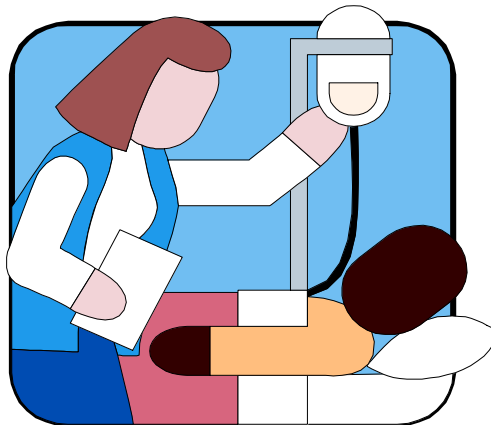


Public Hospital District Planning Guide

Updated for Fiscal Year 2002

March 2003



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RELATED INTERNET SITES:

Hospital Findings, Management Letters, and Exit Items

<http://office.sao.wa.gov/RefGuide/FindingsManagementExit/hospital%20issues.xls>

AG Memos

<http://office.sao.wa.gov/RefGuide/AGIndex/AllDisom.doc>

WA Dept. Health <http://www.doh.wa.gov>

PUBLIC HOSPITAL DISTRICTS

BACKGROUND

As of May 31, 2000, the Washington State Department of Health listed 34 entities as being public hospital districts. Public hospital districts are municipal corporations that are organized and exist as a result of RCW chapter 70.44. While RCW 70.44 is the primary source of powers conferred upon public hospital districts, it is by no means the comprehensive source of powers and limitations. For one, there are numerous laws found in other sections of the RCW's which apply to local governments such as public hospital districts. Many of these provisions flow directly from the fact that public hospital districts, as municipal corporations, are governmental entities and thus are held to the legal requirements of all governmental entities.

Their purpose is to own and operate hospitals and other health care facilities and to provide hospital services and other health care services for the residents of such districts and other persons.

Note: Harborview Medical Center is not a Public Hospital District; it is a County Hospital and is managed by the University of Washington. As such Harborview must comply with King County Regulations and Washington State RCW's as applicable.

Public Hospital Districts are governed by a Board of Commissioners. The individuals who serve as Commissioners are publicly elected officials who have been chosen by the voters.

Under the authority prescribed in Chapter 43.09.200 RCW, the Office of State Auditor (SAO) maintains the Budgeting, Accounting and Reporting Standards (BARS) manual that formulates, prescribes a system of accounting and reporting for all local governments, including public hospital districts. The most recent version of the **BARS supplemental handbook for public health** is located on the Washington Department of Health website under the Publications tab.

UPDATES TO PLANNING GUIDE

3/03 – The Minimum Audit Priorities portion of this planning guide has been updated to reflect policy 6110, which now requires financial statement audits to be performed in accordance with GAGAS and Policy 2105, which requires each audit to consider 20 specific issues in the planning process. Statewide Themes has also been updated to reflect current issues.

MINIMUM AUDIT PRIORITIES

All audits must be designed to meet the public's expectation of accountability. The public expects that our audits will detect important financial and compliance related events. Such an event would have to be significant and be reflected in the auditee's records available to audit. To adequately address the public's expectations, auditors will consider the risk associated with each of the following areas for every audit engagement:

- Fraud
- Not conducting business in an open and public manner
- Conflict of Interest
- Non Compliance with Contract/Bid requirements (including prevailing wage requirements)
- Management Dysfunction

- Financial Statement Misstatement/Wrong Opinion
- Constituent Referrals and Complaints, News Stories
- Going Concern
- Shifting of Restricted Resources
- Budget deficits/Exceeding the Budget
- Inappropriate Use of Bond Proceeds/legality of debt
- Nonpayment of Debt/Non-Compliance with Debt Covenants
- Inappropriate Use of Public Funds (Although unusual, **it is legal** for hospitals to purchase alcohol unless their policies specifically prohibit it).
- Creating new Public Entities
- Inherently Risky Operations
- Lack of Insurance and Bonding
- Single Audit – Missing A-133 audit, Unallowable Use of Funds
- State Grants – Unallowable Use of Funds
- Illegal Investments
- Exceeding Taxation/Revenue authority

In addition to what is in the worksheet below, the auditor is responsible for complying with team and agency policies, which include performing financial statement and single audits in accordance with GAGAS (Generally Accepted Governmental Auditing Standards).

EXPECTED AUDIT TIME ALLOCATION

Expected Audit Time Allocation	Audit Area/Element	Comments
25-30 %	Pre-planning procedures and Audit Administration	
45-50%	High Risk and State Legal Compliance	(E.g., required areas and areas to consider)
0%	Federal Single Audit Testing	See Below *
25%	Financial Statement Audit	
100%	Total	* The above assumes a single audit is not required.

STATEWIDE THEMES

The following unique hospital activities should be evaluated for applicability and significance for each hospital:

- **Physicians using hospital facilities for private practice.** These physicians do both, work for the hospital for a designated number of hours, and hold a private practice using the same hospital facility. The primary risk is whether the contract with each physician is legal (no gift of public funds). An obvious example of a contract that would not be considered legal would be a situation where a physician clearly receives much more benefits (from the use of hospital

facilities) than he/she is providing in return to the hospital. Therefore, in order to properly evaluate the exchange of goods and services between a physician and a hospital, the contract language should be sufficiently specific and clear as to allow management (and auditors) to evaluate and measure the adequacy of the exchange. If it is determined to be legal, then the secondary risk is whether hospitals adequately monitor physicians to make sure they are not using **un**authorized hospital equipment, supplies and personnel for their private practice.

- **Income Subsidies to Private Physicians.** The purpose of subsidy contracts is to help hospitals persuade physicians to establish a practice nearby because of a grave shortage. This practice is legal as long as they have a contract and the subsidy appears reasonable. The following example describes how such an arrangement works.
 - A physician signs an agreement to establish a practice near a hospital for a period of two years, in exchange for an interest-free loan of \$30,000. If the physician does not stay for the entire length of the initial period, the physician has to pay back the entire amount of the advance plus interest. If he/she does stay the entire period, the physician must pay back the principal either in one lump sum, or over a pre-defined period of time. However, at that time, the hospital may decide to make another offer asking the physician to stay for an additional four years in exchange for a complete write off of the original loan. Again, this is legal.
 - The accounting treatment by the hospital is as follows – if the initial payment was \$30,000 and the physician stayed the initial two years, and signed a letter of intent to stay another four years, the hospital would write off \$5,000 per year for six years.
- **Hospital Clinics.** Generally, physicians work for a clinic on a fix salary with an agreement that if they bill more than a certain amount per year, they may qualify for a specified monetary bonus or shared profits. The risk associated with this kind of agreements is, of course, inflated billings. The audit approach is to first determine whether bonuses/ shared profits were paid during the year under audit (and the amount is significant enough to audit), and if so, determine whether they supported with valid billings.
- **Traveling Nurses.** These nurses are usually specialists who travel to remote locations to serve patients in need. The primary risk is whether hospitals adequately monitor these nurses to make sure (1) they actually performed the patient visits called for by their contract, and (2) the fee they are paid is consistent with their particular contract, since traveling nurses negotiate different fees depending on their areas of specialty, etc. Audit steps should begin by determining how much a hospital paid out to traveling nurses for the period under audit. If audit worthy, then determine the process the hospital follows to hire, monitor and pay these nurses.

