Fayette County Memorial Hospital

Financial Report

December 31, 1999

PLANTE & MORAN, LLP

Fayette County Memorial Hospital

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Fayette County Memorial Hospital

Contents

STATE OF OHIO
OFFICE OF THE AUDITOR
JIM PETRO, AUDITOR OF STATE

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Board of Trustees
Fayette County Memorial Hospital

We have reviewed the Independent Auditor's Report of the Fayette County Memorial Hospital, Fayette County, prepared by Plante & Moran LLP for the audit period January 1, 1999 through December 31, 1999. Based upon this review, we have accepted these reports in lieu of the audit required by Section 117.11, Revised Code. The Auditor of State did not audit the accompanying financial statements and, accordingly, we are unable to express, and do not express an opinion on them.

Our review was made in reference to the applicable sections of legislative criteria, as reflected by the Ohio Constitution, and the Revised Code, policies, procedures and guidelines of the Auditor of State, regulations and grant requirements. The Fayette County Memorial Hospital is responsible for compliance with these laws and regulations.

JIM PETRO
Auditor of State

June 20, 2000

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Certified Public Accountants
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Independent Auditor's Report

To the Board of Trustees
Fayette County Memorial Hospital

We have audited the accompanying balance sheet of Fayette County Memorial Hospital (a component unit of Fayette County, Ohio), as of December 31, 1999 and 1998, and the related statements of revenue and expenses, changes in fund balances 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 and the standards applicable to financial audits contained in 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. 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 Fayette County Memorial Hospital at December 31, 1999 and 1998, and the results of its operations and its cash flows for the years then ended, in conformity with generally accepted accounting principles.

In accordance with Government Auditing Standards, we have also issued our report dated February 18, 2000 on our consideration of Fayette County Memorial Hospital's internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts, and grants.

Plante & Moran, LLP

February 18, 2000

Fayette County Memorial Hospital

Balance Sheet

	December 31	
	1999	1998
Assets		
Current Assets		
Cash and cash equivalents (Note 2)	$ 1,333,744	$ 1,274,159
Patient accounts receivable (Note 3)	4,770,678	3,948,884
Current portion of notes receivable (Note 4)	87,724	100,879
Inventories	201,670	196,705
Prepaid expenses and other current assets	60,965	80,643
Third-party settlements (Note 5)	-	225,000
Total current assets	6,454,781	5,826,270
Notes Receivable (Note 4)	168,365	197,553
Investments (Note 2)	48,571	114,326
Assets Limited as to Use (Note 2)	199,489	199,489
Property and Equipment (Note 6)	8,929,727	8,656,127
Total assets	**$ 15,800,933**	**$ 14,993,765**
Liabilities and Fund Balance		
Current Liabilities		
Current portion of long-term debt (Note 7)	$ 88,604	$ 297,655
Accounts payable	560,885	622,405
Accrued payroll and related benefits	984,431	1,023,100
Total current liabilities	1,633,920	1,943,160
Long-term Debt (Note 7)	218,223	116,530
Fund Balance		
Unrestricted	13,749,301	12,734,586
Restricted (Note 2)	199,489	199,489
Total fund balance	13,948,790	12,934,075
Total liabilities and fund balance	**$ 15,800,933**	**$ 14,993,765**

See Notes to Financial Statements.

Fayette County Memorial Hospital

Statement of Operations

	Year Ended December 31	
	1999	1998
Operating Revenue		
Net patient service revenue (Note 8)	$ 19,938,355	$ 18,546,223
Other operating revenue	72,551	74,594
Total revenue	20,010,906	18,620,817
Operating Expenses		
Salaries and wages	6,883,876	6,843,875
Benefits	1,918,338	1,592,951
Physician fees	1,079,940	1,028,693
Other fees	1,483,510	1,503,772
Supplies	3,190,859	2,980,770
Utilities	433,669	415,301
Maintenance and repairs	533,728	467,057
Leases and rentals	88,847	95,420
Insurance	124,787	95,544
Interest expense	19,054	40,199
Depreciation and amortization	996,929	1,034,237
Provision for bad debts	1,860,597	1,411,101
Other expenses	520,277	752,393
Total operating expenses	19,134,411	18,261,313
Income from Operations	876,495	359,504
Nonoperating Gains - Net (Note 9)	138,220	228,005
Excess of Revenue Over Expenses	**$ 1,014,715**	**$ 587,509**

See Notes to Financial Statements.

Fayette County Memorial Hospital

Statement of Changes in Fund Balances

	Year Ended December 31	
	1999	1998
General Fund		
Balance - Beginning of year	$ 12,734,586	$ 12,147,077
Excess of revenue over expenses	1,014,715	587,509
Balance - End of year	**$ 13,749,301**	**$ 12,734,586**
Restricted Fund		
Balance - Beginning of year	$ 199,489	$ 200,504
Income from investments	10,500	10,232
Patient care expenses	(10,500)	(11,247)
Balance - End of year	**$ 199,489**	**$ 199,489**

See Notes to Financial Statements.

