) Certainty of payment of medical remuneration claims

As described in Paragraph 2 of Section I, above, the Fund, etc. serving as the medical remuneration examination and payment bodies are deemed to have quasi-creditworthiness of the Japanese government. It is therefore possible to give an equivalent credit rating to liquidation products of medical remuneration claims.

(2) Screening of medical corporations

Any medical remuneration claim bears the biggest risk of a false claim. For this reason, as a general rule, it is required to have an accounting office and an audit corporation conduct due diligence of the following points (see the "Major Due Diligence Items" at the end of this thesis). Medical remuneration claims subject to the credit rating are limited to those of the medial corporations serving as an originator with no problem reported by them.

- A medical corporation has an appropriate operations system.
- A medical corporation satisfies the medical facility criteria.
- A medical corporation has not fallen into any credit uncertainty and any cash-flow problem.

The medical remuneration claims of a medical corporation serving as an originator that is deemed to have problems in view of the points as described above are likely to be treated as claims unsuitable for the credit rating in some cases. Even when a credit rating is given to such claims, it may sometime be a low credit rating. In the following scheme, however, the screening requirements can be eased on the condition that money amounts of medical remuneration claims by originator are dispersed: Many originators transfer their medial remuneration claims to one liquidation vehicle with subordinated beneficiary rights and subordinated beneficiary interests shared by and between the originators.

(3) Responses to dilution risk

There is a risk that by a setoff against medical remunerations due to returns, point-deduction,

continued examination, and a claim for restitution of overpayment by an insurer, the credit transfer of or the credit amount of medical remuneration claims being resources for the redemption of preferred beneficiary rights may be delayed or deducted in part on the redemption date. Responses are taken to this risk in such a manner that a stress test is conducted on the basis of historical data, according to the result of which excess collateral suitable for the target credit rating is provided.

In order to ensure that the credit rating of preferred beneficiary rights converges with the same credit rating of "J-1+" equivalent to that of the creditworthiness of the Fund, etc., a stress magnification is applied and a credit enhancement level is set according to the percentage of the amount of money yet to be received (uncollected money) in relation to the claim amount of medical remunerations on a monthly basis (taking into account all the dilutive factors including returns, decreases in the amount of money, etc., the respective percentages are calculated for the Social Insurance Medical Fee Payment Fund and for the All-Japan Federation of National Health Insurance Organizations.)

A stress magnification is set with threefold as a minimum level and in consideration of the following items, the final level of excess collateral is determined: volatility of historical data; dispersion degree of securitization claims (the number of hospitals and a percentage of the amount of money by each hospital); the number of claims, operational ability of each medical corporation; large returns or no large returns; and other items as confirmed at the due diligence meeting.

Certainty of the timely redemption of the principals of and the timely payment of dividends of profits on preferred beneficiary rights is the main factor that determines the credit rating of short-term trust beneficiary rights. If the credit amount of money has significantly decreased this month, the timely payment (redemption) cannot be maintained. In the case of one facility, if the amount of money yet to be received (uncollected money) has greatly increased this month, it is impossible to cover the lack of money by cash flows of other facilities. In this context, for the calculation of an excess collateral ratio, it is important to take into consideration the number of relevant facilities and the dispersion degree of the amount of money.

(4) Other Points of Contention

(a) Duplicated Transfer of Claims and Fulfillment of Opposing Requirements

In a normal case of transfer of medical remuneration claims, a medial institution, which is an assignor of the claims, prepares a notification directed to the Fund, etc. pursuant to Article 467, Paragraph 1 of the civil code and has on the notification the transfer date affixed by a notary public as the officially-attested date of transfer. It notifies the Fund, etc. of the transfer of the claims with the notification as a deed bearing an officially-attested date pursuant to Article 467, Paragraph 2 of the civil code. If the same claims have already been transferred or offered as collateral to a third party and the opposing requirements have been fulfilled by notification, these facts will be detected at the time of confirming the transfer of the claims with the Fund., etc. (before payment).

(b) Denegation

The necessary denegation conditions are limited by the revised bankruptcy law and the revised civil rehabilitation law as implemented on May 1, 2005. Any transfer of claims in trust and any transfer of beneficiary rights are not subject to the denegation, regardless of the time of the transfer, based on the premise that the transfer value is appropriate, unless the consignor has an intention to decrease the absolute value of assets, for which it is responsible, by consuming and concealing the transfer value, etc. and the investors as well as their representatives are aware of that intention of the consignor.