Auditors should assess the applicability of the following unique hospital issues and determine whether to include them in the audit scope:

- **Student Tuition -** It is **not** legal for hospitals to enter into contracts agreeing to pay education expenses of a student (non-employees) in exchange for the student's agreeing to work at the district for a specified period of time upon graduation. (For more information, **see attached AG Memorandum**)

- **Recruitment Expenses** - It is **not** legal for hospitals to pay recruitment related travel and lodging expenses for a physician's or candidate's spouse. (For more information, **see attached AG Memorandum**)
- **Bonus and Incentive Pay** – These types of payments are relatively common in hospitals. In order for them to be legal, however, there must be (1) an approved policy (by the board) in place at the time the goals were established, (or as in the case of executive management such as the CEO and CFO, the board signed their contracts which included the specific goals and how they will be measured), (2) adequately defined goals so they can be measured to determine if accomplished, and (3) adequate documentation to enable an auditor to determine whether the goals were in fact achieved and bonuses approved. Problems have been found and reported in all three of these areas.

PRE-PLANNING ACTIVITIES

AUDIT STEP	METHOD (S) TO CONSIDER WHEN PERFORMING STEP	COMMENTS
<p>Identify receipting locations and petty cash funds for cash counts.</p> <p>Perform A/P on petty cash funds and revolving/petty cash checking accounts</p> <p>If appropriate, perform surprise cash counts at receipting and petty cash locations.</p>	<ul style="list-style-type: none"> • Obtain listing of change and petty cash funds with authorized amounts. • Inquiry with previous auditors. • Using AP, determine volume of activity that passes through various locations as a tool to decide where to perform cash counts. <ul style="list-style-type: none"> • Obtain listing of petty cash funds, checking accounts, and procurement/ credit cards. • Determine the volume of expenditures passing through: <ul style="list-style-type: none"> ➢ Petty cash funds ➢ Revolving checking accounts ➢ Procurement cards/ Bank credit cards (e.g., VISA) <p>Perform trend analysis on volume passing through petty cash funds and checking accounts.</p> <ul style="list-style-type: none"> • Complete the SAO standard cash count sheet, tie all activity to receipts, and tie the change fund amount to the authorized amount. • At cash receipting locations tie the last validated bank deposit to the cash receipts. • Ensure the check and cash composition matches the receipts. • Ensure original receipts support all disbursements from petty cash. 	<ul style="list-style-type: none"> • Review prior audit working papers for cash handling locations, change fund amounts, prior audit issues, and audit cycles. See: A/P revenue streams (below) for listing of potential cash receipting locations. <ul style="list-style-type: none"> • Tying the receipts contained in the last bank validated deposit slip to current cash receipts will show if receipts are missing.
Review Minutes	<ul style="list-style-type: none"> • Review district minutes and assess 	Review of the district minutes

	<p>whether actions were taken in full and open manner, as required (determine if the meetings are properly advertised, if they are open to the public, if votes are publicly taken, if executive sessions are for a proper purpose, and if special sessions are properly advertised).</p> <ul style="list-style-type: none"> Summarize audit relevant information during the review. Make note of construction projects, lawsuits, competitive bidding, bond issuance, grants, etc. 	<p>serves as a critical tool for audit planning.</p>
<p>Review Certificate of Need</p>	<p>Determine if there are any new Certificate(s) of Need for capital equipment purchases or hospital restructuring for new or expanded services.</p>	<ul style="list-style-type: none"> This information can be obtained through inquiry, touring facility, and cost reports. The addition of new specialists to the org chart may also be a good indication. The risk is providing services without an approved Certificate of Need. Medicaid/Medicare may not reimburse such services.
<p>Perform analytical procedures (A/P)</p> <p>Identify revenue and disbursement streams & cash receipting locations</p> <p>Perform A/P on Revenue</p>	<ul style="list-style-type: none"> Perform Inquiry of entity personnel Review of permanent files and prior year working papers NOTE: Some perm files may include matrix which depict departments and when they were last audited Review other auditors workpapers Review of financial statements and adopted budget Review revenue reports by location Review of minutes Review of revenue status reports and revenue reports by location Obtain listing of change fund authorized amounts and related location. <ul style="list-style-type: none"> Note that change funds are not consistently used for all receipting operations AP to consider for revenue includes: <ul style="list-style-type: none"> Analyze revenue by trend, type and location. Inquire of main cashiering & analyze sources of deposits; 	<p>If possible, information for A/P and planning should be requested, by letter, prior to going to the audit site. This will increase audit efficiency and is known as requesting a prepared by client (PBC) list.</p> <p>Double click on the icons to observe the letter or suggested items to request:</p> <p>Consider the following potential revenue streams:</p> <ul style="list-style-type: none"> Pharmacy Cafeteria Decentralized Clinics Receipts recorded as "Miscellaneous revenue" Central cashiering Donations Gift shop (may be privately operated)



<p>Perform A/P on Disbursements</p>	<p>determine if departments have direct deposit authority</p> <ul style="list-style-type: none"> ➤ Conduct gross profit testing in cafeteria. ➤ Analyze accounts receivable aging reports ➤ Analyze A/R total write-offs by authorizer or type. ➤ Make comparisons: A/R billings vs. bank deposits vs. A/R credits ➤ Compare operating results with pre-established standards, such as budgets or prior-period results. Identify variances, trends or unusual changes and their causes. <ul style="list-style-type: none"> • Examine federal expenditures and determine if a single audit is required (see Single Audit section) • Perform CAATs tests on expenditures and payroll including: <ul style="list-style-type: none"> (a) List of one time payroll payments, (b) List of one time other payments, (c) Vendor history reports, (d) Compare addresses per payroll to addresses per vendor list. • Benchmark comparisons • Review of the vendor list for employees or unusual vendors. • Review of overtime by department and evaluate largest earners of overtime by percentage of pay and total dollars. • Wages expenditures vs. changes in number of personnel and base compensation (e.g., COLA's). Benefits expenditures as percentage of wages. • Testing of pharmacy inventory; comparison of pharmaceutical purchases to units billed. 	<ul style="list-style-type: none"> • Emergency room fees • Patient trust funds • Community education program fees • Revenue for copies of medical records • Funds received for laboratory services • Facility rental fees • If an entity expends \$300,000 in federal assistance (grants and/or loans) they are subject to a Federal Single Audit using OMB Circular A-133 procedures. • A/P is a substantive test and is used to identify the risks in your entity and set audit scope and budget by area (e.g., accountability, state/local compliance, and financial statements).
<p>Review prior audit issues.</p>	<p>Review working papers, exit documents and audit reports. Determine the status of any prior issues during the current audit.</p>	<p>Requesting a letter from the entity on their corrective actions for prior year audit</p>