Fayette County Memorial Hospital

Statement of Cash Flows

	Year Ended December 31	
	1999	1998
Cash Flows from Operating and Nonoperating Activities		
Cash received from patients and third-party payors	$ 17,480,964	$ 16,548,386
Cash payments to suppliers for services and goods	(7,502,424)	(6,750,175)
Cash payments to employees for services	(8,826,551)	(8,864,812)
Other operating revenue received	74,371	74,594
Interest paid	(19,054)	(40,199)
Net cash provided by operating and nonoperating activities	1,207,306	967,794
Cash Flows from Noncapital Related Financing Activities -		
Donations and other	36,953	158,889
Cash Flows from Capital and Related Financing Activities		
Acquisition and construction of capital assets	(1,272,349)	(939,159)
Principal payments on long-term debt	(308,678)	(402,684)
Proceeds from issuance of long-term debt	201,320	-
Proceeds from sale of equipment	-	8,696
Net cash used in capital and related financing activities	(1,379,707)	(1,333,147)
Cash Flows from Investing Activities		
Proceeds from physician loan repayments	28,011	35,120
Proceeds from sale of investments	65,755	10,713
Purchase of investments	-	(3,000)
Interest received on investments	111,767	108,983
Disbursements - Restricted funds	(10,500)	(11,247)
Net cash provided by investing activities	195,033	140,569
Net Increase in Cash and Cash Equivalents	59,585	(65,895)
Cash and Cash Equivalents - Beginning of year	1,473,648	1,539,543
Cash and Cash Equivalents - End of year	**$ 1,533,233**	**$ 1,473,648**

See Notes to Financial Statements.

Fayette County Memorial Hospital

Statement of Cash Flows (Continued)

The composition of cash and cash equivalents at December 31 is as follows:

	1999	1998
Current assets	$ 1,333,744	$ 1,274,159
Assets limited as to use	199,489	199,489
Total	**$ 1,533,233**	**$ 1,473,648**

A reconciliation of income from operations to net cash from operating and nonoperating activities is as follows:

	Year Ended December 31	
	1999	1998
Income from operations	$ 876,495	$ 359,504
Adjustments to reconcile income from operations to net cash provided by operating and nonoperating activities:		
Bad debt expense	1,860,597	1,411,101
Depreciation and amortization	996,929	1,034,237
Forgiveness of physician loans	14,332	24,332
Loss of disposal of equipment	1,820	-
(Increase) decrease in assets:		
Patient accounts receivable	(2,682,391)	(1,997,815)
Inventories	(4,965)	10,429
Prepaid expenses and other current assets	19,678	16,732
Third-party settlements	225,000	(22)
Increase (decrease) in liabilities:		
Accounts payable	(61,520)	72,403
Accrued payroll and related benefits	(38,669)	36,893
Net cash provided by operating and nonoperating activities	**$ 1,207,306**	**$ 967,794**

See Notes to Financial Statements.

Note 1 - Nature of Business and Significant Accounting Policies

Reporting Entity - Fayette County Memorial Hospital ("the Hospital") is a 70-bed, general short-term acute care facility, owned by Fayette County, Ohio, and operated by a Board of Trustees. The Hospital is a component unit of Fayette County. Members of the Board of Trustees are appointed by the County Commissioners, the Probate Court Judge, and the Common Pleas Judge. Quorum Health Resources, Inc., under a contract expiring on June 30, 2002, currently manages the Hospital. The agreement provides that Quorum Health Resources, Inc., will provide a management team to oversee the operations of the Hospital.

Proprietary Fund Accounting - The Hospital utilizes the proprietary fund method of accounting, whereby revenue and expenses are recognized on the accrual basis. Substantially all revenue and expenses are subject to accrual.

Cash and Cash Equivalents - Cash and cash equivalents include cash and investments in highly liquid investments purchased with a maturity of three months or less, excluding amounts whose use is limited.

Inventories - Inventories, consisting of medical and office supplies and pharmaceutical products, are stated at cost, determined by the first-in, first-out method.

Investments - Investments consist of municipal bonds, carried at market value, as determined by quoted market prices.

Assets Limited as to Use - Assets limited as to use include assets temporarily restricted by donor.

Property and Equipment - Property and equipment are recorded at cost. Depreciation is computed principally on the straight-line basis over the estimated useful lives of the assets. Equipment under capital leases is amortized on the straight-line method over the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the financial statements. Costs of maintenance and repairs are charged to expense when incurred.

Compensated Absences - Vacation and sick pay are charged to operations when earned. Unused and earned benefits are recorded as a current liability in the financial statements.

Note 1 - Nature of Business and Significant Accounting Policies (Continued)

Net Patient Service Revenue - The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others. Retroactive adjustments to these estimated amounts are recorded in future periods as final settlements are determined.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Management believes that it is in compliance with all applicable laws and regulations. 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 programs.

Income from Operations - For purposes of display, transactions deemed by management to be ongoing, major, or central to the provision of health care services are reported as operating revenue and expenses. Peripheral or incidental transactions are reported as nonoperating gains and losses.

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

Pension Plan - Substantially all of the Hospital's employees are eligible to participate in a defined benefit pension plan sponsored by the Public Employees Retirement System of Ohio (PERS). The Hospital funds pension costs accrued, based on contribution rates determined by PERS.

Contributions - Contributions of cash and other assets, including unconditional promises to give in the future, are reported as revenue when received, measured at fair value. Contributions with donor imposed time or purpose restrictions are reported as restricted support. All other contributions are reported as unrestricted support.

Note 2 - Deposits and Investments

The Hospital's deposits and investments are composed of the following:

1999	Cash and Cash Equivalents	Investments	Assets Limited as to Use
Deposits	$ -	$ -	$ 199,489
Bank cash management funds	1,333,744	-	-
Municipal bonds	-	48,571	-
Total	$ 1,333,744	$ 48,571	$ 199,489
1998			
Deposits	$ -	$ -	$ 199,489
Bank cash management funds	1,273,334	-	-
Municipal bonds	-	114,326	-
Petty cash and cash on hand	825	-	-
Total	$ 1,274,159	$ 114,326	$ 199,489

Deposits	1999	1998
Amount of deposits reflected on the accounts of the bank (without recognition of checks written but not yet cleared or of deposits in transit)	$ 1,877,716	$ 1,955,789
Amount of deposits covered by federal depository insurance	399,489	399,489
Amount of deposits uninsured	$ 1,478,227	$ 1,556,300

Note 2 - Deposits and Investments (Continued)

Investments - The Hospital's investments are categorized below to give an indication of the level of risk assumed by the entity. Risk Category 1 includes those investments that meet any one of the following criteria:

a. Insured
b. Registered
c. Held by the Hospital or its agent

Risk Categories 2 and 3 include investments that are neither insured nor registered. Category 2 includes investments that are held by the counterparty's trust department (or agent) in the Hospital's name. Category 3 includes investments held by:

a. The counterparty
b. The counterparty's trust department (or agent) but not in the Hospital's name.

