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Department of Health and Mental Hygiene

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TO: Chief Financial Officers of Hospitals with Fiscal Year Ending December 31, 2017

FROM: Dennis N. Phelps, Associate Director, Audit & Compliance

DATE: December 15, 2017

RE: Special Audit Procedures to be Performed by the Independent CPA's of all Maryland Hospitals

On June 15, 2017, the Commission staff met with the Maryland Hospital Association's Financial Technical Issues Task Force to review this year's Special Audit Procedures. Attached is the final version of the Special Audit Procedures.

The Special Audit Procedure Report will be due 140 days from the close of the fiscal year or May 21, 2018 for December 31st fiscal year hospitals.

In procedure C-1, the three specific departments to be reviewed by the outside auditors for acute hospitals are Laboratory (LAB), Physical Therapy (PTH) and CT Scanner (CAT). The departments to be reviewed for private psychiatric hospitals are Family Therapies (FTH) and Individual Therapies (ITH). If the hospital does not have one of the departments selected for review the alternate is Magnetic Resonance Imaging (MRI). Submit a listing of all procedures for the three specific departments to be reviewed for which the units of service were assigned "By Report." Please provide this listing in the format provided in Attachment F.

Procedure F calls for the Commission to supply the auditor with a sample of inpatient medical abstracts (for both acute and private psychiatric hospitals) as well as ambulatory surgery medical records abstracts. These samples are to be compared with hospital's billing records.

Alternative Rate Setting- To be performed at the end of the Related Entity's Fiscal Year (To be submitted under separate cover)

Audit procedures are to be performed on HSCRC approved Alternative Method of Rate Determination arrangements. The audit procedures to be performed on procedure-based or case based bundled rates arrangements have been added as step I. The audit procedures to be performed on capitation and global price arrangements are included in Supplement I. These audit

procedures involve visiting the risk- taking hospital related entity in order to ascertain the accuracy of the information reported in the HSCRC mandated reports. In procedure A-4, capitation, the three expense centers from schedule AR1 to be reviewed by the auditors are: Med/Surg/Ped/Def, line 10; Emergency Department, line 21, and Imaging, line 31. The alternative, if one of the centers selected for review had no activity, is Pharmacy, line 40.

Consolidated Financial Statements

Special Audit Procedures to be performed by independent CPA's for hospitals filing consolidated financial statements.

Special Procedures- Supplementary Schedules to Audited Financial Statements

- Identify the methodologies used to allocate cost i.e. overhead, capital etc., in the supplementary schedules appended to the audited financial statements.
- Determine that the allocation methodologies were utilized consistently and accurately.
- Review the appropriateness of the allocation methodologies utilized and disclose whether the resulting cost allocations appear to be reasonable.

Please have your auditors contact Chris Konsowski to obtain case mix data (Procedure F), quarterly reports for Hospice samples (Procedure J), quarterly reports for Cosmetic Surgery (Procedure N) and AR1, AR2 and AR3 schedules. Chris can be contacted at 410-764-2579 or via e-mail to chris.konsowski@maryland.gov.

Enclosure(s)

HEALTH SERVICES COST REVIEW COMMISSION
SPECIAL AUDIT PROCEDURES

A. Expenses

1. Review the reconciliation of the base year actual expenses on Schedules UA, C, D, E-1 thru E-9, F-1 thru F-4, OADP1, P2I, P3I, P4I, P5I and UR1 thru UR10 of the budget submission financial statements.
 - Prepare a summary worksheet, in the format described in Attachment A, disclosing the reconciling items between the Rate Review System and the audit trial balance. This reconciliation worksheet must be included in your report.
2. During cash disbursements and payroll compliance testing, perform attribute statistical sampling (using a 95% confidence and 5% maximum error rate) to test departmental classification of expenses. List results of testing, including the number of test items and number of error occurrences.