		issues can save time.
Evaluate the control environment for the significant audit elements. (i.e. accountability, legal compliance, single audit, and financial).	Perform inquiry and determine whether the individuals for each element selected to audit are: <ul style="list-style-type: none"> ➤ committed, ➤ adequately trained, ➤ adequately monitored, ➤ and have time to perform control activities. <ul style="list-style-type: none"> • Observe staff performing their daily activities. • Determine if entity has had staff turnover in key accounting positions • Consider what activities other auditors and regulators have performed. 	This needs to be done at the level where true monitoring occurs. This usually shouldn't be done from an entity-wide perspective.
Update Perm Files	Update the Perm Files as areas are examined, including: <ul style="list-style-type: none"> ➤ trends in analytical procedures, ➤ banks and account numbers, ➤ cash receipting areas, ➤ changes in internal controls, etc. 	Remove old and outdated information.
Write audit plan	Using information gathered from the cash counts, evaluation of control environment, analytical procedures, minutes review, and review of prior audit issues develop a strategic audit plan that can be accomplished within your approved audit budget.	The audit plan should be organized in order of priority. Audit work should be performed in that same order to ensure the highest risk areas are completed first. Changes to audit scope should be documented as attachments to the original plan.

ACCOUNTABILITY FOR PUBLIC RESOURCES

The Accountability portion of the audit focuses on high-risk areas where theft fraud and abuse can occur. While loses in high risk areas are not usually material to the financial statements they are of interest to citizens. High-risk areas usually concern cash receipting operations, disbursements, assets, and decentralized operations. Our focus on the control environment and the results of analytical procedures will help determine what detailed testing needs to be performed.

AUDIT STEP	METHOD(S) TO CONSIDER WHEN PERFORMING STEP	COMMENTS
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<p>Billing, Accounts Receivable, and Cash Receipting</p> <p>Evaluate and test billing /accounts receivable system (s)</p> <p>Based upon planning procedures, test selected cash receipting location(s).</p>	<p>Based on results of your pre-planning work, consider the following:</p> <ul style="list-style-type: none"> ➤ Testing billings to the contracts and cost reports for the risk of management overstating revenues. ➤ Testing accounts receivable write-offs, and other non-cash credits to assess management’s effectiveness in monitoring for employee theft. ➤ Review accounts receivable aging report for the risk of revenue overstatement. ➤ Verify that management performs gross profit tests of its retail operations, and evaluate results. ➤ Evaluate controls and test decentralized billing / receipting systems such as pharmacies, clinics, etc. ➤ Verify that management reviews credit balances/ suspense accounts and evaluate results. 	<p>Testing considerations:</p> <ul style="list-style-type: none"> ➤ Verify documents are official & pre-numbered, as appropriate ➤ Test from the lowest source document to deposit ➤ Verify composition of deposit intact (tracing to bank-validated deposit ticket).
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<p>Disbursements</p> <p>Evaluate and test accounts payable system for universal risks</p>	<p>Based on analytical and/or CAATs work performed in Pre-planning, determine strategy to test unusual transactions.</p> <p>Consider disbursements associated with:</p> <ul style="list-style-type: none"> ➤ advance travel ➤ credit cards, open purchase orders with local vendors ➤ potential related party/beneficial interest ➤ conflict of interest payments. <p>Examine original redeemed warrants/checks for fraud indicators.</p>	<ul style="list-style-type: none"> • Primary risks vested with the following: <ul style="list-style-type: none"> ➤ Fictitious vendors ➤ Payment for goods or services not receipted by entity ➤ Conflicts of interest ➤ Unallowable expenditures (e.g., federal/state grant requirements)
<p>Payroll</p> <p>Evaluate and test controls over payroll for universal risk, with emphasis on management's monitoring of over-time given that hospitals operate 24 hours per day.</p>	<ul style="list-style-type: none"> • Perform additional CAATS where appropriate. • Based on A/P performed in Pre-planning and evaluation of the control environment determine strategy to test unusual fluctuations. • Verify compensation of high-risk employees/ officials, including payroll draws. • Review monitoring process for overtime (properly authorized, supported and reasonable). • Verify elected officials did not increase their own compensation. 	<p>In general, payroll expenditures comprise a significant portion of an entities total expenditures</p> <p>Primary risks are:</p> <ul style="list-style-type: none"> ➤ Overtime ➤ Part time, hourly, temporary employees ➤ Unauthorized pay increases ➤ Compensatory time, ➤ Lump-sum payments, ➤ Retroactive pay. <p>Payroll draws not deducted from payroll</p>
<p>Safeguarding and Accountability of Assets</p> <p>Evaluate and test the system for safeguarding of assets. The significant unique risk for hospitals is the purchase and safeguarding of narcotics.</p>	<ul style="list-style-type: none"> • Evaluate system and determine strategy to test based on weaknesses identified and analytical procedures. • Evaluate and test the system for recording fixed asset transfers, acquisitions, dispositions and related depreciation. • Verify physical inventories have been taken. Trace items to and from the inventory list to test for existence and completeness. (pharmacy, supplies, cafeteria) 	<ul style="list-style-type: none"> • Consider small and attractive assets and highly sensitive inventory (narcotics) and supplies when determining testing strategy.

Insurance	<p>Document the entity's insurance coverage. If the entity procures insurance, review expenditures to ensure premiums have been paid. If the entity self-insures, determine if reserves were determined by independent actuaries.</p> <ul style="list-style-type: none"> • Inquire of management as to the risk-management approach of the entity. Determine if the entity is a sponsor of a risk management pool. 	<p>Risk for entities that procure insurance is that does not meet industry standards.</p> <p>A secondary risk is that if the entity is having financial difficulty, it is possible premiums may go unpaid.</p> <ul style="list-style-type: none"> • Risk for self-insurance is that the entity may not have used an actuarial firm and thus reserves might not be adequate.
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LEGAL COMPLIANCE CONSIDERATIONS

The suggested legal compliance audit procedures are not intended to be all-inclusive. They are presented to assist an auditor in developing tests for the audit issues encountered. Furthermore, there is no requirement that any or all the procedures listed are to be performed on every audit. Rather, the circumstances of each situation should be assessed and the type of testing utilized should be based on those assessments.

Also note that additional references for legal compliance issues can be found in appendix 1.