	Category			
	1	2	3	Carrying Amount
1999				
Municipal bonds	$ 48,571	$ -	$ -	$ 48,571
1998				
Municipal bonds	$ 114,326	$ -	$ -	$ 114,326

The bank cash management funds are not categorized because they are not evidenced by securities that exist in physical or book entry form.

Note 2 - Deposits and Investments (Continued)

Assets Limited as to Use - Assets limited as to use are designated or restricted as follows:

	1999	1998
Temporarily restricted by donor - for specific purposes	$ 199,489	$ 199,489

Note 3 - Patient Accounts Receivable

The details of patient accounts receivable are set forth below:

	1999	1998
Total patient accounts receivable	$ 9,623,678	$ 7,335,884
Less allowance for:		
Uncollectible accounts	(1,331,000)	(1,348,000)
Contractual adjustments	(3,522,000)	(2,039,000)
Net patient accounts receivable	$ 4,770,678	$ 3,948,884

Note 4 - Notes Receivable

Notes receivable represent loans to physicians under various cash flow support and loan arrangements. These loans are to be repaid in varying monthly installments including interest at rates ranging from 0 percent to 6.0 percent, and are unsecured. A portion of the physician notes receivable are forgiven over time under the terms of the physician loan agreement. A summary of these amounts outstanding is as follows:

	1999	1998
Total notes receivable	$ 256,089	$ 298,432
Less: Current portion	87,724	100,879
Long term portion	$ 168,365	$ 197,553

Note 5 - Cost Report Settlements

Approximately 53 percent of the Hospital's revenues from patient services are received from the Medicare and Medicaid programs. The Hospital has agreements with these payors that provide for reimbursement to the Hospital at amounts different from its established rates. Contractual adjustments under third-party reimbursement programs represent the difference between the Hospital's established rates for services and amounts reimbursed by third-party payors. A summary of the basis of reimbursement with these third-party payors follows:

Medicare - Inpatient, acute-care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Some outpatient services and defined capital costs related to Medicare beneficiaries are paid based upon a cost reimbursement method. Other outpatient services, including ambulatory surgery, radiology and laboratory services, are reimbursed on an established fee-for-service methodology.

Medicaid - Inpatient, acute-care services rendered to Medicaid program beneficiaries are also paid at prospectively determined rates per discharge. Capital costs relating to Medicaid inpatients are paid on a cost-reimbursement method. The Hospital is reimbursed for outpatient services on an established fee-for-service methodology.

Cost report settlements result from the adjustment of interim payments to final reimbursement under these programs and are subject to audit by fiscal intermediaries. Although these audits may result in some changes in these amounts, they are not expected to have a material effect on the accompanying financial statements.

Note 6 - Property and Equipment

Cost of property and equipment and depreciable lives are summarized as follows:

	1999	1998	Depreciable Life - Years
Land	$ 309,750	$ 309,750	
Land improvements	602,117	597,157	10-20
Building	8,026,256	7,991,323	15-50
Fixed equipment	1,021,458	884,375	5-20
Major movable equipment	6,781,720	6,027,807	5-25
Construction in progress	632,879	314,193	
Total cost	17,374,180	16,124,605	
Less accumulated depreciation	8,444,453	7,468,478	
Net carrying amount	$ 8,929,727	$ 8,656,127	

Construction in progress at December 31, 1999, consists of renovations to the existing buildings. Estimated costs to complete the renovations to the existing buildings is approximately $200,000. Management anticipates financing these costs through operations.

Note 7 - Long-term Debt

Long-term debt consists of the following:

	1999	1998
Fixed Rate Hospital Improvement Revenue Notes:		
Series 1995 A	$ -	$ 207,164
Obligations under capital leases	306,827	207,022
Total	306,827	414,185
Less: Current portion	88,604	297,655
Long-term portion	$ 218,233	$ 116,530

The Fixed Rate Hospital Improvement Revenue Note (Series 1995 A) matured in equal monthly installments through December 1, 1999, and bears interest at 6.05 percent. The note was collateralized by a medical office building. The note also contained various restricted covenants including interest coverage ratios, restrictions on investment purchases and insurance coverages. The note was paid in full during 1999.

Note 7 - Long-term Debt (Continued)

Minimum principal payments to maturity on these capital lease obligations as of December 31, 1999, are as follows:

2000	$ 104,483
2001	102,284
2002	46,625
2003	46,625
2004	42,740
Total	342,757
Less interest	35,930
Net present value	$ 306,827

The above capital leases are due in monthly installments totaling approximately $8,700 at December 31, 1999, including imputed interest at rates ranging from 5.32 percent to 7.46 percent. They expire at various times through 2004, and are collateralized by the equipment leased.