B. Revenue

1. Review the reconciliation of the base year actual revenue for the year by department as accumulated on the monthly Experience Report to the year-end trial balance.
 - Verify that **only** regulated revenue has been reported on the Monthly Experience report.
 - Prepare a summary worksheet in the format described in Attachment B, disclosing the reconciling items between the departmental revenue reported on the monthly submission and the year end trial balance. This reconciliation worksheet must be included in your report.
 - List the amount and a description of all classifications made in reconciling revenue between the monthly and the year end trial balance. **This is to be included in your report in journal entry form.**
2. Review Schedule RE-R, Statement of Revenues and Expenses- Reconciliation to audited financial statements.
 - Verify that the reconciliation is complete and accurate. Trace the revenue, deductions from revenue and expenses to the general ledger.
 - Determine by inquiry of the appropriate personnel and review of applicable hospital records that the classification of revenue and allocation of expenses are in conformance with HSCRC regulation and policy. Report results of your inquiry in detail.

C. Statistics

1. For three (3) departments (two departments for private psychiatric hospitals) as stipulated by the Executive Director of the Commission.
 - Determine by inquiry of the appropriate clinical and financial personnel and reference to department source data that the department is using the standard unit of measure as prescribed in the Health Services Cost Review Commission's Accounting and Budget Manual. Please review any variances found with hospital staff and note how the hospital is going to fix the variances noted.
 - Utilize a representative sample of the procedures from one month's data. A selection of the high volume procedures that constitute at least 50% of the department's volume is recommended.
 - Trace the number of units reported to the HSCRC on the monthly PS schedule per procedure to the number of units assigned in Appendix D of the manual.
 - Submit a list of discrepancies found.
 - For each of the discrepancies, determine how long the incorrect number of units has been utilized for reporting and billing purposes.
 - Obtain a list from the appropriate clinical and financial personnel of procedures, **performed in the ancillary department**, for which the units of service were assigned "By Report". Provide this list to the Commission in **Excel format (see Attachment F)** with the submission of this report. List **all** of the procedures for only the rate centers under review in your report as follows:

<u>CPT Code</u>	<u>Descriptions</u>	<u>RVUs Assigned</u>
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- Summarize the actual base year department statistics (inpatient, outpatient and total) by month and reconcile them to the base year units as reported on the hospital's monthly Experience Report and to the total reported on Schedule V3, Line O of the Annual Report. Test a two (2) month's accumulation of these statistics by tracing them to the source document data to the monthly and Annual Reports. Identify the source document.
- In order to ensure that patients are charged appropriately and that the HSCRC receives accurate data, hospitals are directed to establish procedures to review their Charge Master on at least an annual basis. Please review these procedures and obtain from the Chief Financial Officer written verification as to when the charge master was last reviewed and whether or not processes have been established to regularly review the hospital's Charge Master.
- Obtain a copy of the Hospital's Charge Master Review procedures. Include these procedures in your report.

D. Case Mix Data

Acute Hospital- Inpatient

1. The Commission staff will supply the auditor with a sample hospital of medical record abstracts from the Commission's database. The sample listings will include the following information for each patient:

- Patient medical records Number
- Third Party Payor (i.e., Medicare Fee for Service, Medicare Managed Care, Medicaid, Blue Cross and Other)
- Zip Code
- Total Patient Charges
- Daily hospital services and admission services charges
- Operating room charges
- Admission from the Emergency Room

2. For each patient, the auditor will verify back to the hospital's billing records for items:

- That the major third party payor classification on the Commission's listing agrees with the hospital's billing records. If errors in payor classification exceed 5% of cases, list the number of errors by category, i.e., self pay should be Medicaid, etc. (show percentage of all errors and a percentage less errors involving Medicaid admissions).
- That the zip code on the Commission's listing agrees with the Hospital's billing records. List all zip code errors showing incorrect zip code and correct zip code.
- That the total patient charges, for regulated services, agree with the hospital's billing records.
- That the total Daily Hospital services and Admission Services charges agree with the hospital's billing records.
- That the total Operating Room charges agree with the hospital's billing records.
- Whether there are Emergency Service charges on the hospital's billing records for each case coded as "Admitted from Emergency Room" in the case mix sample.

(Differences in dollar amounts in bullets 3 through 6 above, which are less than 1% should not be counted as errors.)