AUDIT STEP	METHOD(S) TO CONSIDER WHEN PERFORMING STEP	COMMENTS
Investments (RCW 39.59 & 43.84.080)	<ul style="list-style-type: none"> • Review investments purchased during the audit period to determine if they were of the authorized type. • Review the amount of uninvested cash for the audit period to determine if investments are being made timely and in sufficient amounts. • Verify that all public funds are being deposited in a qualified public depository by reviewing the listing from the Public Deposit Protection Commission. • Review carefully the trust agreements for any repurchase agreements. • Verify that the governing body is authorizing investments. 	<p>For additional guidance on investments see <u>Investment Planning Guide</u> http://office.sao.wa.gov/RefGuide/Planning%20Guide/Planning%20Guides.htm</p> <p>Also see <u>State Treasurer Brochure</u> http://www.wa.gov/tre/elig_inv.htm#toc1.1</p>

<p>Competitive Bid Laws (RCW 70.44.140, 39.04.155, 39.04.280, 60.28.011)</p>	<p>Review applicable bid requirements in SAO's Competitive Bid Guide found on SAO's office page Reference Guide @ http://office.sao.wa.gov/RefGuide/Misc/bidlaws2000.doc</p> <ul style="list-style-type: none"> • Determine if a small works roster or rosters are used as indicated. • Document authorized purchases found in the Board minutes. Scan expenditure reports for purchases that may be subject to bid requirements. Vouch these transactions to the procurement records, and test the files for compliance with applicable statutory requirements. 	<p>Competitive bid laws do not apply for materials and equipment except when they are related to public works.</p> <p>Areas of concern include:</p> <ul style="list-style-type: none"> ➤ Artificial splitting of contracts to achieve lower dollar amount per transaction. ➤ Using bids of other entities (unless there is an interlocal agreement with that entity for the purpose of achieving lower price by combining purchasing power.) ➤ Declaring an emergency where there is no crisis. ➤ Entering into a new contract as a result of changes to the initial one when changes are unrelated to the original contract. ➤ Declaring a sole source. ➤ Proclaiming convenience or logistic expediency. ➤ Adopting drastic modifications beyond the original scope of the contract (change orders).
<p>Contracts</p> <p>Evaluate the contract monitoring system and determine contracts necessary to review</p>	<ul style="list-style-type: none"> • Determine the significant types of contracts the hospital enters into. Such contracts may include capitation contracts, traveling nurse contracts, lease contracts for capital medical equipment, among others. • Determine, through inquiry and observation, the contract monitoring procedures that have been implemented by the hospital for each significant type of contract. • Consider joint operations - public hospitals are often involved in joint operations with other hospitals in their area to provide specialty services. (i.e. hospitals join to establish a Cancer Center to provide services for Cancer patients) • Review note disclosures to ensure joint operations are included 	<p>The risk of not monitoring contracts adequately is that the hospital may be paying more than the contract amount or paying for services not rendered.</p> <ul style="list-style-type: none"> • Joint operation risks includes hospitals not receiving their portion of revenues generated by the joint operation based on the contract agreement, and hospitals not disclosing the existence of these operations in the footnotes of their financial statements.
<p>Budgets</p>	<p>Obtain a copy of the budget and all amendments. Compare the final amended budget amounts with the reported</p>	<p>RCW 70.44.060 (6)</p>

	amounts in the annual report. Ensure no appropriations were exceeded by expenditures.	
Compensation of Public Officers	<ul style="list-style-type: none"> • Inquire of management if there were any changes to elected • Official salaries during the audit period. If so, determine if individuals set their own salaries. • Review payroll records to determine if the salaries for board members or councilpersons changed. • Review authorized salary document to W-2 and investigate any differences. <ul style="list-style-type: none"> ➤ Commissioners may receive \$70 per day, not to exceed \$6,720 annually for attending district meetings ➤ Each commissioner shall be reimbursed for reasonable expenses actually incurred in connection with such business and meetings, including his or her subsistence and lodging and travel while away from his or her place of residence. ➤ Any district providing group insurance for its employees, covering them, their immediate family, and dependents, may provide insurance for its commissioners with the same coverage 	<p>RCW 70.44.050</p> <p>The Legislature has “fixed” the compensation (per diem increase) of certain commissioners (e.g. fire, hospital, port, and water-sewer districts) by use of the word “shall” in the language of the statute. Consequently, commissioners from these respective districts do not “fix” their compensation and may receive the midterm increase in their compensation as directed by law.</p>
Incentive Compensation	<p>Determine if employment contracts, resolutions or other documents define the performance goals <u>in advance</u> (and with enough specificity to measure) for which compensation, in addition to base pay, is to be granted.</p> <ul style="list-style-type: none"> • Evaluate whether documentation prepared <u>before</u> the incentive compensation was paid is sufficient to support whether performance goals were achieved. Test whether financial or other performance indicators used were accurate. • Recalculate the incentive compensation. 	<p>See also – State Wide Themes Washington State Constitution - Article II, Sec. 25; and Article VIII, Sec. 7</p> <p>Consider testing inherently high-risk employees such as senior executives.</p>

<p>Interlocal agreements (RCW 39.34)</p>	<ul style="list-style-type: none"> • Inquire of management if they are involved in joint efforts with other entities. Review governing body minutes for joint or cooperative actions with other entities. Review interlocal agreements for applicable activities for existence and compliance with the RCW. Inquire with county auditor to determine agreements are being filed. • Review the interlocal agreement. Verify that the appropriate fiscal terms are being followed. 	<p>When reviewing agreement, be especially sensitive to:</p> <ul style="list-style-type: none"> ➤ Purpose of agreement ➤ Establishment of an entity ➤ Budgeting requirements ➤ Reporting requirements ➤ Funding or billing terms ➤ Procedures upon liquidation ➤ Ownership of property <p>Note: Entities may form an interlocal agreement in attempt to perform acts it is not authorized to. When an entity signs an agreement that forms an entity (a consortium) find out what that entity does and whether it's acts are with in the authority of the creating entities.</p>
<p>Bond Coverage for Public Officials</p>	<p>Review the surety bond coverage which covers employee and public official dishonesty and faithful performance for:</p> <ul style="list-style-type: none"> ➤ Coverage of all employees (usually a blanket bond) ➤ Amounts are reasonable 	<p>Recovery of audit costs should be included in the bond terms. The terms should allow for either the entity's attorney or the Attorney General to file on the bond for losses covered.</p>
<p>Travel Expenses</p>	<ul style="list-style-type: none"> • Review the ordinance or resolution which establishes the travel policy. • Determine if policies are followed and personal expenses are not reimbursed. • Charge Cards - The issuance of charge cards to district employees is permitted for the sole purpose of covering expenses incident to authorized travel. Within 30 days of the billing date, the employee must submit a fully itemized travel expense voucher. Any disallowed charges not repaid permit the district to lien any amounts payable to the employee from the district, such as salary or wages (RCW 42.24.115) <p>Remember, the purchase of alcohol is authorized unless hospital policies specifically prohibit it.</p>	<p>RCW 42.24</p> <ul style="list-style-type: none"> • In general, travel costs of management officials are the area of focus because these officials are often not subject to monitoring or review. • Home Health Program is for patients who can't travel that require health care services. Nurses travel to their homes to provide these services. If significant in dollars, consider including in audit scope. Risk is that they are not adequately monitored to ensure travel related expenditures are valid.
<p>Beneficial Interests/ Conflict of Interest (RCW</p>	<ul style="list-style-type: none"> • Determine where if officials work at other jobs and whether they have an interest in companies that could do business with the hospital. • Inquire and document the occupation 	<ul style="list-style-type: none"> • Be alert for companies which are sidelines of or employers of officials who are in a supervisory capacity over the letting of contracts. • For elected officials, obtain and