	1999	1998
Cost of equipment under capital lease	$ 473,854	$ 1,096,798
Less accumulated amortization	119,124	825,719
Net carrying amount	$ 354,730	$ 271,079

Note 8 - Net Patient Service Revenue

Net patient service revenue consists of the following:

	1999	1998
Revenue:		
Inpatient services:		
Routine services	$ 3,320,044	$ 3,748,730
Ancillary services	5,810,303	6,657,348
Outpatient ancillary services	21,156,496	18,386,319
Total patient revenue	30,286,843	28,792,397
Revenue deductions:		
Provision for contractual allowances	9,771,511	9,682,814
Provision for charity care	419,265	386,430
Other allowances	157,712	176,930
Total revenue deductions	10,348,488	10,246,174
Total net patient service revenue	$ 19,938,355	$ 18,546,223

Note 9 - Nonoperating Gains

Nonoperating gains consist of the following:

	1999	1998
Donations, gifts and grants	$ 8,573	$ 56,302
Investment income	101,267	98,751
Other gains	28,380	72,952
Nonoperating gains - Net	$ 138,220	$ 228,005

Note 10 - Defined Benefit Pension Plan

Plan Description - The Hospital contributes to the Public Employees Retirement System of Ohio (PERS), a cost-sharing, multiple-employer defined benefit pension plan administered by the Public Employees Retirement System. PERS provides retirement and disability benefits, annual cost of living adjustments, and death benefits to plan members and beneficiaries. Chapter 145 of the Ohio Revised Code assigns authority to establish and amend benefit provisions to the PERS Board of Trustees. PERS issues a stand-alone financial report available to the public that includes financial statements and required supplementary information for PERS. That report may be obtained by writing to Public Employees Retirement System, 277 East Town Street, Columbus, Ohio 43215-4642 or by calling 614-466-2085 or 1-800-222-PERS (7377).

Funding Policy - Plan members are required to contribute 8.50 percent of their annual covered salary, and the Hospital is required to contribute at an actuarially determined rate, which is currently 13.55 percent, of annual covered payroll. The contribution requirement of plan members and the Hospital is established and may be amended by the PERS Board of Trustees. The Hospital's contributions to PERS for the years ended December 31, 1999, 1998 and 1997, were $898,371, $890,857 and $867,395, respectively.

Postretirement Benefits - Public Employees Retirement System of Ohio provides postretirement health care coverage to age and service retirants with ten or more years of qualifying Ohio service credit. Health care coverage for disability recipients and primary survivor recipients is available. The health care coverage provided by the retirement system is considered an Other Postemployment Benefit (OPEB), as described in GASB Statement No. 12. A portion of each employer's contribution to PERS is set aside for the funding of postretirement health care. The Ohio Revised Code provides statutory authority for employer contributions. The 1999 employer contribution rate for local government employer units was 13.55 percent of covered payroll; 4.2 percent was the portion that was used to fund health care for the year.

The Ohio Revised Code provides the statutory authority requiring public employers to fund postretirement health care through their contributions to PERS.

OPEBs are financed through employer contributions and investment earnings thereon. The contributions allocated to retiree health care, along with investment income on allocated assets and periodic adjustments in health care provisions, are expected to be sufficient to sustain the program indefinitely.

Note 10 - Defined Benefit Pension Plan (Continued)

Expenditures for OPEB during 1999 for PERS were $524 million. As of December 31, 1999, the unaudited estimated net assets available for future OPEB payments for PERS were $9,870 million. The number of benefit recipients eligible for OPEB for PERS at December 31, 1999, was 118,062.

Note 11 - Risk Management

The Hospital is exposed to various risks of loss related to property loss, torts, errors and omissions, and employee injuries (workers' compensation). The Hospital has purchased commercial insurance for malpractice, general liability, employee medical and workers' compensation claims.

The Hospital is insured against medical malpractice claims under a claims-made policy, whereby only the claims reported to the insurance carrier during the policy period are covered regardless of when the incident giving rise to the claim occurred. Under the terms of the policy, the Hospital bears the risk of the ultimate costs of any individual claim exceeding $1,000,000 or aggregate claims exceeding $3,000,000 for claims asserted in the policy year.

Should the claims-made policy not be renewed or replaced with equivalent insurance, claims based on occurrences during the claims-made term, but reported subsequently, will be uninsured.

There are several pending claims against the Hospital. There is insurance coverage, but it is possible that the liability for the claims may exceed the aggregate insurance coverage. There are also pending claims against the Hospital that are not insured. Management intends to vigorously defend these claims. Presently, it is not possible to determine the resolution of the claims or amount of liability, if any.

Note 12 – Contingency

In June 1993, the Office of the Inspector General of the Department of Health and Human Services requested information from Quorum in connection with an investigation involving Quorum's procedures for preparing Medicare cost reports. In January 1995, the U.S. Department of Justice issued a Civil Investigative Demand, which also requested information from Quorum in connection with that same investigation. As part of the government's investigation, several former and current employees of Quorum were interviewed. Quorum cooperated fully with the investigation. Quorum received no communication from the government on this matter from approximately June 1996 until August 1998.

In August 1998, the government informed Quorum that the investigation was prompted by allegations made by a former employee of a hospital managed by Quorum. The allegations concern the preparation of cost reports for Medicare and other government payment programs for hospitals owned or managed by Quorum since January 1, 1984. In October 1998, the government commenced litigation under the False Claims Act. Quorum intends to cooperate with the government's inquiry, and, if appropriate, will try to reach a settlement of this case.

The Hospital has been managed by Quorum, and thus is a potential defendant in the case, along with hundreds of other hospitals owned and managed by Quorum. The Hospital has not been identified as a specific defendant in the litigation and has not been served in the case. Whether the Hospital will ever be named as a party defendant in the litigation is unclear. Even if the Hospital were at some point to be brought into the case as a party defendant, it is unclear whether the Hospital would be subject to fines, penalties, damages or other actions or whether any such action or liability would have a material adverse effect on the Hospital's financial condition or results of operations.

