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Morehouse General Hospital

Years ended May 31, 1997 and 1996

Schedule of Per Diem Amounts Paid to the Board of Commissioners

Materials Presented to Board of Commissioners on November 3, 1997

Under provisions of state law, this report is a public document. A copy of the report has been submitted to the audited, or reviewed, entity and other appropriate public officials. The report is available for public inspection at the Baton Rouge office of the Legislative Auditor and, where appropriate, at the office of the parish clerk of court

Release Date NOV 19 1997

Morehouse General Hospital

Per Diem Amounts Paid to the Board of Commissioners

Year ended May 31, 1997
(Unaudited)

Board Members	Amount Paid
Charles Arant	$ 240
Dr. Carter Cox	480
Leonard Posey	280
Nancy Sawyer	360
Gary Stevenson	160
Mattie Washington	240
John Michael Yeldell	440
	$ 2,200

(Note: Board members are paid a per diem of $40 for each meeting attended up to a maximum of 12 paid meetings in a year.)

Report to the Board of Commissioners

MOREHOUSE
GENERAL HOSPITAL

May 31, 1997

Ernst & Young LLP

ERNST & YOUNG LLP

- 4200 One Shell Square
701 Poydras Street
New Orleans
Louisiana 70139-9869

- Phone: 504 581 4[illegible]

November 3, 1997

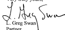
Management and
The Board of Commissioners of
Morehouse General Hospital

Ernst & Young LLP congratulates the Hospital on another year of favorable operating results. I would like to thank the Hospital's management and accounting department for their efforts in helping us to timely meet your reporting deadlines. As a result of our audit, I am pleased to present this 1997 Audit Results Binder for Morehouse General Hospital.

The 1997 Audit Results Binder includes, among other items, audited financial statements, compliance reports, selected operating statistics and graphs, and *The Board Report*, an Ernst & Young LLP publication on current trends and developments in the health care industry.

I hope you find the 1997 Audit Results Binder an effective tool for reviewing operations for 1997 and useful as a stepping stone into 1998. If you would like additional information or have questions, please contact me. I wish you continued success in 1998 and look forward to continuing to serve you.

Very truly yours,



L. Greg Swan
Partner

Ernst & Young LLP is a member of Ernst & Young International, Ltd.

Morehouse General Hospital

May 31, 1997
Audit Results Binder

I. Audited Consolidated Financial Statements

II. Other Reports

- Report on Internal Control Structure
- Report on Compliance with Laws and Regulations
- Letter of Recommendations

III. Presentation Material

IV. Operating and Financial Indicators

V. *The Board Report*

Tab I

Ernst & Young LLP

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Report of Independent Auditors

The Board of Commissioners
Morehouse Parish Hospital Service District

We have audited the accompanying balance sheets of Morehouse Parish Hospital Service District (Morehouse General Hospital) as of May 31, 1997 and 1996, and the related statements of revenue, expenses, and fund balance and cash flows for the years then ended. These financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Morehouse General Hospital at May 31, 1997 and 1996, the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

Ernst & Young LLP

July 25, 1997

Morehouse General Hospital

Balance Sheets

	May 31	
	1997	**1996**
Assets		
Current assets:		
Cash and cash equivalents	**$ 3,334,620**	$ 2,125,353
Patient accounts receivable, less allowances for uncollectible accounts of $2,008,224 in 1997 and $1,613,715 in 1996	**5,820,182**	5,305,450
Inventories	**861,990**	824,843
Prepaid and other assets	**239,005**	277,171
Total current assets	**10,255,797**	8,532,817
Assets whose use is limited	**2,324,243**	2,220,094
Other assets:		
Unamortized bond issuance costs	**13,249**	15,915
Amounts due from physicians	**320,659**	322,524
Property, plant, and equipment:		
Land	**241,678**	193,805
Buildings	**9,504,779**	8,847,021
Equipment	**18,140,025**	16,425,526
	27,886,482	25,466,352
Less accumulated depreciation	**17,413,010**	15,646,391
	10,473,472	9,819,961
Total assets	**$23,387,420**	$20,911,311

	May 31	
	1997	**1996**
Liabilities and fund balance		
Current liabilities:		
Trade accounts payable	**$ 603,231**	$ 481,044
Employee compensation and payroll taxes	**1,158,892**	937,198
Settlements due to third-party payors	**1,289,376**	529,291
Other accrued liabilities	**369,112**	314,645
Current portion of capital lease obligations	**864,538**	707,394
Current portion of long-term debt	**–**	151,260
Total current liabilities	**4,285,149**	3,120,832
Capital lease obligations, less current portion	**1,927,297**	1,704,687
Long-term debt, less current portion	**–**	63,025
Total liabilities	**6,212,446**	4,888,544
Fund balance	**17,174,974**	16,022,767
Total liabilities and fund balance	**$23,387,420**	$20,911,311

See accompanying notes.