42.23.030)	<p>of official's spouses and determine if potential conflict exists.</p> <ul style="list-style-type: none"> Review the vendor listing to determine if any business is transacted with those companies. 	review reports from PDC.
Annual Financial Report (RCW 43.09.230)	<ul style="list-style-type: none"> Review the annual report certification date for timely filing. 	Annual financial reports are to be filed each year within 150 days after the close of the fiscal year.

SINGLE AUDIT CONSIDERATIONS

OMB Circular A-133 requires a Single Audit if the District expends more than \$300,000 in federal funds in a year. It is the District's responsibility to inform SAO if it needs a Single Audit performed. In addition, the District is required to prepare a Schedule of Expenditures of Federal Awards (SEFA).

Single Audit reports must be issued and sent to the Federal Clearinghouse no later than 9 months following the District's year-end. For a December year-end, the report must be issued and received by September 30 of the following year. It is recommended that the audit be completed within 8 months of year-end to ensure enough time for report processing, data collection form, mailing, etc.

Hospital districts are incorporated as municipal corporations, RCW 70.44.010, and as such are considered local governments. As a local government, they are subject to OMB Circular A-87 cost principles for the determination of allowable costs for federal grants unless specific guidance to use other cost principles are given by a grantor agency for their specific grant.

The following are the most common federal awards received by Hospital Districts:

1. Childhood Immunization Program (CFDA 93.268)

This is a HHS program administered by the WA Department of Health (DOH). Funding can be awarded in the form of Discretionary Section 317 cash grants and non-cash assistance (vaccines). The discretionary grants are awarded for activities such as research, public information, education and training. The vaccine program supplies immunizations for children. Both forms of assistance must be reported in the SEFA.

Compliance Area	Applicability
Activities Allowed/Unallowed	This area should be tested if the auditee charges any funds under a 317 Discretionary grant or charges any administrative costs associated with ordering, distributing, and coordinating vaccines.
A-87 Cost Principles	Test in conjunction with Activities Allowed/Unallowed above.
Cash Management	Applicable if auditee receives cash in advance of expenditure.
Davis Bacon Act	Not Applicable.

Eligibility	WA DOH has a standardized eligibility form to be used by the auditee, but DOH makes the actual eligibility determination. We should test to ensure the auditee is complying with DOH documentation requirements.
Equipment/Real Property	Not Applicable.
Matching, Level of Effort, Earmarking	Not Applicable.
Period of Availability	Review the grant agreement/contract for the time period that any administrative funds must be used. This can be tested in conjunction with Activities Allowed/Unallowed.
Procurement / Suspension and Debarment	Procurement should be tested if the auditee has significant contracts for good and services (e.g., amounts exceeding 5% of total award). Suspension and Debarment is applicable for any vendor contract exceeding \$100,000 and all subrecipient contracts.
Program Income	Grantees can charge a fee for immunization services. However, no one may be denied immunization services due to the inability to pay the fee. This area should be tested if the auditee is generating significant amounts of program income (e.g., amounts exceeding 5% of total award).
Real Property Acquisition	Not Applicable
Reporting	Review the grant agreement for any financial reports or program-related reports required by WA DOH.
Subrecipient Monitoring	See Special Tests below.
Special Tests and Provisions	There are 3 special tests for this program: Vaccine Inventory, Immunization Records, and For-Profit Subrecipients. These areas should be tested.

2. Medicaid (CFDA 93.778)

The Medicaid program is administered by WA DSHS. The majority of Medicaid funds are paid to medical providers for services rendered to individuals.

According to OMB Circular A-133, Section 205(i), Medicaid payments to subrecipients for “patient care services to Medicaid eligible individuals” are not subject to audit under A-133 and should not be included on the SEFA. However, DSHS also enters into various contracts with Hospitals, Health Districts, and Schools to perform tasks that may not fall under the “patient care services to individuals” classification. For these types of contracts, DSHS typically considers the auditee as a “vendor,” but in substance, these contracts might be considered a subrecipient relationship and therefore subject to audit.

Compliance Area	Applicability
Activities Allowed/Unallowed	Review the terms of the agreement/contract for allowable activities.
A-87 Cost Principles	Test in conjunction with Activities Allowed/Unallowed above. If the auditee is charging salaries and benefits, these costs must be supported by time and effort records (DSHS usually refers to this as a “time study”).
Cash Management	Applicable if the auditee receives cash in advance of expenditure.
Davis Bacon Act	Review the terms of agreement/contract – Not likely that this will

	apply.
Eligibility	Review the terms of agreement/contract – Not likely that this will apply because patient care services are exempt from A-133 audits as described above.
Equipment/Real Property	This area should be tested if the auditee has purchased significant amounts of equipment (e.g., amounts exceeding 5% of total award).
Matching, Level of Effort, Earmarking	Review the terms of the agreement/contract.
Period of Availability	Review the terms of the agreement/contract.
Suspension and Debarment	Procurement should be tested if the auditee has significant contracts for good and services (e.g., amounts exceeding 5% of total award). Suspension and Debarment is applicable for any vendor contract exceeding \$100,000 and all subrecipient contracts.
Program Income	This area should be tested if the auditee is generating significant amounts of program income (e.g., amounts exceeding 5% of total award).
Real Property Acquisition	Review the terms of agreement/contract – Not likely that this will apply.
Reporting	Review the grant agreement for any financial reports or program-related reports required by WA DSHS.
Subrecipient Monitoring	Review the terms of agreement/contract – Not likely that this will apply.
Special Tests and Provisions	Review the terms of agreement/contract - Test areas that (1) potentially could result in noncompliance and questioned costs exceeding \$10,000, (2) affect a large part of the program (significant dollar amounts), and (3) could cause the granting agency to seek reimbursement for the part award or reduce future awards.