3. In its report the auditor will describe the results of this work and the data compiled will be summarized in the following manner:

a. Hospital Name	Total Charges per HSCRC Computer Listing	Verified Final Charges	Difference Over (Under)	Percentage Variances	
b. Hospital Name	Case Mix Sample Size	Number of Variances in Charges Reported	Error Rate	Number of Variances in Payor Sources	Error Rate
c. Hospital Name	Case Mix Sample Size	Var in Daily Serv. & Adm. Charges	Error Rate	Num. of Var. in Oper. Room Charges	Error Rate
d. Hospital Name	Number of Cases coded as admitted from ER	Number of cases coded as admitted from E/R without ER charges	Error Rate		

Private Psychiatric Hospitals

1. The Commission staff will supply the auditor with sample by hospital of medical records abstracts from the Commission's database. The sample listing will include the following information for each patient:
 - Patient Medical Records Number
 - Third Party Payer (i.e., Medicare Fee for Service, Medicare Managed Care, Medicaid, Blue Cross and Other)
 - Zip Code
 - Total Patient Charges
 - Daily hospital services and admission services charges
 - Therapy charges

2. For each patient, the auditor will verify back to the hospital's billing records for items:
 - That the major third party payor classification on the Commission's listing agrees with the hospital's billing records. If errors in payor classification exceed 5% of cases, list the number of errors by category, i.e., self pay should be Medicaid, etc.

- That the zip code on the Commission's listing agrees with the Hospital's billing records. List all zip code errors showing incorrect zip code and correct zip code.
- That the total patient charges, for regulated services, agree with the hospital's billing records.
- That the total Daily Hospital services and Admission Services charges agree with the hospital's billing records.
- That the therapy charges agree with the hospital's billing records.

(Differences in dollar amounts in bullets 3 through 5 above, which are less than 1% should not be counted as errors.)

3. In its report the auditor will describe the results of this work and the data compiled will be summarized in the following manner:

a. Hospital Name	Total Charges per HSCRC Computer Listing	Verified Final Charges	Difference Over (Under)	Percentage Variances	
b. Hospital Name	Case Mix Sample Size	Variations in Charges Reported	Error Rate	Number of Variations in Payor Sources	Error Rate
c. Hospital Name	Case Mix Sample Size	Number of Var in Daily Serv. & Adm. Charges	Error Rate	Num. of var. in Therapy Charges	Error Rate

Ambulatory Care

1. The Commission staff will supply the auditor with sample by hospital of medical records abstracts from the Commission's database. The sample listing will include the following information for each patient:

- Patient Medical Records Number
- Third Party Payer (i.e., Medicare Fee for Service, Medicare Managed Care, Medicaid, Blue Cross and Other)
- Zip Code

- Operating Room and Same Day Surgery Charges
- Clinic and Emergency Department Charges
- Observation Charges
- Medical Surgical Supplies Charges
- Drugs Charges
- Other Charges

2. For each patient, the auditor will verify back to the hospital's billing records for items:

- That the major third party payor classification on the Commission's listing agrees with the hospital's billing records. If errors in payor classification exceed 5% of cases, list the number of errors by category, i.e., self pay should be Medicaid, etc.
- That the zip code on the Commission's listing agrees with the Hospital's billing records. List all zip code errors showing incorrect zip code and correct zip code.
- That the total patient charges, for regulated services, agree with the hospital's billing records.
- That the total Operating Room and Same Day Surgery charges agree with the hospital's billing records.
- That the total Clinic and Emergency Department Charges agree with the hospital's billing records.
- That the total Observation charges agree with the hospital's billing records.
- That the total Medical Surgical Supplies charges agree with the hospital's billing records.
- That the total Drugs charges agree with the hospital's billing records.
- Identify and report the charges in the "Other Charges" category.

(Differences in dollar amounts in bullets 3 through 9 above, which are less than 1% should not be counted as errors.)