Morehouse General Hospital

Statements of Revenue, Expenses, and Fund Balance

	Year ended May 31	
	1997	**1996**
Net patient service revenue	**$29,082,378**	$26,464,193
Other revenue	**1,104,963**	796,525
Total revenue	**30,187,341**	27,260,718
Expenses:		
Routine services	**4,998,079**	4,760,570
Ancillary services	**11,607,102**	9,484,280
General services	**2,679,016**	2,270,873
Fiscal and administrative services	**5,848,932**	5,013,486
Depreciation and amortization	**1,902,220**	1,855,600
Provision for bad debts	**1,792,307**	1,494,447
Interest	**208,241**	215,099
Total expenses	**29,035,897**	25,094,355
Revenue in excess of expenses	**1,151,444**	2,166,363
Fund balance at beginning of period	**16,022,767**	13,861,266
Net unrealized gain (loss) on marketable securities	**763**	(4,862)
Fund balance at end of period	**$17,174,974**	$16,022,767

See accompanying notes.

Morehouse General Hospital

Statements of Cash Flows

	Year ended May 31	
	1997	**1996**
Operating activities and gains and losses		
Revenue in excess of expenses	**$ 1,151,444**	$ 2,166,363
Adjustments to reconcile revenue in excess of expenses to net cash provided by operating activities and gains and losses:		
Depreciation and amortization	**1,902,220**	1,855,600
Interest expense	**208,241**	215,099
Investment income	**(251,498)**	(144,658)
Provision for bad debts	**1,792,307**	1,494,447
Provision for uncollectible physician receivables	**178,918**	165,326
Gain on sale of building and equipment	**(17,923)**	–
Changes in operating assets and liabilities:		
Patient accounts receivable	**(2,307,039)**	(3,215,647)
Inventories, prepaid, and other assets	**1,019**	(97,849)
Trade accounts payable	**122,187**	(151,239)
Employee compensation, payroll taxes, and other accrued liabilities	**276,161**	181,597
Settlements due to third-party payors	**760,085**	571,170
Net cash provided by operating activities and gains and losses	**3,816,122**	3,040,209
Capital and related financing activities		
Purchases of land, buildings, and equipment	**(1,527,954)**	(617,006)
Payments of capital lease obligations	**(810,592)**	(818,462)
Payments of long-term debt	**(214,285)**	(151,261)
Interest expense	**(208,241)**	(215,099)
Net cash used in capital and related financing activities	**(2,761,072)**	(1,801,828)
Investing activities		
Investment income	**251,498**	144,658
Increase in assets whose use is limited	**(103,386)**	(406,264)
Advance to physicians	**–**	(20,901)
Loan payments from physician	**6,105**	–
Net cash provided by (used in) investing activities	**154,217**	(282,507)
Net increase in cash and cash equivalents	**1,209,267**	955,874
Cash and cash equivalents at beginning of period	**2,125,353**	1,169,479
Cash and cash equivalents at end of period	**$ 3,334,620**	$ 2,125,353

See accompanying notes.

Morehouse General Hospital

Notes to Financial Statements

May 31, 1997

1. Accounting Policies

Description of Business

Morehouse Parish Hospital Service District (District), doing business as Morehouse General Hospital (Hospital), was organized on December 17, 1982 under powers granted to parish police juries by the State of Louisiana. The geographical boundaries of the District coincide with those of Morehouse Parish. All corporate powers are vested in a board of commissioners appointed by the Morehouse Parish Police Jury. The District is exempt from income taxes as a political subdivision of the State of Louisiana under Section 115 of the Internal Revenue Code. The District is also exempt from federal income tax under Section 501(a) as a hospital organization described in Section 501(c)(3). The federal income tax exemptions also extend to state income taxes.

Net Patient Service Revenue and Related Receivables

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered. The Hospital provides services to patients who reside primarily in the local geographic region. Patient accounts receivable for which the Hospital receives payment under contractual arrangements are stated at the estimated net amounts from such payors, which are generally less than established billing rates.

Charity Care

The Hospital provides care without charge, or at amounts less than established rates, to patients who meet certain criteria under its charity care policy. Because the Hospital does not pursue collection of amounts determined to qualify for charity care, they are not reported as revenue.

Contractual Third-Party Payors

The Hospital provides acute care inpatient services to Medicare beneficiaries and are paid a predetermined amount for these services based, for the most part, on the Diagnosis Related Group (DRG) assigned to the patient. Medicare inpatient acute care capital-related costs are paid on a prospectively determined amount per discharge, subject to a minimum level based on a percentage of capital-related costs.

1. Accounting Policies (continued)

Medicaid inpatient services are paid on a prospective per diem basis. Medicare bad debts and outpatient, psychiatric and home health services to Medicare beneficiaries are reimbursed, subject to certain limitations imposed by governmental authorities, on a cost basis. Retroactive cost settlements based upon annual cost reports are estimated and recorded in the financial statements. Final determination of amounts to be received under cost reimbursement regulations is subject to review by program representatives. The difference between a final settlement and estimated settlement in any year is reported as an adjustment of net patient service revenue in the year the final settlement is made.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

Inventories

Inventories are valued at the latest invoice price which approximates the lower of cost (first-in, first-out method) or market.

Property, Plant, and Equipment

The Hospital records all property, plant, and equipment acquisitions at cost, except for assets donated to the Hospital. Donated assets are recorded at appraised value at the date of donation. The Hospital provides for depreciation of its plant and equipment using the straight-line method in amounts sufficient to amortize the cost of its assets over their estimated useful lives.

Assets held under capital lease obligations are included in equipment. These assets have been recorded at the present value of the minimum lease payments which approximated the fair market value of the leased assets (see Note 6). Amortization of leased assets is provided for using the straight-line method over the term of the related lease and is included in depreciation and amortization expense.