3. Women, Infants, and Children (WIC) (CFDA 10.557)

This is a USDA program administered by the WA Department of Health (DOH). DOH uses both federal and state funds to provide supplemental nutritious foods, nutrition education, and referrals to health care for low-income women who are at nutritional risk and who are pregnant, who have just given birth, or who are breastfeeding. The program also serves infants and children up to age five who are determined to be at nutritional risk.

About 75 percent of the WIC Program's annual appropriation is used to provide WIC participants with monthly food package benefits. The remainder is used to provide additional services to participants and to manage the program. Additional services provided to WIC participants include nutrition education, breast-feeding promotion and support activities, and client services, such as diet and health assessments, referral services for other health care and social services, and coordination activities.

DOH contracts with subrecipients to determine eligibility and to enter eligibility data electronically into the DOH Client Information Management System. The subrecipients also print and deliver checks to recipients. A primary risk in WIC program is payments of duplicate benefits. This can occur when a participant enters the program and payment system at more than one location. A dual payment occurs when a participant cashes a food check that has been declared lost, stolen, or void and then receives and cashes a replacement check. Currently, DOH does not have adequate

controls in place to investigate lost, stolen, and voided checks that are cashed to ensure the expenditures are appropriate and are not dual payments.

Compliance Area	Applicability
Activities Allowed/Unallowed	Yes. Review the terms of the agreement/contract for allowable activities.
A-87 Cost Principles	Test in conjunction with Activities Allowed/Unallowed above. If the auditee is charging salaries and benefits, these costs must be supported by time and effort records.
Cash Management	Applicable if the auditee receives cash in advance of expenditure.
Davis Bacon Act	Not applicable.
Eligibility	Yes. Subrecipients normally determine eligibility of clients for this program.
Equipment/Real Property	This area should be tested if the auditee has purchased significant amounts of equipment (e.g., amounts exceeding 5% of total award).
Matching, Level of Effort, Earmarking	Not applicable.
Period of Availability	Review the grant agreement/contract for the time period that the funds must be used. This can be tested in conjunction with Activities Allowed/Unallowed.
Suspension and Debarment	Procurement should be tested if the auditee has significant contracts for good and services (e.g., amounts exceeding 5% of total award). Suspension and Debarment is applicable for any vendor contract exceeding \$100,000 and all subrecipient contracts.
Program Income	This area should be tested if the auditee is generating significant amounts of program income (e.g., amounts exceeding 5% of total award).
Real Property Acquisition	Not applicable.
Reporting	Review the grant agreement for any financial reports or program-related reports required by WA DOH.
Subrecipient Monitoring	Not likely that this will apply.
Special Tests and Provisions	There are no special tests at the subrecipient level.

Audit Step	Methods to consider when	Comments
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Single Audit PG

<p>Audit Federal Expenditures</p>	<ul style="list-style-type: none"> • During the analytical procedures it should have been determined if an A-133 single audit was required. • Review the Single Audit Planning Guide if a single is required. <p>To open the Single Audit Planning Guide double click the icon.</p>	<ul style="list-style-type: none"> • Inquire with management of auditee if a Single Audit is required. • Determine if Schedule of Expenditures of Federal Awards (SEFA) is complete by: <ul style="list-style-type: none"> ➤ Reviewing grant revenues recorded on GL. ➤ During cash counts at Decentralized Receipting locations inquire if any grants are written / received by the location. Some hospitals do not have policies in place to inform the person who prepares the SEFA that they are receiving grants. • Hospital districts are incorporated as municipal corporations, RCW 70.44.010, and as such are local governments. Under A-133, as a local government they are subject to A-87 cost principles in the determination of allowable costs for federal grants; unless, specific guidance to use other cost principles are given by a grantor agency for their specific grant.
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FINANCIAL STATEMENT CONSIDERATIONS

Many public hospital districts contract with a CPA firm to perform their financial statement audit. When a CPA firm performs the financial statement audit, SAO will use their opinion as a basis for our financial opinion. In order to rely on the CPA's opinion we must adhere to SAO policy number 3620. However, it is important to note that as a result of the new GAO Independence standard issued on January 25, 2002, which takes effect on January 1, 2003, it may not be appropriate for a CPA firm to perform both audit and non-audit services for the same client without impairing their independence. Under these circumstances, a district may have to choose which of these services an audit organization will provide.

Another area of concern (especially with the smaller hospitals) is their ability to remain in operations - going concern. Whether we are reviewing a CPA firm's work papers or conducting the audit of the financial statements ourselves, when a district has a going concern risk, we must allocate sufficient audit resources to adequately scrutinize those financial statement balances at greatest risk of being misstated. Generally, these include the following:

- Billing/Accounts Receivable – risk of overstatement
- Revenues – risk of overstatement
- Accounts Payable – risk of understatement
- Long Term Debt – risk of understatement

AUDIT STEP	METHOD(S) TO CONSIDER WHEN PERFORMING STEP	COMMENTS
<p>Determine if the District has contracted with an independent CPA for a financial audit.</p>	<ul style="list-style-type: none"> • Perform inquiry with Financial Personnel • If an independent CPA was used send a letter to CPA firm regarding our policy: <ul style="list-style-type: none"> ➢ Will not use name of CPA firm in our audit report. ➢ SAO intends to rely on procedures the CPA firm has performed. ➢ Request a representation letter from the CPA firm stating the CPA firm is independent from the auditee. • SAO conducts such procedures or tests as deemed necessary to ensure procedures performed by the independent CPA's are adequate to support SAO objectives. This includes reviewing the CPA firm's work papers. If it is determined that the district has a going concern risk, our review of the CPA firm's work papers should especially focus on the financial statement balances listed in the introductory section above. • Determine whether the CPA firm is in compliance with the new GAO Independence standard. • Review SAO policy 3620 	<p>Note: This policy does not apply where SAO contracts with independent CPA's to work under our direct supervision.</p>
<p>Audit Financial Statements</p>	<p>Review Financial Statement Planning Guide</p>	<p>If a CAFR review is needed and help will be required contact Team Audit Support.</p>
<p>Provisions for contractual and other adjustments</p> <p>Evaluate and test the reasonableness of management's estimates</p> <p>For important background</p>	<p>The audit approach should encompass an understanding of the entity's process for developing estimates. Having gained such an understanding, one or a combination of the following approaches should be adopted:</p> <ul style="list-style-type: none"> • Review and test the process used by management to develop the estimate. <ul style="list-style-type: none"> ➢ Identify management controls and supporting data 	<ul style="list-style-type: none"> • In evaluating the reasonableness of management's estimate, the auditor should consider the basis for management's assumptions regarding the nature of future adjustments and its calculations as to the effects of such