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Report Letter on Compliance with Laws and Regulations and Internal Control – General Purpose Financial Statements

Board of Trustees
Fayette County Memorial Hospital

We have audited the financial statements of Fayette County Memorial Hospital as of and for the year ended December 31, 1999, and have issued our report thereon dated February 18, 2000. We conducted our audit in accordance with generally accepted auditing standards and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

Compliance

As part of obtaining reasonable assurance about whether Fayette County Memorial Hospital financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grants, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance that are required to be reported under *Government Auditing Standards*.

Internal Control Over Financial Reporting

In planning and performing our audit, we considered Fayette County Memorial Hospital's internal control over financial reporting 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 over financial reporting. Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control over financial reporting that might be material weaknesses. A material weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements 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 over financial reporting and its operation that we consider to be material weaknesses.

This report is intended solely for the information and use of the Auditor of the State of Ohio, Board of Trustees, and management and others within the organization and is not intended to be and should not be used by anyone other than these specified parties.

Plante & Moran, LLP

February 18, 2000

PLANTE & MORAN, LLP

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February 18, 2000

To the Board of Trustees
Fayette County Memorial Hospital
Washington Court House, Ohio

During our audit, we were observant for opportunities for improvement in certain procedures for financial reporting, none of which were considered reportable conditions or material weaknesses.

We have also summarized significant regulatory, reimbursement and tax developments that may impact the Fayette County Memorial Hospital. Our observations relative to are enclosed in the following reports:

I. Regulatory and Reimbursement Developments
II. Required Communications to the Board of Trustees

We appreciate the opportunity to be of service to the Hospital. The cooperation extended to us by your staff throughout the audit was greatly appreciated. Should you wish to discuss any of the items included in this report, we would be happy to do so at your convenience.

Very truly yours,

PLANTE & MORAN, LLP

David L. Scheffler
Partner

Jordan F. Pace
Associate

I. Regulatory and Reimbursement Developments

BALANCED BUDGET ACT OF 1997

Hospitals

The Hospital continues to be affected by the Balanced Budget Act of 1997. The following is a summary of the significant items that will continue to impact the Hospital over the next four to five year period:

- The Act reduced Medicare spending by $116 billion and Medicaid spending by $24 billion over a five-year period.
- Most of the Medicare savings would come from provider and managed care payment reductions.
- A prospective payment system will be implemented for hospital outpatient and home health services, and shifts home health costs from Medicare Part A to Part B.
- Medicare savings of $15 billion would be achieved through a 25 percent increase in Part B premiums, to be phased in over seven years.
- Medicare DRG updates will be as follows:

Federal Fiscal Year Ended September 30	
2000	Market basket less 1.8%
2001, 2002	Market basket less 1.1%

- Medicare capital rates were decreased nearly 18 percent for1998. This will have the effect of reducing rates for 1999 through 2002 as future years inflationary updates are now based on a lower initial rate.
- Medicare reimbursable bad debts for unpaid deductibles and coinsurance are reduced by 40 percent for federal fiscal year beginning October 1, 1998, and 50 percent thereafter. Previously, the amounts were fully reimbursed by Medicare.
- Outpatient reimbursement calculations were revised to eliminate what the government calls "formula-generated overpayments," resulting in a significant decrease in outpatient radiology, ambulatory surgery, and other diagnostic reimbursement.

FEDERAL FISCAL YEAR ENDED SEPTEMBER 30, 1999 FINAL REGULATIONS

- BBA Refinement Act of 1999 – Addresses flawed policy and excessive payment reductions resulting from the Balanced Budget Act of 1997. It provides for increased payments for certain Medicare covered services.
- According to preliminary CBO estimates, payment increases will be $1.2 billion in 2000 and $16.4 billion over five years.
- Increased payments to hospitals over this 5-year period are expected to total $7.1 billion.
- Clarifies Congress intent that the new PPS system IS NOT supposed to impose an additional 5.7% reduction on top of the removal of formula driven overpayment.
- Delays 15% reduction in payment limits for home health until after the first year of implementation of home health PPS.
- Inpatient DRG Rates – For discharges occurring on or after October 1, 1999, the update has been established at market basket less 1.8 percent. It is estimated that the net update will total 1.1 percent.
- Outliers – Outlier payments are expected to decrease by 1.2 percent
- Federal Capital Rate – For discharges occurring on or after October 1, 1999, the capital rate is established at $377.03 for fiscal year 2000, down from $378.05 for fiscal year 1999.

PART A SERVICES

SNF's

- 20% increase in per diem for specific RUG-III groups
- Authorized facilities to elect immediate transition to federal rate. The must file request from FI. For cost report periods beginning on or after 1-1-2000.
- Pass through payments for certain ambulance services, prostheses and chemotherapy drugs. Effective date for services on or after 4-1-2000.

Hospitals

- Indirect medical education adjustment frozen at 6.5% through FY 2000, reduced to 6.25% for FY 2001(1.54 in the calculation) and 5.5% for 2002. There will be a special adjustment made for the first 6 months of 2000.
- DSH reduction frozen at 3% for 2001 and changed to 4% for FY 2002. The secretary is to study the payment methodology and recommend an alternative method.

FEDERAL FISCAL YEAR ENDED SEPTEMBER 30, 1999 FINAL REGULATIONS (CONT.)

PART B SERVICES

Hospital Outpatient PPS

- There will be an outlier payment for those high cost procedures. The methodology will be consistent with the inpatient system.
  - Pool of payments not to exceed 2.5% of outlier funds
  - Budget neutral
  - Cost will be calculated based upon a hospital total rather than specific departments

- For the first 2 to 3 years under APC's, there will be additional payments for certain devices, drugs and biologicals. The additional payment will be adjusted for the amount of already included in the APC payment.