1. Accounting Policies (continued)

Investments and Investment Income

The Hospital's mutual fund investment, included in assets whose use is limited, is carried at the lower of cost or market value at the balance sheet date. Net unrealized gains and losses on noncurrent marketable securities, other than permanent declines, are recorded in fund balance. Investment income from all investments is reported as other revenue.

Cash Equivalents

The Hospital considers all highly liquid investments with a maturity of three months or less when purchased to be cash equivalents.

Reclassifications

Certain reclassifications have been made to the 1996 financial statements to conform to 1997 presentation.

2. Cash and Investments

Statutes authorize the Hospital to invest in United States government obligations, certificates of deposit of national banks located in Louisiana or banks organized under the laws of Louisiana, any federally insured investment, guaranteed investment contracts issued by a financial institution having one of the two highest rating categories of Standard & Poor's Corporation or Moody's Investors Services, or in mutual or trust institutions which are registered with the Securities Exchange Commission under the Securities Act of 1933 and the Investment Act of 1940 and which have underlying investments consisting solely of securities of the United States government or its agencies.

The Hospital's bank deposits consist of demand deposit accounts and certificates of deposit. These bank deposits are included in cash and cash equivalents and assets whose use is limited. At May 31, 1997, the Hospital's deposits were fully insured or collateralized with securities held by the agent of the pledging banks in the Hospital's name.

2. Cash and Investments (continued)

In addition to the bank deposits held, the Hospital had invested $1,375,737 and $1,312,113 at May 31, 1997 and 1996, respectively, in a mutual fund whose underlying investments consist solely of securities of the United States government or its agencies (see Note 3). The market value of the mutual fund was $1,326,534 and $1,262,147 at May 31, 1997 and 1996, respectively. The Hospital recorded the change in the valuation reserve as a net unrealized gain of $763 for the year ended May 31, 1997 and a net unrealized loss of $4,682 for the year ended May 31, 1996.

3. Assets Whose Use Is Limited

The Hospital's board of commissioners has designated certain assets to be used for future plant and equipment additions and replacement and to collateralize the letter of credit agreement. The composition of assets whose use is limited is set forth in the following table:

	May 31	
	1997	**1996**
Savings account	**$ 68,648**	$ 59,370
Certificates of deposit	**929,061**	898,577
Mutual fund investment, net of valuation allowance of $49,203 in 1997 and $49,966 in 1996	**1,326,534**	1,262,147
	$2,324,243	$2,220,094

4. Third-Party Reimbursement

The Hospital participates in the Medicare and Medicaid programs as a provider of medical services to program beneficiaries. During the years ended May 31, 1997 and 1996, approximately 77% and 78%, respectively, of gross patient service charges were derived from Medicare and Medicaid program beneficiaries. Certain Medicare and Medicaid services are reimbursed on a cost basis. Regulations in effect require annual retroactive settlements for these costs based upon cost reports filed by the Hospital. Although final settlements are not made until a subsequent period, the Hospital estimates and records these retroactive settlements in its financial statements in the period in which services are rendered.

4. Third-Party Reimbursement (continued)

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Hospital believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid program.

Differences between original estimates and subsequent revisions (including final settlements) are included in the statement of revenue, expenses, and fund balance in the period in which the revisions are made. During the year ended May 31, 1997, net patient service revenue was increased by approximately $700,000 to reflect changes in the estimated settlements for certain prior years. Management does not anticipate significant unfavorable adjustments by program representatives to unaudited Medicare or Medicaid settlements for the years ended May 31, 1994 through 1997.

5. Employee Retirement Plan

The Hospital sponsors a noncontributory, defined-contribution retirement plan, which covers substantially all full-time employees after they have met certain eligibility requirements. Under the provisions of the plan document, the Hospital is required to contribute 10% of the eligible employee's salary. The plan provides for the contributions (and interest allocated to the employee's account) to become partially vested after three years of continuous employment and fully vested after seven years of continuous employment. The unvested portion of an account of an employee who terminates employment before becoming fully vested is used to reduce the Hospital's current year contribution requirement. For the years ended May 31, 1997 and 1996, the contribution requirements were $943,675 and $810,146, respectively.

The Hospital has an additional retirement plan which covers all employees not covered under the above plan. Under the provisions of the plan, the Hospital is required to contribute 6.05% of the participating employee's salary. The employee becomes partially vested after three years of continuous employment and fully vested after seven years of continuous employment. For the years ended May 31, 1997 and 1996, the contribution requirements were $63,721 and $91,207, respectively.

5. Employee Retirement Plan (continued)

Contributions made during the periods for both plans discussed above were $909,294 and $723,799 in 1997 and 1996, respectively. The Hospital's unfunded contribution requirement related to both plans of $180,127 and $128,825 at May 31, 1997 and 1996, respectively, is included in other accrued liabilities on the balance sheet. Total payroll for all employees was $10,919,291 and $9,688,183 for the years ended May 31, 1997 and 1996, respectively. All employees of the Hospital are covered by one of the two plans discussed above.

The Hospital established the Morehouse General Hospital Tax Deferred Savings Plan. This plan, which qualifies as a tax-sheltered annuity plan under Section 403(b) of the Internal Revenue Code, covers all employees who elect to participate. The plan allows participants to defer a portion of their annual compensation. The amount of annual contributions to the plan by participants is subject to certain limitations as defined in the plan agreement. The participants vest 100% immediately in their contributions and investment earnings of the plan. The plan agreement allows discretionary employer contributions to be made to the plan. No employer contributions were made during the years ended May 31, 1997 and 1996.