<p>information, please read Attachment</p> <hr/>	<ul style="list-style-type: none"> ➤ Identify sources of data and factors used. ➤ Consider whether other factors or assumptions are appropriate. ➤ Determine if assumptions are internally consistent with other assumptions and supporting data. ➤ Determine that historical data used are comparable and consistent with data of the period under audit and that such data are reliable. ➤ Determine whether changes during the current period require that other factors be considered in developing assumptions. ➤ Review documentation supporting assumptions used to make estimates ➤ Recompute calculations. <ul style="list-style-type: none"> • Develop an independent expectation of the estimate to corroborate the reasonableness of management’s estimates • Review subsequent events or transactions occurring prior to completion of fieldwork 	<p>adjustments. The auditor cannot determine with certainty whether such estimates are right or wrong because the accuracy of management’s assumptions cannot be confirmed until future events occur.</p> <ul style="list-style-type: none"> • Any difference between an estimated amount best supported by the audit evidence and the estimated amount included in the financial statements may be reasonable, and such difference would not be considered a likely misstatement. However, if the auditor believes the estimated amount included in the financial statements is unreasonable, he should treat the difference between that estimate and the closest reasonable estimate as a likely misstatement and aggregate it with other likely misstatements.
<p>Review notes for disclosures unique to hospitals</p>	<p>Determine if material exposure exists regarding changes in estimates for third-party payments, and if so, is the uncertainty regarding revenue realization disclosed in the notes to the financial statements.</p>	<p>In the health care environment, it is reasonably possible that estimates regarding third-party payments could change in the near term as a result of one or more future events. For most entities with significant third-party revenues, the effect of the change could be material to the financial statements. Where material exposure</p>

		exists, the uncertainty regarding revenue realization is disclosed in the notes to the financial statements.
Obtain management representations for estimates.	When the auditor prepares the management rep letter, he should include additional representations concerning the absence of violations or possible violations of laws or regulations whose effects should be considered for disclosure or as a basis for recording a loss contingency. These representations concern: <ul style="list-style-type: none"> ➤ Receivables ➤ Cost reports filed with third-parties ➤ Contingencies 	<ul style="list-style-type: none"> • SOP 00-1 includes a sample listing of specific representations that the auditor should consider in preparing the rep letter. • Management’s refusal to furnish written representations constitutes a limitation on the scope of the audit.
Debt (RCW 39.36)	<ul style="list-style-type: none"> • List bond covenant requirements and state in memo form if they were complied with. The listing should be included in the permanent file. Key requirements which should be considered: <ul style="list-style-type: none"> ➤ Funds were spent for the purposes stated and within the required deadline ➤ Financial covenants were met including debt payment margin • Vouch new bond proceeds. • Determine if debt limit was exceeded. Review Schedule 10 (Limitation of Indebtedness) for correctness and consistency with financial statements. • Agree assessed valuation used in debt limit calculation to assessor’s records. Re-compute if necessary. 	<ul style="list-style-type: none"> • Consider going concern issue when reviewing long-term debt (are payments delinquent?).

APPENDIX 1

Index Chapter 70.44 RCW PUBLIC HOSPITAL DISTRICTS

SECTIONS

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- [70.44.007](#) Definitions.
- [70.44.010](#) Districts authorized.
- [70.44.015](#) Validation of existing districts.
- [70.44.016](#) Validation of districts.
- [70.44.020](#) Resolution -- Petition for county-wide district -- Conduct of elections.
- [70.44.028](#) Limitation on legal challenges.
- [70.44.030](#) Petition for lesser district -- Procedure.
- [70.44.035](#) Petition for district lying in more than one county -- Procedure.
- [70.44.040](#) Elections -- Commissioners, terms, districts.
- [70.44.041](#) Validity of appointment or election of commissioners -- Compliance with 1994 c 223.
- [70.44.042](#) Commissioner districts -- Resolution to abolish -- Proposition to reestablish.
- [70.44.045](#) Commissioners -- Vacancies.
- [70.44.047](#) Redrawn boundaries -- Assignment of commissioners to districts.
- [70.44.050](#) Commissioners -- Compensation and expenses -- Insurance -- Resolutions by majority vote -- Officers -- Rules -- Seal -- Records.
- [70.44.053](#) Increase in number of commissioners -- Proposition to voters.
- [70.44.054](#) Increase in number of commissioners -- Commissioner districts.
- [70.44.056](#) Increase in number of commissioners -- Appointments -- Election -- Terms.
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- [70.44.260](#) Contracts for purchase of real or personal property.
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- [70.44.900](#) Severability -- Construction -- 1945 c 264.
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- [70.44.903](#) Savings -- 1982 c 84.
- [70.44.910](#) Construction -- 1945 c 264.

APPENDIX 2

Glossary of Healthcare Terminology

Diagnosis Related Groups (DRGs): patient classification system that relates demographic, diagnostic, and therapeutic characteristics of patients to length of inpatient stay and amount of resources consumed, that provides a framework for specifying hospital case mix, and that identifies a number of classifications of illnesses and injuries for which Medicare payment is made under the prospective pricing system

Ambulatory Patient Group (APG), Ambulatory Payment Classification (APC): institutional outpatient reimbursement system based on the methodology developed by 3M for HCFA; APCs/APGs are to outpatient visits/services what DRGs are to inpatient hospital admissions; the payments are based on categories or groupings of like or similar services requiring like or similar professional services and supply utilization; may be used by other payers

Bundling: practice of combining services into one provider's claim to a payer; for Medicare, it includes combining services of non-physician providers inside and outside of a facility into the facility claim

Case Mix: (1) clinical composition of a provider's population among various diagnoses used as a factor in determining cost of service and rate setting (2) mix of patients who have different third party payers for their medical bills (i.e., Medicare, private insurance, workers' compensation)

Case Mix Index: measure of the relative costliness of patient treated in each hospital or group of hospitals

Case Mix Severity: level of illness or disability within a particular case-mix grouping

Current Procedural Terminology, Fourth Edition (CPT-4(tm)): set of 5-digit codes that apply to medical services delivered

Disproportionate Share Hospital (DSH): a designation given to a hospital that meets HCFA criteria for care given to indigent and/or state healthcare related program patients

DRG Creep: systematic coding of a patient's diagnosis to maximize hospital reimbursement, often inappropriately used to refer to natural growth in case-mix severity and efforts to provide more accurate and descriptive coding

DRG Rate: fixed dollar amount reimbursement based on averaging of all patients in that diagnosis related group

DRG Validation: review by a peer review organization of medical records to ascertain that the DRG assignment was substantiated and that the admission was medically necessary and appropriate

DRG Weight: index number that reflects the relative resource consumption associated with each diagnosis related group

Fiscal Intermediary (FI): public or private insurer agency selected by HCFA providers to pay institutional claims under Medicare

HCFA Common Procedure Coding System (HCPCS): set of codes used by Medicare that describes services and procedures; HCPCS Level I codes are CPT codes, Level II codes are for supplies and other non-CPT codes, and Level III are locally set codes