3. In its report the auditor will describe the results of this work and the data compiled will be summarized in the following manner:

a	Hospital Name	Total Charges per HSCRC Computer Listing	Verified Final Charges	Difference Over (Under)	Percentage Variances
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b	Hospital	Sample	Case Mix in Charges	Error	Variances in Payor	Variances Error
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Name	Size	Reported	Rate	Sources	Rate
c Hospital Name	Case Mix Sample Size	Number of Var in O/R and SDS Charges	Error Rate	Number of Var. in MSS Charges	Error Rate
d Hospital Name	Case Mix Sample Size	Number of Var in CL and EMG Charges	Error Rate	Number of Var. in CDS Charges	Error Rate

E. Uncompensated Care and Denials Reconciliation

1. Maryland hospitals report deductions from patient revenue in their required annual filings. The deduction categories include charity care, bad debts, contractual adjustments, denials and other deductions from revenue. See Attachment E for a copy of the relevant section of the HSCRC Accounting and Budget Manual.
 - Perform an analysis of the bad debt write off activity in excess of \$1,000 but not less than 50% of the total dollars written off, for a calendar month of the fiscal year. Determine that accounts unpaid by third party payors for medically unnecessary care are not included. Obtain a letter of representation from the Patient Accounting Manager and Chief Financial Officer that the bad debt expense does not include medically unnecessary care, denials or other courtesy discounts provided to police, fire, hospital, employees, etc.
 - Disclose in your report whether or not the hospital maintains these denials
 - in a separate account pending final resolution of appeal.
2. For fiscal year 2017, provide reconciliation between the amount of uncompensated care per the hospital's audited financial statements and trial balance.
3. For fiscal year 2017, provide reconciliation between the amount of uncompensated care per the hospital's trial balance and that reported on Schedule PDA of the Annual Report of Revenues, Expenses and Volumes.
4. Reconcile the Charity Care amount per the audited financial statements to the hospital's supporting documentation. Provide reconciliation between the

hospital's trial balance and that reported on Schedule RE Line G Column 3 of the Annual Report of Revenues, Expenses and Volumes. Note any differences.

5. For fiscal year 2017, provide reconciliations between the amount of denials per the hospital's trial balance and that reported on Schedule RE of the Annual Report of Revenue, Expenses and Volume and the quarterly Denials Report.

The reconciliations shall be provided in the following format:

Audited Financial Statement

Bad debts	\$
Charity Care	
Uncompensated Care	\$ _____

Trial Balance

Bad Debt Write-offs	\$
Charity Write-offs	
Change in Balance Sheet Reserve	
Bad Debt Recoveries	
* Other	
Uncompensated Care per Trial Balance	\$ _____
* Explain in Detail	

Annual Report of Revenues, Expenses and Volumes

Uncompensated Care- Schedule PDA	\$
Unregulated Charity & Bad Debts*	
Uncompensated Care Fund	
** Other	
Uncompensated Care per Annual Report	\$ _____

Denials

Denials per the Trial Balance
\$ _____

Schedule RE Line H2 Column 3,

Annual Report of Revenues, Expenses and Volumes
\$ _____

Quarterly Denials Report

\$ _____

***Variance

\$ _____

* Hospitals with unregulated services are expected to have unregulated bad debts

** Explain in detail

***Explain in Detail the Variance

6. Determine by inquiry of the appropriate hospital personnel and report whether bad debt write-offs include denials, collection agency's or attorney's expenses.

F. Financial Assistance, Credit & Collection Policies and Recoveries

Financial Assistance

1. Hospitals are required by regulation to post notices in conspicuous places throughout the hospital describing their financial assistance policy and how to apply for free and reduced-cost, medically necessary care.
 - Determine whether such notices are posted.
 - Describe the content of the notices and list where they are posted in the hospital.
 - Determine by inquiry of the appropriate hospital personnel if patients are informed of the availability of financial assistance in any way other than by the posted notices.
2. Hospitals are required by regulation to develop an information sheet that shall be provided to the patient, the patient's family, or the patient's authorized representative before discharge; with the hospital bill: and on request.
 - Determine if an information sheet is provided before discharge; with the hospital bill; and upon request
 - Does the information sheet include the following items:
 - Description of the hospital's financial assistance policy;
 - Description of patient's rights and obligations with regard to hospital billing and collection;
 - Contact information for the individual or office at the hospital that is available to assist patient or the patient representative in understanding the hospital bill and how to apply for free and reduced cost care:

- Contact information for the Maryland Medical Assistance Program;
 - Statements that physician charges are not included in the hospital bill and are billed separately.
3. Review the hospital's Financial Assistance Policy (provided by the HSCRC) Select a representative sample of 50 cases, from the period April 1st through June 30, 2017 of patients who have applied for financial assistance. The sample shall include both patients approved for financial assistance and those who were denied.
- Determine whether the Financial Assistance Policy was followed:
 - Provide the number of cases and percentage of sample in which the policy was followed 100%.
 - Provide the number and percentage of cases in which the policy was not followed.
 - When the policy was not followed, provide examples of deviation from the policy and their frequency.
4. Determine by inquiry of the appropriate personnel whether or not the Hospital is participating in the Medicaid "Hospital Presumptive Eligibility" provision of the Affordable Care Act.
- If the Hospital is not participating, ascertain and report the reason why they are not participating.
 - For participating hospitals, ascertain and report the process utilized to obtain the necessary patient information to implement the presumptive eligibility process.
 - Report the number of patients that have applied for presumptive eligibility in FY 2017.

Credit and Collection Policy

Review the hospital's Credit & Collection Policy (provided by the HSCRC). Select a representative sample of 50 cases that have required collection effort within the last twelve months. The sample shall include both inpatient and outpatient cases and shall include cases from insured as well as self-pay patients, as well as patients who have been granted partial financial assistance, if applicable.

- Determine whether the Credit and Collection Policy was followed:
 - Provide the number of cases and percentage of sample in which the policy was followed 100%
 - Provide the number and percentages of cases in which the policy was not followed.

- When the policy was not followed, provide examples of deviation from the policy and their frequency.

Recoveries

Select a representative sample of 50 cases from the period April 1st through June 30, 2017 where recoveries of bad debts were made (add cases from prior recent calendar quarters to reach sample size if necessary).

- Determine if the hospital's uncompensated care for the year of recovery was reduced by the full amounts recovered and that the recovered amount is not reduced by collection agency fees or other collection expenses:
 - Provide the number of cases and the percentage of the sample in which any part of the recovery was applied to the hospital's bad debt expense or reserve;
 - Of the cases where all or part of the recovery was applied to the hospital's bad debt expense or reserve:
 - 1) Provide the number of cases and percentages of the sample in which the gross amount of the bill recovered was applied to the hospital's bad debt expense or reserve; and
 - 2) Provide the number of cases and percentages of the sample in which the gross amount of the bill recovered was not applied to the hospital's bad debt expense or reserve.

5. DCFA- Debt Collection/Financial Assistance Report

- Debt Collection
 - 1) Verify the names of the collection agency(s) listed against hospital records.
 - 2) Verify the number of liens listed against hospital records.
 - 3) Verify the number of extended payment plans against hospital records. Note: Extended patient payment plans exceeding 5 years should be reported.
- Financial Assistance
 - 1) Verify the number of applications for financial assistance listed against hospital records.
 - 2) Verify the number of applications for financial assistance approved against hospital records.

G. Hospice General Inpatient Services

In March 2001, the Commission approved a Demonstration Project for the provision of general inpatient care to hospice patients to registered Medicare Hospice patients at Maryland hospitals. The project was approved with the following provisions:

- Hospices must bill HSCRC approved rates;
 - Hospital may agree to accept reimbursement on a per diem amount other than HSCRC approved rates;
 - The balance remaining of the hospital bill for each individual hospice patient after payment of the agreed amount must be written off by the hospital as a voluntary contractual allowance. These voluntary contractual allowances may not be included as uncompensated care in reports submitted to the HSCRC.
1. Determine by inquiry of appropriate hospital personnel and report whether or not the hospital has signed an agreement to provide inpatient services to hospice patients. Provide a list of hospices involved in the agreement.
 2. Obtain the following data from the hospital records and reconcile the data to the hospital's quarterly reports:
 - the number of hospice patients admitted in FY 2017;
 - the total of HSCRC approved charges billed for inpatient services provided to hospice patients;
 - the total reimbursement received on behalf of hospice patients;
 - the amount of revenue written off associated with the difference between HSCRC charges billed for inpatient services provided to hospice patients and the total reimbursement received on behalf of hospice patients;
 - the account to which the revenue, described in bullet 4 above, was written off.