Retirement expense net of forfeitures related to the above plans included in fiscal and administrative services on the statements of revenue, expenses, and fund balance was $960,596 and $846,449 for the years ended May 31, 1997 and 1996, respectively.

6. Leases

The Hospital has entered into several capital leases for various types of equipment. Under the terms of the leasing arrangements, the Hospital is obligated to pay a monthly rental payment over the primary term of the leases, which range from five to seven years.

6. Leases (continued)

Future minimum lease payments, by year and in the aggregate, under capital leases consisted of the following at May 31, 1997:

Fiscal year ending May 31	
1998	$1,058,899
1999	752,192
2000	733,049
2001	424,975
2002	166,462
Thereafter	114,138
Total minimum lease payments	3,249,715
Amount representing interest (ranging from 2.1% to 14.4%)	457,880
Present value of net minimum lease payments (including $864,538 classified as current)	$ 2,791,835

The cost of leased assets included in equipment totaled $5,602,902 and $5,014,656 and accumulated amortization was $3,106,073 and $2,747,235 at May 31, 1997 and 1996, respectively. The equipment collateralizes the capital lease obligations.

During the years ended May 31, 1997 and 1996, the Hospital entered into capital leases totaling $1,190,346 and $976,061, respectively.

7. Malpractice Insurance

During the ordinary course of operations, the Hospital has been named a defendant in lawsuits alleging medical malpractice. The Hospital is insured for malpractice insurance coverage on a claims-made basis for individual claims up to $100,000. For individual malpractice claims in excess of $100,000, the Hospital participates in the State of Louisiana Patient Compensation Fund. This fund provides malpractice insurance coverage on a claims-made basis for claims up to the statutory maximum exposure of $500,000, which currently exists under Louisiana law, plus interest and future medical costs. The Hospital has purchased additional malpractice insurance providing coverage up to $900,000 in the aggregate. The Hospital has renewed its existing malpractice insurance through October 31, 1997.

Tab II

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Report of Independent Auditors on the Internal Control Structure

The Board of Commissioners
Morehouse Parish Hospital Service District

We have audited the financial statements of Morehouse Parish Hospital Service District (Morehouse General Hospital) (the Hospital) as of and for the year ended May 31, 1997, and have issued our report thereon dated July 25, 1997.

We conducted our audit in accordance with generally accepted auditing standards and *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

The management of the Hospital is responsible for establishing and maintaining an internal control structure. In fulfilling this responsibility, estimates and judgments by management are required to assess the expected benefits and related costs of internal control structure policies and procedures. The objectives of an internal control structure are to provide management with reasonable, but not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition, and that transactions are executed in accordance with management's authorization and recorded properly to permit the preparation of financial statements in accordance with generally accepted accounting principles. Because of inherent limitations in any internal control structure, errors or irregularities may nevertheless occur and not be detected. Also, projection of any evaluation of the structure to future periods is subject to the risk that procedures may become inadequate because of changes in conditions or that the effectiveness of the design and operation of policies and procedures may deteriorate.

In planning and performing our audit of the financial statements of the Hospital for the year ended May 31, 1997, we obtained an understanding of the internal control structure. With respect to the internal control structure, we obtained an understanding of the design of relevant policies and procedures and whether they have been placed in operation and we assessed control risk in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide assurance on the internal control structure. Accordingly, we do not express such an opinion.

Our consideration of the internal control structure would not necessarily disclose all matters in the internal control structure that might be material weaknesses under standards established by the American Institute of Certified Public Accountants. A material weakness is a condition in which the design or operation of one or more of the specific internal control structure elements does not reduce to a relatively low level the risk that errors or irregularities in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. We noted no matters involving the internal control structure and its operation that we consider to be material weaknesses as defined above.

However, we noted certain matters involving the internal control structure and/or its operation that we have reported to the board of commissioners of the District in a separate letter dated July 25, 1997.

This report is intended for the information of the board of commissioners, management, and the Office of Legislative Auditor, State of Louisiana. However, this report is a matter of public record and its distribution is not limited.

Ernst & Young LLP

July 25, 1997

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Report of Independent Auditors on Compliance With Laws and Regulations

The Board of Commissioners
Morehouse Parish Hospital Service District

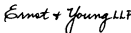
We have audited the financial statements of Morehouse Parish Hospital Service District (Morehouse General Hospital) (the Hospital) as of and for the year ended May 31, 1997, and have issued our report thereon dated July 25, 1997.

We conducted our audit in accordance with generally accepted auditing standards and *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

Compliance with laws, regulations, contracts, and grants applicable to the Hospital is the responsibility of the Hospital's management. As part of obtaining reasonable assurance about whether the financial statements are free of material misstatement, we performed tests of the Hospital's compliance with certain provisions of laws, regulations, and contracts. However, the objective of our audit of the financial statements was not to provide an opinion on overall compliance with such provisions. Accordingly, we do not express such an opinion. The Hospital has advised us that it has not received any grants; accordingly, no procedures were applied by us with respect to grants.

The results of our tests disclosed no instances of noncompliance that are required to be reported herein under *Government Auditing Standards*.