Health Insurance Portability and Accountability Act of 1996 (HIPPA): multi-faceted law whose primary purpose is the protection of patients from loss of healthcare coverage due to pre-existing conditions when changing jobs

Integrated Delivery System (IDS): a system of healthcare providers organized to deliver a broad range of healthcare services. Other terms include integrated healthcare delivery system (IHCDS), integrated delivery network (IDN), and integrated delivery and financing system (IDFN)

Joint Commission on Accreditation of Healthcare Organizations (JCAHO): private, not-for-profit organization composed of representatives of the American College of Surgeons, American College of Physicians, American Hospital Association, American Medical Association, and American Dental Association whose purpose is to establish standards for the operation of health facilities and services, conduct surveys, and award accreditation

Joint Venture: arrangement involving risk and benefit sharing between a hospital and one or more other entities, with rights and obligations specified in contractual terms for a specific purpose

Major Diagnosis: diagnosis accounting for the greatest resource consumption during a patient stay

Major Diagnostic Category (MDC): grouping of patients into major clinical categories based on organ systems and disease etiology

Medicaid (Title XIX): federally aided, state-operated and administered program which provides medical benefits for certain indigent or low-income persons in need of health and medical care; benefits, program eligibility, rates of payment for providers, and methods of administering determined by the state subject to federal guidelines

Medicare (Title XVIII): U.S. health insurance program for people aged 65 and over, for persons eligible for social security disability payments for two years or longer, and for certain workers and their dependents who need kidney transplantation or dialysis; consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B)

Medicare + Choice: Medicare Part C program created by the Balanced Budget Act in which the Medicare program contracts with health plans, provider sponsored organizations, private PPS plans, and medical savings accounts to provide beneficiary health care

Medicare Economic index (MEI): index used to update physician fee levels in relation to annual changes in the general economy for inflation, productivity, and changes in specific health sector practice expense factors including malpractice, personnel costs, rent, and other expenses

Medicare Geographical Classification Review Board (MGCRB): board established by HCFA to review applications by facilities for modification of their wage index under the prospective payment system

Medicare Loss Recapture: the Medicare reimbursement provision by which, when a Medicare-participating hospital is sold at a loss within a year after the owner stops participating in the program, Medicare reimburses the selling owner for Medicare's percentage of the loss

Medicare Part A: hospital insurance program portion of Medicare, which automatically enrolls all persons aged 65 and over entitled to benefits under the Old Age, Survivors, Disability and Health Insurance Program or railroad retirement; generally pays for institutional care

Medicare Part B: voluntary portion of Medicare, which generally covers physician services; requires enrollment and the payment of a monthly premium

Prospective Payment System (PPS): method of payment by which rates of payment to providers for services to patients are established in advance for the coming fiscal year. Providers are paid these rates for services delivered regardless of the costs actually incurred in providing these services

APPENDIX 3

Key Hospital Financial Statistics

This information may be of use in performing analytical procedures.

HFMA Knowledge Network[®]
Key Hospital Financial Statistics and Ratio Medians
September 1999

Measure	<u>Moody's</u> All Ratings	<u>S&P</u> All Ratings	<u>HCIA</u>
Sample size (n)	303	534	2,454
<u>Average length of stay</u> (a declining number is considered favorable)	5.0 days	4.8 days	3.96 days
<u>Maintained bed occupancy</u> (an increasing number is considered favorable)	61.8%	59.12%	41.63%
<u>Net patient revenues</u> (an increasing number is considered favorable)	\$121,932,000	\$98,973,000	N/A
<u>Operating margin</u> (an increasing number is considered favorable)	2.2%	1.80%	3.76%
<u>Excess margin</u> (an increasing number is considered favorable)	4.9%	4.91%	4.93%
<u>Debt service coverage ratio</u> (an increasing number is considered favorable)	3.67	3.37	4.21
<u>Current ratio</u> (an increasing number is considered favorable)	2.0	1.92	2.06
<u>Cash on hand</u> (an increasing number is considered favorable)	154.6 days	141.7 days	N/A
<u>Cushion ratio</u> (an increasing number is considered favorable)	11.2	9.67	N/A
<u>Accounts receivable</u> (a declining number is considered favorable)	64.2 days	64.8 days	64.18 days
<u>Average payment period</u> (a declining number is considered favorable)	65.1 days	65.4 days	57.24 days
<u>Average age of plant</u> (a declining number is considered favorable)	8.7 years	9.01 years	9.64 years
<u>Debt-to-capitalization</u> (a declining number is considered favorable)	37.7%	37.14%	27%
<u>Capital expense</u> (a declining number is considered favorable)	N/A	8.4%	6.72%

Measure	<u>Data Advantage Corp.</u>	<u>INGENIX CHIPS</u>	<u>HBSI</u>
Sample size (n)	4,482	1,586	427
<u>Average length of stay</u> (a declining number is considered favorable)	4.90 days	4.32 days	4.90 days
<u>Maintained bed occupancy</u> (an increasing number is considered favorable)	52.27%	53.20%	61.6%
<u>Net patient revenues</u> (an increasing number is considered favorable)	\$63,021,000	\$76,475,000	\$25,243,000
<u>Operating margin</u> (an increasing number is considered favorable)	-.10%	N/A	3.81%
<u>Excess margin</u> (an increasing number is considered favorable)	7.41%	3.9%	5.60%
<u>Debt service coverage ratio</u> (an increasing number is considered favorable)	N/A	3.72	4.23
<u>Current ratio</u> (an increasing number is considered favorable)	1.93	1.95	2.37
<u>Cash on hand</u> (an increasing number is considered favorable)	41.50 days	115.6 days	N/A
<u>Cushion ratio</u> (an increasing number is considered favorable)	N/A	9.58	N/A
<u>Accounts receivable</u> (a declining number is considered favorable)	64.05 days	65.1 days	67.98 days
<u>Average payment period</u> (a declining number is considered favorable)	74.39 days	59.9 days	54.64 days
<u>Average age of plant</u> (a declining number is considered favorable)	8.61 years	9.31 years	N/A
<u>Debt-to-capitalization</u> (a declining number is considered favorable)	31.79%	26.5%	48%
<u>Capital expense</u> (a declining number is considered favorable)	6.86%	7.3%	8.85%

Source information:

Moody's Investors Service, Not-For-Profit Health Care Medians, as of September 1999

Standard & Poor's, Not-For-Profit Hospital Ratios, preliminary data for 1999

HCIA, Inc., 1999 Comparative Performance of U.S. Hospitals: preliminary data (unpublished)

Data Advantage Corporation, For - Profit & Not - For Profit Health Care Medians 1999 (unpublished)

Center for Healthcare Industry Performance Studies, 2000 Almanac of Hospital Financial and Operating Indicators

HBSI, second quarter 1999 data (unpublished)