H. Outpatient Plastic/Cosmetic Surgery

1. Reconcile Columns 2-5 of the hospital's Outpatient Plastic/Cosmetic Surgery Pricing worksheet to their Plastic/Cosmetic Surgery quarterly reports.
2. Ensure that the total difference in Col. 6 per the Outpatient Plastic/Cosmetic Pricing worksheet agrees with the hospital's Cosmetic Surgery contractual allowance account.

I. Audit of Trauma Costs

Hospitals with designated trauma centers incur incremental trauma costs to meet the Maryland Institute for Emergency Services System (MIEMMS) regulatory requirements. Such incremental costs are the costs associated with operating a hospital with a designated trauma center that are over and above the costs normally associated with hospitals that do not have a designated trauma center. These

incremental costs consist of the costs associated with: a Trauma Director, Trauma Department, Trauma Protocol, Specialized Trauma Staff, Education and Training and Special Equipment included in the costs of the Emergency on Schedule D 18.

For each of the following schedules trace the amounts to the hospital source documents. Review the method used to allocate costs between trauma requirements and normal emergency room operations. Include the method of allocation in your report.

Schedule MTC- A Trauma Director

Schedule MTC- B Trauma Department

Schedule MTC- C Trauma Protocol

Schedule MTC- D Specialized Trauma Staff

Schedule MTC- E Education and Training Costs

Schedule MTC- F Specialized Equipment

Schedule MTC- Incremental MIEMMS Requirements for Trauma Hospitals

Hospitals with designated trauma centers incur for trauma physicians to “standby”. Trauma physicians’ standby cost is defined as the costs generated as a result of the necessity to have the physical presence of a trauma physician, under a formal arrangement, to render services to trauma patients. These physicians must be on the hospital premises in reasonable proximity of the Emergency Department or trauma center and may not be “on-call”.

Trace the reported amounts on the following schedules to the hospital source document.

Schedule SBC I standby Costs Trauma Physicians- Hourly or Salary Based Arrangement

Schedule SBC II Standby Costs trauma Physicians- Minimum Guaranteed Arrangements

J. Community Benefit Report

1. Reconcile the Charity Care amount per the FY 2016 Community Benefit Report (line H) to the RE Schedule per the FY 2016 Annual Filing. Note any differences.

K. Admissions Denied for Medical Necessity

1. Determine whether the data submitted on the Admissions Denied for Medical Necessity report is complete and accurate:

- Select a representative sample of cases from the Admission Denied for Medical Necessity reports for the first three quarters of FY 2017.
- Reconcile the data from the hospital's records to the hospital's quarterly reports.
- Obtain from the hospital's Chief Financial Officer a letter of attestation that all admissions written off after final adjudication in FY 2017 have been reported on the hospital's quarterly reports.

L. Supplemental Schedule UR6-A Physician Part B Services

1. Reconcile the information provided on Supplemental Schedule UR6-A to the information provided on Schedule UR6 submitted by the hospital

M. Report

1. Prepare a report in accordance to SAS 75, as amended, to be submitted to the hospital (with a copy mailed by the auditing firm to the Health Services Cost Review Commission) summarizing the procedures performed and the results. Prepare the report in accordance with the following specific report format instructions.

- After the "report of "Independent Public Accountants", each step will be detailed in the following manner:
 - Reference specific audit step.
 - State the procedures performed to accomplish each audit step.
 - Summarize your audit findings for each step.

2. This report is to be filed with the Commission 140 days after the end of the hospital's fiscal year.

ATTACHMENT A

Expense Reconciliation

We compared the reconciliation of the base year actual expense on Schedules UA, OADP, P2I, P3H, P4I, P5I, C, D, E1 through E9, F1 through F4 and UR1 through UR 7 of the annual report to the Commission with the year-end trial balance used to prepare the audited financial statements.