This report is intended for the information of the board of commissioners, management, and the Office of Legislative Auditor, State of Louisiana. However, this report is a matter of public record and its distribution is not limited.



July 25, 1997

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The Board of Commissioners
Morehouse Parish Hospital Service District

In planning and performing our audit of the financial statements of the Morehouse Parish Hospital Service District (Morehouse General Hospital) (the Hospital) for the year ended May 31, 1997, we considered its internal control structure in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide assurance on the internal control structure. Our consideration of the internal control structure would not necessarily disclose all matters in the internal control structure that might be material weaknesses under standards established by the American Institute of Certified Public Accountants. A material weakness is a condition in which the design or operation of one or more of the specific internal control structure elements does not reduce to a relatively low level the risk that errors or irregularities in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. However, we noted no matters involving the internal control structure and its operations that we consider to be material weaknesses as defined above.

The following observations and suggestions in procedures and controls at the Hospital have been included for your consideration.

Balanced Budget Act of 1997

The Balanced Budget Act of 1997 has steered Medicare down a new path—one from which there is no turning back. From now forward, the private sector will play a significant role in assuming the financial risk of the Medicare program. Slowly, the federally operated fee-for-service (FFS) system will erode, partly a result of public policy and partly of the growth of the newly created, and much favored, Medicare Choices program.

Change is most often measured in monetary terms, and this Budget Act is no different. Over the next five years, Medicare program outlays will be reduced by a total of $115 billion. Despite these changes, the Congressional Budget Office (CBO) estimates that the Medicare Trust Fund will still go bankrupt by 2007.

Although the spending reductions are significant, the underlying program changes, coupled with the looming Trust Fund insolvency issue, are driving the more fundamental changes included in the Budget Act. When reviewing the Act, the Hospital needs to take a

visionary approach, one that enables you to see beyond the numbers to the changes the Act will have on the long-term health care landscape. While many of the Act's provisions will have consequences today and will need to be dealt with from a tactical standpoint, their impact will also be felt in the years ahead.

In planning for the changes the Budget Act will create for the Hospital, we urge you to consider the following steps:

> ***Step 1, Financial Impact*** — Consider how the Budget Act payment reduction and managed care growth provisions will affect the Hospital's bottom line.
>
> ***Step 2, Environment*** — Discuss the attributes of the environment in which the Hospital does business. What will the focus in the Budget Act mean for your market environment? Your key stakeholders?
>
> ***Step 3, Enterprise Vision*** — After you assess the overall effects of the Act on your environment, consider how it affects your organization's mission and your stakeholders' wants.
>
> ***Step 4, Strategic Implications*** — What are the strategic implications for your enterprise as a whole? On selected departments? On your strategic partners? What are the strategic implications for your key stakeholders? Consider the interrelationships between implications for your key stakeholders and for your enterprise.
>
> ***Step 5, Infrastructure*** — What kinds of people, processes, and technologies will be needed for your enterprise and your key stakeholders to succeed?
>
> ***Step 6, New Competencies*** — What new skills will you need to bring to your organization? How will you bring them there? What new skills will your stakeholders need?
>
> ***Step 7, Change Assessment: The Proactive Approach*** — Using this method to assess the overall changes in your environment, mission, strategy, infrastructure, and competencies, assess the degree of change you will need to go through to meet your priorities. Then develop specific action steps from your answers to each question above.

Corporate Compliance Program

The federal government is aggressively pursuing strategies to eliminate fraud and abuse in the health care system. Unfortunately, the laws and regulations in this area are not always clear and are continually evolving. In some cases, what was generally accepted practice in the past has subsequently been deemed to be fraudulent or abusive.

In addition to the obvious business reasons for establishing an effective corporate compliance program, organizations have another incentive as well—the requirements of the Federal Sentencing Guidelines for Organizations ("Guidelines"), issued by the Federal government in 1991. In implementing a corporate compliance program, the Hospital should consider the requirements of the Guidelines. The negative ramifications of violations of laws and regulations may be mitigated if management has exercised due care in establishing a corporate compliance program that meets the minimum aspects of an effective program under the Guidelines. For example, the range of the fine for an organization with a corporate compliance program that meets the requirements of the Guidelines is substantially less than the range of the fine for an organization without such a program.

It is not enough to simply establish a corporate compliance program. As noted above, fines under the Guidelines may be mitigated only if the organization maintains an effective program. Therefore, after the Hospital establishes a corporate compliance program, it is important that the program's effectiveness be evaluated and documented on a periodic basis.

To strengthen controls, we encourage management and the board to implement procedures to evaluate the effectiveness of its Corporate Compliance Program on a periodic basis.

The following is a list of areas specifically identified by the Office of the Inspector General as potential problem areas in the industry:

- Capital Cost Prospective Payment System
- Outlier Payments
- Multiple Providers Within the 72-Hour Payment Window
- Diagnosis-Related Group Miscoding
- Outlier Adjustment Follow-Up
- Cost at Non-Prospective Payment System Providers
- Hospital Discharge Planning
- Ownership of Home Health Agencies and its Impact on Discharge Planning
- Medicare Paying for Items Included in Medicaid Rates
- Bad Debt Claims by Medicare Providers Yet HMO Liable

The Impact of the Year 2000

The Hospital's information systems and other business technologies are dependent on certain date-specific processing for patient care, billing and other relevant information. With the imminent arrival of the year 2000, a significant business issue has been created that directly impacts the technology utilized by the Hospital system. The problem relates to the manner in which technology handles dates. Most technology does not incorporate specific logic for addressing dates after December 31, 1999 due to assumptions made by software and magnetic chips that a two-digit year is in the twentieth century (i.e., 1900s).