- Transitions from the cost based system over the first 3 years.

- Payment floors established based on pre-BBA amounts.

- Pre-BBA amount is the hospital's outpatient reimbursement for services furnished in the cost report ending in federal fiscal year 1996, adjusted for the elimination of the formula driven overpayment.

- Before 2002: 80% of the 1st 10% of the difference, 70% of the next 10%, 60% of the nest 10%. If difference exceeds 30%, then the payment will be an additional 21%.

- 2002, 70% of the 1st 10%, 60% of the nest 10%. If difference is greater than 20%, additional 13%.

- 2003, 60% of 1st 10%. If difference is greater than 10%, additional 6%.

- Cancer hospital are permanently excluded.

- The coinsurance is limited to the inpatient deductible.

- The budget neutrality will be applied. The estimated overall impact from the 6-30-1999 was a reduction of 5.7%. The rates will be increased to remove the 5.7% reduction.

Other Services

- 2 year moratorium on the $1,500 caps for therapy for 2000 and 2001.

- Temporary increase in payment rates for DME and oxygen. The increase for 2001 is .3% and 2002 is .6%.

Home Health

- One year delay of 15% reduction in payments
- Exception of DME from consolidated billing.
- Additional $10 per patient for OASIS for cost report periods beginning in 2000
- 2% increase in PBL for periods starting on or after 10-1-1999
- Full Market basket update for 2002 and 2003
- Surety Bonds lessor of $50,000 or 10% of Medicare payments.

Corporate Compliance

Regulatory agencies have placed continuing emphasis on providers of health care services in the area of compliance-related issues. Laws and regulations governing health care are often ambiguous, and in many cases, practices accepted in the past are subsequently considered instances of fraud and abuse. Accordingly, we recommend that the Hospital continue its development and, more importantly, continue the implementation of the Corporate Compliance Program to reduce the risk of noncompliance in several areas. The areas that are receiving high levels of scrutiny by the Office of the Inspector General (OIG) include the following:

- DRG Upcoding
- Improper billing of inpatient transfer cases
- Laboratory unbundling
- 72-Hour window violations for outpatient services
- Pharmaceuticals administered to outpatients
- Payment for referrals

Recently, the Justice Department and the OIG published its annual report. During 1998, the government imposed $480 million in fines and settlements in healthcare fraud cases, and federal prosecutors filed 322 criminal cases during this period. These results are expected to continue for years to come as the federal government continues to fund these agencies with significant resources. The OIG and the U.S. Attorneys received $119 million to combat fraud and abuse during 1998 and the FBI received funding to hire 44 additional agents specifically for fraud and abuse. In 1992, there were 112 FBI agents addressing healthcare fraud. There are now in excess of 460 agents.

These actions by the government place added importance on the Hospital's compliance program. Keep in mind that having a written program is not sufficient. The program needs to be part of the everyday practices of the Hospital to be effective in the eyes of the government. Although the Hospital has developed a written plan, we strongly recommend Management continue placing a high priority on the implementation and ongoing monitoring of the plan.

HIPAA: Important Federal Regulation for Employers, Health Plans, Providers and Service Organizations in the Health Care Industry

President Clinton signed into law the Health Insurance Portability and Accountability Act of 1996 (HIPAA) on August 21, 1996. Don't be misled by the name. This new federal law (P.L. 104-191) applies to many health care market players, not just health plans and insurance companies. It is the most sweeping legislation to affect the health care industry in over thirty years. HIPAA is comprised of two major legislative actions including health insurance reform and administrative simplification. The health insurance reform provisions have been in effect for some time and required implementation of certain practices by health plans and insurers regarding portability and continuity of health coverage. Administrative Simplification (AS) provisions which may become effective as soon as the 4th qtr of 1998.

AS provides for the establishment of various protections, standards and requirements for the transmission, storage and handling of certain electronic health care transactions. Market players affected include government and private health plans and insurers, hospitals, physicians, care providers, employers, clearinghouses, practice management system vendors, billing agents, and other service organizations. The intent of AS is to improve the efficiency and effectiveness of the health care system and is expected by many in the industry to promote long term benefits through the use of widely adopted electronic health care transaction standards.

AS includes provisions for five distinct areas regarding the exchange of electronic administrative health care transactions. The five areas include transaction standards, code set standards, standards for unique health identifiers, security standards, and privacy protections. The Department of Health and Human Services (DHHS) is required under HIPAA to adopt the specified standards. Prior to adoption, the proposed standards will be published in the Federal Register and the public will have a sixty-day period in which to provide comments to DHHS through the Notice of Proposed Rule Making (NPRM) process. Sometime after the sixty-day comment period, the DHHS Secretary will adopt the final standards. Finally, DHHS is required to submit recommendations to Congress for privacy legislation to protect individually identifiable health information (submitted on September 11, 1997). If Congress fails to enact privacy legislation by August 21, 1999, the DHHS Secretary must issue privacy regulations by February 21, 2000.

Compliance with AS must be attained within two years of the standards adoption date, except for small health plans with fifty or fewer members. These small health plans must comply within three years of the standards adoption date. Those who do not comply may be fined up to a maximum of $25,000 for any identical requirement violated in a one-year period. Wrongful disclosure of individually identifiable health data is a felony offense and punishable by one to ten years imprisonment and fines of $50,000 - $250,000.

Much of the initial work to develop the AS standards has been completed by the DHHS Data Council. The following paragraphs summarize the standards proposed, or in some cases to be proposed later, for adoption by the DHHS Secretary.

The transaction standards, subject to modification through the NPRM process, include the American National Standards Institute (ANSI), Accredited Standards Committee (ASC) X12 transaction sets (version 4010) for claims/encounters, attachments, enrollment, disenrollment, eligibility, payment/remittance advice, premium payments, first report of injury, claim status, referral certification/authorization and coordination of benefits. Under HIPAA, compliance with the ANSI ASC X12 transaction sets may be achieved through the use of a clearinghouse.