3. Claims yet to be made in the case where medical cares have already been provided

Taking a look at the point in time on April 15th in Figure 2, there are three types of claims for the remunerations for medical cares that have already been provided: i) claims made on March 10th for the remunerations for medical cares provided in February; ii) claims made on April 10th for the remunerations for medical cares provided in March; and iii) claims yet to be made for the remunerations for medical cares provided until April 15th. Based on the premise that claims yet to be made for the remunerations for medical cares that have already been provided are treated as current claims[5], if claims for medical remunerations are liquidated every month beginning the first liquidation scheduled for April 15th, it is possible to deem that there are always current claims for a period of at least one month and half on and after April 15th , even excluding those for the remunerations for medical cares provided in February with a residual period of 15 days only.

In the case of liquidation of claims for medical remunerations including those yet to be made in the case where medical cares have already been provided, the following requirements in additions to the points of contention as described in Paragraph 2 of Section III must be fulfilled for assigning a credit rating. In the following scheme, however, even when the amount of collected money is zero (0) from the claims as concerned with one originator, it is possible to secure the resources for the redemption of the principals of liquidation products subject to the credit rating with the collected money from the claims as concerned with other originators: Many originators transfer their medial remuneration claims to one liquidation vehicle with subordinated beneficiary rights and subordinated beneficiary interests shared by and between the originators. For this reason, it is possible to ease the following requirements, when money amounts of medical remuneration claims by originator are dispersed and if it is admitted that the

[5] For the judgment of when any medical remuneration claim arises, the judgment made on March 23, 1981 by the Osaka District Court states as follows: A medical remuneration claim as retained by an insurance medical institution is understood to have the same nature of a claim for the remuneration for the consigned operations and accordingly the claim for the remuneration for the consigned operations arises when the consignee has implemented the operations in compliance with the consignment purpose. Meanwhile, the judgment made on May 27, 1983 by the Osaka Supreme Court states as follows: When a medical institution has implemented the operations in compliance with the consignment purpose as described earlier, so to speak, when it has provided medical cares in conformity with the applicable laws and regulations, the medical remuneration claim arises accordingly.

appropriate setting of the levels of subordinated beneficiary rights and subordinated beneficiary interests covers the risk inherent in claims yet to be made in the case where medical cares have already been provided.

- It is required to obtain a written legal opinion to the effect that any medical remuneration claim is understood to take effective form at the point in time when medical actions have been taken.
- In order to prevent any fraud aimed at the providers of funds including a claim for medical remunerations in excess of actual medical fees, it is required to add items to the representations and warranties, and to make the screening criteria more rigorous.
- In case that any claim for medical remunerations is not made by a medical corporation due to its bankruptcy, it is required to arrange a backup servicer, a business agent to make claims for medical remunerations on behalf of the medical corporation. Besides, in consideration of the time lag until the backup servicer starts the operation, it is required to set a tail period (time lag) of one to two months between the scheduled maturity and the final maturity of the redemption of trust beneficiary rights.
- Based on the assumption i) that there arise some receipts in a certain amount of money, by which a claim for medical remunerations will not be made in the next month and ii) that it is impossible to obtain detailed symptoms of doctors in the case of bankruptcy of an medical corporation, it is required to set the excess collateral for a second-month claim for medical remunerations at a high level.

[Major Due Diligence Items]

1. Facility Criteria

- Conditions of satisfaction of doctors (confirmation of real existence of doctors)
- Conditions of satisfaction of nurses (confirmation of real existence of nurses)
- Conditions of satisfaction of facility criteria

2. Historical Data

- Correctness and accuracy of a claimed/credited amount of money, etc.
- Causes of and responses to a large sum of returns and causes of sharp increases and decreases in the money amount of claims
- Reconciliation (matching) of receipts, etc. with a list of claims for medical remunerations by patient (or any quasi data)
- Existence/nonexistence pf high-value medical cares
- Relationship with a medical association and a faculty of medicine
- Effects of the revision of medical remunerations

3. Organization of Medical Professions Division

- The number of personnel, years of experience, job turnover ratio, and external entrusted company in the medical professions division
- Years of experience, etc. of personnel to input receipts, personnel in charge of checking receipts, and personnel responsible for the medical professions division
- Training program and frequency
- Existence of a medical remunerations claim manual
- Cause analysis of and responses to returns and deductions of points
- Effects of the most recent revision of medial remunerations on the operations of making a claim for medical remunerations

4. Financial Conditions and Management Results

- Conditions of management and conditions of tax payments
- Companies and individuals to which money is lent, and those from which money is borrowed
- Relationship with the president, a medical service corporation, etc.

5. Other Items

- Conditions of preventive measures for medical accidents (existence and nonexistence of a safety management committee, organization of the committee if any, existence and nonexistence of personnel in charge of safety management, and responses to in-hospital infection)

- Results of the most recent on-site inspection (Article 25 of the Medical Care Law) and conditions of improvements
- Compliance program with various kinds of laws and regulations (training conditions, training frequency, etc.)
- Conditions of getting a certification from the Japan Council for Quality Health Care and from ISO.