Most technologies have been developed with the two-digit year assumptions due to the lack of computer memory and this being a way to save on that precious memory in the past.

The Hospital utilizes a significant amount of date-dependent information. Based on discussions with Harold Naff, Chief Financial Officer, and Annette Robertson, Data Processing Manager, we understand the Hospital is relying on its software vendor, SMS, to provide application updates that resolve year 2000 issues. We understand that one application has been completed, another is currently underway and other applications are planned that will address issues in an appropriate timetable. Mr. Naff and Ms. Robertson are currently satisfied with the actions taken by SMS. In conjunction with the steps currently underway, we recommend that the Hospital develop a formal plan to ensure that SMS changes made to software programs, data files and software systems are thoroughly tested before placed in use.

PC software utilized throughout the Hospital independent of SMS must be assessed to ensure year 2000 issues, if any, are identified and addressed. Equipment functioning with the aid of computer chips could also have underlying year 2000 issues that should be assessed and corrected. In addition, because the Hospital cannot be assured that its vendors, bankers and others will be properly prepared for the year 2000, the Hospital should consider implementing additional verification procedures to test the accuracy of information received from outside parties that is date-dependent.

Inventory

During our testing of inventory, we noted an error related to the compilation of the physical inventories for the dietary department. The error included only a partial amount of the counts made to the summary schedule which was used to record the actual physical counts. The effect of this error was clearly insignificant; however, we recommend that management develop policies to oversee the inventory levels reported and recorded by the department managers. We recommend that all inventory compilations be reviewed for reasonableness and clerical accuracy prior to recording book-to-physical adjustments. Any significant adjustments resulting form the physical counts should be investigated.

Form 1099 Timing

During our review of the forgiveness of certain debt to physicians, we noted that the Hospital issued a Form 1099-Misc to the physicians at the time of the debt issuance rather than the date of forgiveness. The Form 1099-Misc should be issued at the time that the compensation is earned, which in this case was at the time the debt was forgiven.

We recommend that the Hospital evaluate these procedures and appropriately report this type of compensation to the physicians.

* * * * *

We would like to express our appreciation to the management and staff of the Hospital for their assistance during our audit. We will be pleased to discuss the above comments or other items at your convenience and are available to provide any assistance needed in the development and implementation of any actions which you deem appropriate.

This report is indented solely for the use of management.

Ernst + Young LLP

July 25, 1997

Tab III

Presentation of Audit Results

Morehouse General Hospital
May 31, 1997

Ernst & Young Reports

- Morehouse General Hospital Audited Financial Statements
- Report on Internal Control Structure
- Report on Compliance With Laws and Regulations

SAS 61 Communications

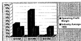
- Auditors' Responsibility under GAAS
- Significant Accounting Policies
- Accounting Estimates and Management Judgments
- Audit Adjustments
- Other

Financial Statement Overview

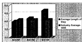
Condensed Statements of Revenues and Expenses

	Year ended May 31 1997	1996
Net patient service revenue	$ 29,002,378	$ 26,484,183
Other revenue	1,184,963	766,535
Total revenue	30,187,341	27,250,718
Routine and ancillary services	18,695,551	14,290,830
General, fiscal and admin services	6,527,048	7,394,300
Depreciation and amortization	1,882,270	1,833,600
Provision for bad debts	1,700,307	1,494,441
Interest expense	208,591	215,099
Total expense	29,025,807	25,894,550
Revenue in excess of expense	$ 1,161,456	$ 2,100,363

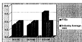
Operating Profit Margin



Average Length of Stay



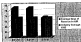
FTEs per Adjusted Average Daily Census



Condensed Balance Sheets

	May 31	
	1997	1996
Current assets	$ 10,259,787	$ 8,532,817
Assets whose use is limited	2,324,353	2,220,064
Other assets	320,008	338,430
Property, plant and equipment, net	10,473,472	9,819,861
Total Assets	$ 23,387,420	$ 20,911,311
Current liabilities	$ 4,293,149	$ 3,120,832
Debt and capital leases	1,927,297	1,767,712
Fund balance	17,174,974	16,022,767
Total Liabilities and Fund Balance	$ 23,387,420	$ 20,911,311

Average Days of Revenue in A/R



Condensed Statements of Cash Flows

	Year ended May 31 1997	1996
Revenue in excess of expense	$ 1,151,444	$ 2,366,363
Depreciation and amortization	1,902,200	1,865,600
Changes in operating assets and liabilities and other	762,458	(981,754)
Net Cash Provided by Operating Activities	3,816,122	3,250,209
Purchases of property, plant and equipment	(1,527,854)	(817,808)
Principal and interest payments on debt and capital leases	(1,233,118)	(1,184,822)
Interest received on investments	251,496	144,608
Other	(87,291)	(427,185)
Net Cash Used in Investing and Financing Activities	(2,645,855)	(2,064,335)
Net Increase in Cash and Cash Equivalents	$ 1,200,267	$ 983,874