HIPAA: Important Federal Regulation for Employers, Health Plans, Providers and Service Organizations in the Health Care Industry (Continued)

The code set standards for diagnosis and procedure codes, subject to modification through the NPRM process, include those defined under the International Classification of Diseases -- 9th Revision -- *Clinical Modification (ICD-9-CM) and the Health Care Financing Administration (HCFA) Common* Procedure Coding System (HCPCS). Pharmacy transactions will use the code set specified by the National Council of Prescription Drug Programs (NCPDP). Standards for unique health identifiers include identifiers for payers, providers, employers and individuals. HCFA has established standards for payers and providers, the PAYERID and the National Provider Identifier (NPI), respectively. Also, the widely used Employer Identification Number (EIN) is specified for use as the unique employer health identifier. The standard for unique individual health identifiers continues to undergo evaluation and is not ready due to unresolved privacy concerns.

Standards for all unique health identifiers are subject to change resulting from the aforementioned NPRM process.

Finally, the security standards protect the integrity, confidentiality and availability of health care information through the establishment of administrative, physical and technical controls. The standards, which are subject to modification through the NPRM process, include a comprehensive matrix of security requirements to be implemented, as appropriate, by organizations involved in the exchange of the above listed electronic health care transactions. A list of security standards is included in the requirement that organizations may choose from to help implement their security program. The technologies, techniques and measures that may be deployed are discretionary based upon the organization's exposure and risk levels. It is up to each organization to deploy the appropriate security measures commensurate with the circumstances and operations of their organization.

The AS provisions under HIPAA present important and far-reaching regulations throughout the health care industry. These regulations extend beyond the traditional relationships between caregivers and health plans. Consequently, employers and other organizations exchanging electronic health care transactions are also a part of the HIPAA landscape.

Federal Omnibus Appropriations Bill

The bill, which was passed on October 21, 1998, had the following significant effects on healthcare finance:

- The HHS Office of Inspector General received an additional $126 million to continue its efforts in Medicare and Medicaid fraud issues.

- Home Health Agency per visit and per beneficiary limits will see some increases effective for cost reporting periods after October 1, 1998. In addition, the Bill delays the 15 percent cost reduction in HHA payments until after October 1, 2000, limits the increase in HHA payment rates to the market basket minus 1.1 percent and extends the scheduled elimination of periodic interim payments until October 1, 2000. HCFA is currently in the process of developing regulations that will implement these changes.

Other Medicare Developments

- HCFA to Proceed with Physician Practice Expense Values – HCFA is proceeding, as required by law, with the development of new Medicare relative values for practice expenses. Currently, the relative values for practice expenses are calculated using historical Medicare charge data. The new practice expense values will be based on actual resources used to provide care.

- Outpatient Physical Therapy – Effective January 1, 1999, outpatient physical therapy services are reimbursed on a fee-for-service basis for the Medicare program.

- Home Health Billings - HCFA has announced that claims for Medicare Home Health services provided after July 1, 1999 must be billed in fifteen-minute increments. Timing for the visit begins when the service provider reaches the patient's residence and does not include travel time.

- Home Health Assessment and Data Requirements – Final rules have been issued detailing that home health agencies must now give patients a comprehensive assessment that identifies patients needs and addresses the patient's medical, nursing, rehabilitative, social, and discharge planning needs.

Department of Justice Activities

- As noted in recent publications, hospitals in almost half of the states in the nation have received notification from the Department of Justice alleging that they violated Medicare's **three day window rule (72-hour rule)** by billing separately for outpatient charges that should have been included in DRG payments. It is our understanding that the State of Michigan has been targeted for investigation under this rule.

- The Department of Justice and the Office of Inspector General have started an initiative to target hospitals that **upcode pneumonia** cases and violate transfer rules. At the recent annual meeting for the American Hospital Association, it was noted that both the DOJ and OIG have found not only that hospitals have upcoded pneumonia cases, but also that various healthcare consultants are advising clients to upcode these cases to improve reimbursement.

- The OIG has initiated a specific effort to focus on **inpatient transfer cases** that have been erroneously billed as discharges. Recently the Department of Justice has notified approximately 200 hospitals in the United States informing them that they may have improperly coded transfers to other prospective payment system facilities as discharges, which resulted in overpayments to the hospitals.

Tax Developments

- Big changes are in store for the 1999 Form 5500, the annual information return that many retirement, health and welfare and fringe benefit plans must file. The first noticeable change is the major revision in the layout of the Form 5500. However, perhaps even more importantly, processing the fillings will become the responsibility of the Department of Labor instead of the Internal Revenue Service. The DOL has hired a private company to build and manage the Form 5500 computer processing system. This system is will be much more sophisticated that will allow the DOL to identify inconsistencies and perform comparison that could identify compliance problems.

Tax Developments (Continued)

- The Internal Revenue Service has issued final rules requiring all Employee Retirement Income Security Act (ERISA) benefit plan administrators to give written notice of plan amendments when there is a significant reduction in the rate of future benefit accruals.

Physician Recruitment

A recently publicized IRS private letter ruling states that a hospital's use of recruitment incentives to get doctors to join its staff will not jeopardize the hospital's tax-exempt status. The IRS approved the hospital's offer of income guarantees, relocation assistance, and signing bonuses to attract physicians. The physicians were practicing out of the area, were about to join a practice in the area, or were practicing in the area for less than four years and had not established a significant client base. The IRS reasoned that the hospital had demonstrated a need for doctors in the area and that its recruitment incentives were reasonable.