The following is a reconciliation between the annual report and June 30, 2015 audit financial statements:

Balance per annual report

<u>Description</u>	<u>Source</u>	<u>Amounts</u> (In Thousands)
Cafeteria, Parking, Data Processing	Sch. OADP, Line C1, Col. 4	
Unassigned Expense	Sch. UA, Line A, Col. 10	
Medical Staff Services	Sch. P2I, Line A, Col. 3	
Physician Support Staff	Sch. P3H, Line A, Col. 7	
Resident & Intern Services- Eligible	Sch. P4I, Line D, Col. 7	
Resident & Intern Services, Ineligible	Sch. P5J, Line D, Col. 7	
General Services Centers	Sch. C, Lines C1- C14, Col. 4	
Patient Care Centers	Sch. D, Lines D1-D81, Col. 5	
Auxiliary Enterprises	Schs. E1- E9, Line B, Col. 3	
Other Institutional Programs	Schs. F1- F7, Line B, Col. 3	
Unregulated Services	Schs. UR1- UR10	
* Reconciliation Amount		
HSCRC TOTAL		
OPERATING EXPENSES		

Balance per audited financial statements:

<u>Description</u>	<u>Amounts</u> (In Thousands)
Salaries and Wages	
Employee Benefits	
Supplies	
Services and Other	
Depreciation and Amortization	
Interest	
TOTAL OPERATING EXPENSES PER AUDITED FINANCIAL STATEMENTS	

Attachment B

Revenue Reconciliation

We compared the reconciliation of the base year actual revenue for the year by department as reported on monthly reporting schedules RSA, RSB and RSC to the hospitals year-end trial balance.

The following is a reconciliation between the departmental revenue reported on the monthly submissions and the year-end trial balance.

Reconciliation of Operating Revenues

Per Schedule RS

For the Base Year Ended

June 30, 2015

	<u>Revenue Per</u>	<u>Revenue Per</u>	<u>Variance</u>	<u>Explanation</u>
	<u>Schedule RS</u>	<u>Audited Trial Balance</u>		
Medical/Surgical				
Pediatrics				
Obstetrics				
ICU				
Nursery				
Emergency Room				
Part A and B				
Admissions				
Labor and Delivery				
Operating Room				
Anesthesiology				
Laboratory				
Blood Bank				
EKG				
Radiology Diagnostic				
Nuclear Medicine				
Cat Scanner				
Respiratory Therapy				
Physical Therapy				
Medical/Surgical Supplies				
Drugs				
Psychiatric				
Clinical Services				
Ambulatory Surgery				

Explanation of Reclassifications

Attachment C

HEALTH SERVICES COST REVIEW COMMISSION

ALTERNATIVE METHOD OF RATE DETERMINATION ARRANGEMENTS

SPECIAL AUDIT PROCEDURES

As a result of the adoption and implementation of the Commission's Alternative Method of Rate Determination Policy, audit procedures must be performed by an independent CPA to ensure that the information provided concerning approved alternative rate setting arrangements is accurate. This will require the independent CPA to visit the offices and review the appropriate documents and records of the risk taking entity. These audit procedures will be due in a report under separate cover 140 days from the close of the fiscal year of the risk taking related entity.

A. Capitation- Schedules AR-1 and AR-2

1. Member Months- For each contract trace to source document the number of member months for the fiscal year on line A, schedule AR-1.
2. Revenue- For each contract, reconcile the actual revenue for the year as reported on Schedule AR-1 by component to the trial balance and source documents.
 - Prepare a summary worksheet, reconciling the revenue reported on the quarterly AR-1 schedules and the year end trial balance. This reconciliation worksheet must be included in your report.
 - List the amount and a description of all reclassification made in reconciling revenue between the quarterly reports and the year end trial balance. This is to be included in your report in journal entry form. Prepare a reconciliation between the total amounts above and the amounts in the audited financial statement. Include this reconciliation in your report.
3. Expenses- For each contract, reconcile the actual expense as reported on quarterly and annual Schedules AR-1 to the trial balance.
 - Prepare a summary worksheet, disclosing the reconciling items between the AR-1 schedule and the trial balance. This reconciliation worksheet must be included in your report.
4. Expenses and Statistics- For each contract for each of the three expense centers as stipulated by the Executive Director of the Commission:
 - Determine by inquiry of appropriate personnel and reference to source data whether or not the standard unit of measure as prescribe in the Health Services Cost Review Commission's Accounting and Budget Manual is being used and reported on Schedule AR-2.