Operating and Financial Indicators

	5/31/97	5/31/96	Industry Averages 1995
FTEs per adjusted average daily census	4.8	4.9	5.8
Salary and benefits per FTE	$34,118	$30,473	$34,939
Salary and benefits as a % of operating exp.	45.4%	46.3%	51.0%
Capital costs as a % of operating expenses	7.3%	8.3%	8.6%
Occupancy rate (acute only)	46.8%	49.5%	37.7%
Average length of stay (acute only)	4.0	4.2	4.1
O/P revenue as a % of total patient revenue	37.7%	37.8%	41.1%
Operating profit margin	4.0%	8.3%	2.8%
Total liabilities per bed	$51,023	$44,886	$49,646
Current ratio	3.9	3.4	2.3
Days revenue in accounts receivable	73.6	77.6	69.2
Return on fund balance	6.7%	13.5%	9.8%
Days expenses of cash on hand	81.3	72.9	29.8

Notes to Financial Statements

- Notes are similar in organization and content as prior year
- Includes all disclosures required by governmental health care entities

Balanced Budget Act of 1997

- Private sector assuming more Medicare risk
- Spending reductions significant
- Visionary approach-beyond numbers

Budget Act Action Plan

- Financial Impact
- Environment
- Enterprise Vision
- Strategic Implications
- Infrastructure
- New Competencies
- Change Assessment

Corporate Compliance

Current Issues and Developing an Effective Program

10

Goals

- **Develop and implement a corporate compliance program.**
- **Meet or exceed the U. S. Sentencing Commission Guidelines.**
- **Sleep peacefully at night !!!**

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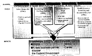

Six Steps To Developing A Successful Compliance Program:

STEP I Initial organization assessment

STEP II Building infrastructure for the Corporate Compliance Program

STEP III Building standards of conduct

STEP IV Establishing employee/compliance hotlines

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Six Steps To Developing A Successful Compliance Program: (cont.)

STEP V Communicating the Corporate Compliance Program to employees

STEP VI Evidencing effectiveness of the Corporate Compliance Program

20

Year 2000 Impact

- Business issue affecting all companies
- Morehouse relying on SMS-currently satisfied
- Test all changes
- Other PC systems
- Dealings with others

Other Observations

- Inventory error
- Form1099 timing

Tab IV

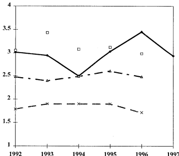
CURRENT RATIO

Morehouse General Hospital

$$\frac{\text{Current Assets}}{\text{Current Liabilities}}$$

The current ratio defines the number of dollars held in current assets per dollar of current liabilities. It is perhaps the most widely used measure of liquidity.

** Higher values are favorable *



Actual   Upper   Median   Lower

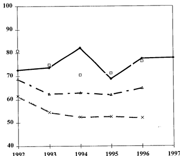
DAYS IN A/R - NET

Morehouse General Hospital

$$\frac{\text{Net Patient Accounts Receivable}}{\text{Net Patient Services Revenue / 365}}$$

The days in patient accounts receivable defines the average time that receivables are outstanding or the average collection period.

** Lower values are favorable **



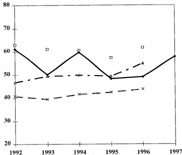
—+—Actual   Upper   —▲— Median   —×— Lower

AVERAGE PAYMENT PERIOD

Morehouse General Hospital

$$\frac{\text{Current Liabilities}}{(\text{Operating Expenses - Depreciation}) / 365}$$

The average payment period provides a measure of the average time that elapses before current liabilities are paid. High values may indicate potential liquidity problems.



Actual   Upper   Median   Lower

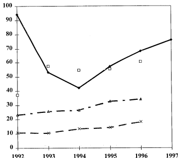
DAYS CASH ON HAND

Morehouse General Hospital

$$\frac{\text{Cash + Marketable Securities}}{\text{(Operating expenses - Depreciation) / 365}}$$

The days cash on hand measures the number of days of average cash expenses that the hospital maintains in cash and marketable securities. Higher values usually imply a greater ability to meet short-term obligations.

** Higher values are favorable **



Actual Upper Median Lower

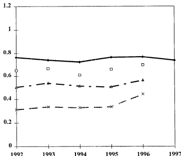
EQUITY FINANCING

Morehouse General Hospital

$$\frac{\text{Fund Balance}}{\text{Total Assets}}$$

The equity financing ratio measures the proportion of total assets that have been financed with equity. High Values for this ratio imply that the hospital has used little debt financing in its asset acquisition program and has relatively low financial leverage.

** Higher values are favorable **



Actual **Upper** **Median** **Lower**

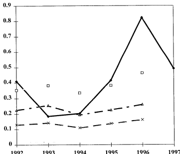
CASH FLOW TO TOTAL DEBT RATIO

Morehouse General Hospital

Excess of Revenues Over Expenses	+	Depreciation
Current Liabilities	+	Long-Term Debt

The cash flow to total debt ratio defines the proportion of cash flow to total liabilities, current and long-term. This ratio has been found to be an important indicator of future financial problems or insolvency.

** Higher values are favorable **



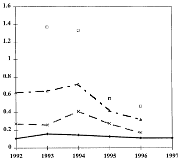
Actual　　Upper　　Median　　Lower

LONG-TERM DEBT TO EQUITY

Morehouse General Hospital

$$\frac{\text{Long-Term Liabilities}}{\text{Fund Balance}}$$

The long-term debt to equity ratio defines the proportion of long-term debt to unrestricted fund balances. Higher values for this ratio imply a greater reliance on debt financing and may imply a reduced ability to carry additional debt.