Although this ruling may not be used as precedent except for the hospital that requested it, the ruling does provide helpful suggestions when developing or reviewing physician recruitment incentive programs. These suggestions allow greater flexibility in the types of incentives that hospitals offer to physicians, as well as the parties to whom the incentives may be offered. The ruling is also valuable for developing and reviewing recruitment programs at other types of health care organizations, such as faculty practice plans, medical foundations, community clinics, and health maintenance organizations.

As a reminder, physician recruitment programs should be regularly monitored to ensure compliance with the tax rules.

II. Required Communications to the Board of Trustees

To the Board of Trustees
Fayette County Memorial Hospital

We have recently completed our audit of the financial statements of Fayette County Memorial Hospital for the year ended December 31, 1999. As required by generally accepted auditing standards, the independent auditor is required to make several communications to the "Audit Committee" or a governing body having oversight responsibility for the audit. The purpose of this communication is to provide you with additional information regarding the scope and results of our audit that may assist you with your oversight responsibilities of the financial reporting process for which management is responsible. This report is intended solely for the use of the Board of Trustees and others within the organization.

Auditor's Responsibility Under Generally Accepted Auditing Standards

We conducted our audit of the financial statements of Fayette County Memorial Hospital in accordance with generally accepted auditing standards. The following paragraphs explain our responsibilities under those standards.

Management has the responsibility for adopting sound accounting policies, for maintaining an adequate and effective system of accounts, for the safeguarding of assets, and for devising an internal control structure that will, among other things, help assure the proper recording of transactions. The transactions that should be reflected in the accounts and in the financial statements are matters within the direct knowledge and control of management. Our knowledge of such transactions is limited to that acquired through our audit. Accordingly, the fairness of representations made through the financial statements is an implicit and integral part of management's responsibility. We may make suggestions as to the form or content of the financial statements or even draft them in whole or in part, based on management's accounts and records. However, our responsibility for the financial statements is confined to the expression of an opinion on them. The financial statements remain the representations of management.

The concept of materiality is inherent in the work of an independent auditor. An auditor places greater emphasis on those items that have, on a relative basis, more importance to the financial statements and greater possibilities of material error than with those items of lesser importance or those in which the possibility of material error is remote.

Auditor's Responsibility Under Generally Accepted Auditing Standards (Continued)

For this purpose, materiality has been defined as "the magnitude of an omission or misstatement of accounting information that, in light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would have been changed or influenced by the omission or misstatement Auditor's Responsibility Under Generally Accepted Auditing Standards

An independent auditor's objective in an audit is to obtain sufficient competent evidential matter to provide a reasonable basis for forming an opinion on the financial statements. In doing so, the auditor must work within economic limits; the opinion, to be economically useful, must be formed within a reasonable length of time and at reasonable cost. That is why an auditor's work is based on selected tests rather than an attempt to verify all transactions. Since evidence is examined on a test basis only, an audit provides only reasonable assurance, rather than absolute assurance, that financial statements are free of material misstatement. Thus, there is a risk that audited financial statements may contain undiscovered material errors or irregularities. The existence of that risk is implicit in the phrase in the audit report, "in our opinion."

In the audit process, we gain an understanding of the internal control structure of an entity for the purpose of assisting in determining the nature, timing, and extent of audit testing. Our understanding is obtained by inquiry of management, testing transactions, and observation and review of Hospital documents and records. The amount of work done is not sufficient to provide a basis for an opinion on the adequacy of the internal control structure.

Significant Accounting Policies

Auditing standards call for us to inform you regarding the initial selection of, and changes in, significant accounting policies or their application. In addition, we are expected to inform you about the methods used to account for significant unusual transactions and the effect of significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus. The significant accounting policies are described in Note 1 to the financial statements. There were no significant changes in accounting policies in 1999.

Management Judgments and Accounting Estimates

Auditing standards call for us to report to you on accounting estimates that are particularly sensitive because of their significance to the financial statements or because of the possibility that future events affecting them may differ markedly from management's current judgments. Further, we are expected to report to you covering the process used by management in formulating particularly sensitive accounting estimates and about the basis for our conclusions regarding the reasonableness of those estimates. In this connection, we are reporting the following matters:

As described in the notes to the financial statements, a significant portion of the Hospital's net patient revenue is received from the Medicare, Medicaid, Medical Mutual of Ohio, and various HMO programs. These programs pay the Hospital less than full charges for the services rendered to patients. Management has estimated the amount of loss resulting from these programs' payment methods based on the cost reports for the year and other anticipated disallowance and adjustments. Our conclusions regarding the reasonableness of those estimates are based on reviewing the cost reports and related documents, historical information related to these accounts and settlements with these third parties during and after the end of the year.

Management Judgments and Accounting Estimates (Continued)

Management has estimated bad debt expense for the year, as well as the related allowance for uncollectable accounts. These estimates are based on percentage of patient revenue, actual bad debt write-offs, and of accounts receivable aging categories. The percentages used are based on prior experience. Our conclusions regarding the reasonableness of these estimates are based on reviewing historical trends, on testing collectability of large accounts, and on testing management's computations.

Significant Audit Adjustments

Auditing standards call for us to report to you significant audit adjustments that, in our judgment, may not have been detected except through the auditing procedures we performed. No significant audit adjustments were required for the year ended December 31, 1999.

We welcome any questions you may have regarding the foregoing comments, and we would be happy to discuss any of these or other questions that you might have at your convenience.

Plante & Moran, LLP

February 18, 2000

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FAYETTE COUNTY MEMORIAL HOSPITAL

FAYETTE COUNTY

CLERK'S CERTIFICATION

This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.

By: Susan Babbitt

Date: JULY 6, 2000