- Summarize base year actual expenses and statistics by quarter and reconcile to the actual statistics and expenses reported on Schedules AR-1 and AR-2. Test one quarter's accumulation of these expenses and statistics by tracing source data. Include in your report the reconciliation of the source document to the quarterly and annual reports. Determine that expense are reported in the appropriate category, e.g., capitated, fee for service, related entity, out-of-network, etc., identify the source documents.

5. Overhead Allocation

- Determine by review and by inquiry of the appropriate personnel the method used to allocate overhead expenses to each contract. Disclose the methodology and verify that the methodology was properly utilized.

6. Stop-Loss

- Ascertain by review and inquiry of the appropriate personnel and disclose the cost, terms, (e.g. when stop loss kicks in) and coverage of all reissuance, stop-loss contracts and/or other arrangements to limit risk associated with each contract.

B. Global Price- Schedule AR-3

1. Revenue- For each contract reconcile the global payments as reported on Schedule AR-3 by DRG to the trial balance and source documents.
 - Prepare a summary worksheet reconciling the revenue reported on the quarterly AR-3 schedules and the year end trial balance. This reconciliation must be included in your report.
2. Number of Cases, Patient Days and Hospital Charges- For each contract; reconcile the number of cases, patient days and hospital charges by DRG as reported on AR-3 schedule to the appropriate source documents.
 - Test one quarter's hospital charges as reported on AR-3 schedule for 2 DRG's by examining the hospital bills of individual cases.

Attachment D

E.1 Hospital Inpatient

Rebundled Service	Part A Hospital's Average Charge	Part B Average Charge per Case	Combined Average

E.2 Non-Hospital Patients

	Part A Average Charge per Case	Part B Average Charge per Case	Combined Average

E.3 Comparison

Rebundled Service	Non-Hospital Patients	Hospital Inpatients
Part A Avg. Charge Per Case		
Part B Avg. Charge per Case		

Rebundled Service	Non-Hospital Patients	Hospital Inpatients
Part A Avg. Charge Per Case		
Part B Avg. Charge per Case		

Rebundled Service	Non-Hospital Patients	Hospital Inpatients
Part A Avg. Charge Per Case		
Part B Avg. Charge per Case		

Uncompensated Care

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Uncompensated care is defined by the Commission to include Charity Care and Bad Debts. Charity Care Services are those Commission regulated services rendered for which payment is not anticipated. Bad Debts Services are those Commission regulated services rendered for which payment is anticipated and credit is extended to the patient. (Bad Debt expense is estimated and recognized by providing an allowance for such amounts estimated to be written off.)

Charity Care: Hospitals should have a written charity care policy. Charity care patients should be identified at the time of admission or service date or as soon thereafter as possible. Charity care, as reported to the Commission, shall consist only of the difference between the hospital's approved rates and the amount, if any, received from such patients in payment.

Bad Debts: Bad Debts, as reported to the Commission, may include only the following:

1. Bad debt write-offs, made after following the provisions of the hospital's collection and write-off policy, less gross Bad Debt recoveries. (Outside collection agency, attorney expenses or any other expenses associated with the collection of patient accounts may not be written off as Bad Debts but must be reported as collection expenses in the Patient Accounting cost center.)

Hospital charges written-off for the following reasons are not bad debts and may not be included in uncompensated care reported to the Commission:

- a. Contractual allowances and adjustments associated with Commission approved differentials—i.e., prompt payment, SAAC, and the differential granted to Medicare and Medicaid.
- b. Administrative, Courtesy and Policy Discounts and Adjustments - These include, but are not limited to, reductions from established rates for courtesy discounts, employee discounts, administrative decision discounts, discounts to patients not meeting charity policy guidelines, undocumented charges and, payments for services denied by third party payers.
- c. Charges for medically unnecessary hospital services.
- d. Charges written off that are not the result of a patient's inability to pay or where the hospital has not expended a reasonable collection effort.

Attachment F

Hospital Name

FYE

Special Audit Procedure C Statistics- By Report

Rate Center

<u>CPT Code</u>	<u>Description</u>	<u>RVUs Assigned</u>
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