Actual — Upper — Median — Lower

FIXED ASSET FINANCING RATIO

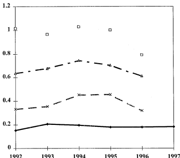
Morehouse General Hospital

Long-Term Liabilities

Net Fixed Assets

The fixed asset financing ratio expresses a relationship between a use of funds (debt principal) and a source of funds (depreciation). Depreciation on net fixed assets is a significant source of cash flow to retire the principal on long-term indebtedness.

** Lower values are favorable **



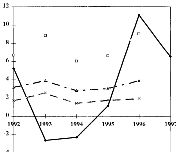
TIMES INTEREST EARNED RATIO

Morehouse General Hospital

$$\frac{\text{Excess of Revenues Over Expenses} + \text{Interest Expense}}{\text{Interest Expense}}$$

The times interest earned ratio defines the multiple by which current interest expense is being met from existing income. Higher values for this ratio usually imply better debt repayment ability.

** Higher values are favorable **



Actual   Upper   Median   Lower

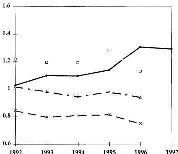
TOTAL ASSET TURNOVER RATIO

Morehouse General Hospital

Total Operating Revenue

Total Assets

The total asset turnover ratio provides an index of the number of operating revenue dollars generated per dollar of asset investment. Higher values for this ratio imply greater generation of revenue from the existing resource base.



Actual Upper Median Lower

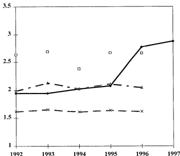
FIXED ASSET TURNOVER RATIO

Morehouse General Hospital

$$\frac{\text{Total Operating Revenue}}{\text{Net Fixed Assets}}$$

The fixed asset turnover ratio measures the number of operating dollars generated from the existing fixed asset base. High values are usually regarded as positive indicators of operating efficiency.

** Higher values are favorable **



Actual   Upper   Median   Lower

CURRENT ASSET TURNOVER RATIO

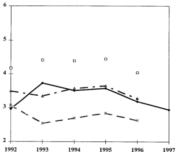
Morehouse General Hospital

Total Operating Revenue

Current Assets

The current asset turnover ratio measures the number of operating revenue dollars generated per dollar of investment in current assets. Higher values usually imply a greater efficiency in the employment of current assets.

** Higher values are favorable **



Actual — Upper — Median — Lower

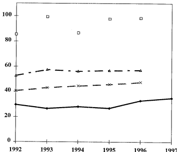
INVENTORY TURNOVER

Morehouse General Hospital

Total Operating Revenue
Inventory

The inventory ratio defines the number of operating revenue dollars generated per dollar of investment in inventory. High values for this ratio imply greater efficiency with respect to inventory investment.

** Higher values are favorable **



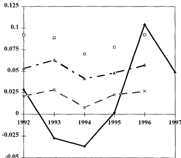
Actual **Upper** **Median** **Lower**

RETURN ON TOTAL ASSETS

Morehouse General Hospital

$$\frac{\text{Excess of Revenues Over Expenses}}{\text{Total Assets}}$$

The return on total assets ratio defines the amount of net income earned per dollar of investment. It is a widely used summary measure of profitability.



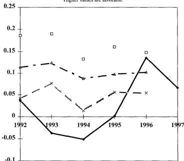
Actual   Upper   Median   Lower

RETURN ON EQUITY RATIO

Morehouse General Hospital

Excess of Revenues Over Expenses
Fund Balance

The return on equity ratio defines the amount of net income earned per dollar of unrestricted equity investment fund balance.

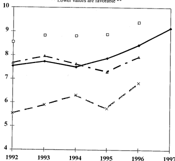


AVERAGE AGE OF PLANT

Morehouse General Hospital

Accumulated Depreciation
Depreciation Expense

The average age of plant provides a measure of the average age in years of the hospital's fixed assets. Lower values indicate a newer fixed asset base and thus less need for near-term replacement.



Actual Upper Median Lower

Operating Indicators
Hospital Size: 50-99 Beds

	Hospital		Industry Averages
	May 31, 1997	**May 31, 1996**	**1995**
FTEs per adjusted average daily census	**4.8**	4.8	5.0
Salary and benefits per FTE	**$31,119**	$30,473	$34,928
Salary and benefits as a % of operating expense	**45.6%**	46.3%	51.0%
Occupancy-acute	**46.5%**	49.1%	33.7%
Average length of stay-acute (days)	**4.0**	4.2	4.1
O/P revenue as a % of total patient revenue	**37.7%**	37.0%	41.1%
Operating profit margin	**4.0%**	8.2%	2.8%
Debt per bed	**$57,523**	$48,885	$49,546
Current ratio	**2.9**	3.4	2.5
Days in accounts receivable	**77.8**	77.6	68.2
Return on fund balance	**6.7%**	13.5%	9.8%
Days cash on hand	**81.5%**	72.9%	29.8%
Capital costs as a % of operating expenses	**7.3%**	8.3%	6.6%
Cash flow margin	**10.8%**	15.5%	10.1%