Financial Audit of the Hilo Medical Center

A Report to the Governor and the Legislature of the State of Hawaii

Report No. 96-4
January 1996

THE AUDITOR
STATE OF HAWAII

The Office of the Auditor

The missions of the Office of the Auditor are assigned by the Hawaii State Constitution (Article VII, Section 10). The primary mission is to conduct post audits of the transactions, accounts, programs, and performance of public agencies. A supplemental mission is to conduct such other investigations and prepare such additional reports as may be directed by the Legislature.

Under its assigned missions, the office conducts the following types of examinations:

1. *Financial audits* attest to the fairness of the financial statements of agencies. They examine the adequacy of the financial records and accounting and internal controls, and they determine the legality and propriety of expenditures.

2. *Management audits,* which are also referred to as *performance audits,* examine the effectiveness of programs or the efficiency of agencies or both. These audits are also called *program audits,* when they focus on whether programs are attaining the objectives and results expected of them, and *operations audits,* when they examine how well agencies are organized and managed and how efficiently they acquire and utilize resources.

3. *Sunset evaluations* evaluate new professional and occupational licensing programs to determine whether the programs should be terminated, continued, or modified. These evaluations are conducted in accordance with criteria established by statute.

4. *Sunrise analyses* are similar to sunset evaluations, but they apply to proposed rather than existing regulatory programs. Before a new professional and occupational licensing program can be enacted, the statutes require that the measure be analyzed by the Office of the Auditor as to its probable effects.

5. *Health insurance analyses* examine bills that propose to mandate certain health insurance benefits. Such bills cannot be enacted unless they are referred to the Office of the Auditor for an assessment of the social and financial impact of the proposed measure.

6. *Analyses of proposed special funds* and existing *trust and revolving funds* determine if proposals to establish these funds and existing funds meet legislative criteria.

7. *Procurement compliance audits* and other *procurement-related monitoring* assist the Legislature in overseeing government procurement practices.

8. *Fiscal accountability reports* analyze expenditures by the state Department of Education in various areas.

9. *Special studies* respond to requests from both houses of the Legislature. The studies usually address specific problems for which the Legislature is seeking solutions.

Hawaii's laws provide the Auditor with broad powers to examine all books, records, files, papers, and documents and all financial affairs of every agency. The Auditor also has the authority to summon persons to produce records and to question persons under oath. However, the Office of the Auditor exercises no control function, and its authority is limited to reviewing, evaluating, and reporting on its findings and recommendations to the Legislature and the Governor.

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OVERVIEW

THE AUDITOR
STATE OF HAWAII

Financial Audit of the Hilo Medical Center

Summary

The Office of the Auditor and the certified public accounting firm of Arthur Andersen LLP conducted a financial audit of the Hilo Medical Center for the fiscal year July 1, 1994 to June 30, 1995. The audit examined the center's financial records and its systems of accounting and internal controls and tested these for compliance with applicable laws and regulations.

We found that the financial management practices at the Hilo Medical Center are deficient. Problems are such that the center is far from being capable of functioning as an independent or autonomous entity. Problems are primarily the result of several layers of bureaucracy and inattention by the Division of Community Hospitals; State of Hawaii job classification and pay scales; and a failure to properly manage important functions such as billings and collections, contracts, and workers' compensation claims.

The audit identified four reportable conditions, which, taken together, constituted a material weakness in the center's internal control structure. The reportable conditions resulted in errors in the accounting records of such magnitude that Arthur Andersen LLP has stated an exception to the fair presentation of the Hilo Medical Center's June 30, 1995 financial statements.

Specifically, we found that the center's financial reporting system is inadequate to effectively manage operations; the center's billing and collection system is inadequate; business office personnel are improperly classified and lack adequate training; some functions of the business office are poorly organized; and the information processing system has severe limitations.

The audit also identified other problems that limit the center's ability to contain costs or improve revenues. We found that the agreements for laboratory, radiological, and kidney dialysis services are not adequately monitored and that the center's self-insured workers' compensation program is poorly managed. The center would benefit from expanding the role of utilization review in managing costs. We pointed out that waitlisted long-term care patients may impact the financial viability of the center.

Recommendations and Response

To correct these problems, the center must have the help and support of the Division of Community Hospitals. We recommend that the division and the center make a concerted effort to improve the center's accounting, billing, and information system

functions; make it a priority to improve staff capabilities at the center; and begin to develop plans to deal with the potential problems associated with its waitlisted patients. We also recommend that the division cease negotiating contracts that are financially detrimental to the center and allow the center to negotiate its own agreements.

We further recommend that the center continue its efforts to improve the utilization review function, that the center take steps to ensure that it is paying for only contract services that are authorized and that conform to the contract, and that it evaluate the need to continue its contracts to pay for radiological, laboratory, and kidney dialysis services. We also recommend that the center take steps necessary to effectively manage its workers' compensation claims.

The department concurs with our findings and is taking steps to implement many of our recommendations. The department believes that many of the problems noted can be better dealt with if the Hilo Medical Center were authorized to operate autonomously. Until the Legislature approves an autonomy proposal, the department is taking steps to make improvements. We are pleased that the department is taking immediate corrective actions at the Hilo Medical Center.

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Conducted by

The Auditor
State of Hawaii
and
Arthur Andersen LLP

Submitted by

THE AUDITOR
STATE OF HAWAII

Report No. 96-4
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Foreword

This is a report of our financial audit of the Hilo Medical Center for the fiscal year July 1, 1994 to June 30, 1995. The audit was conducted pursuant to Section 23-4, Hawaii Revised Statutes, which requires the State Auditor to conduct postaudits of all departments, offices, and agencies of the State. The audit was conducted by the Office of the Auditor and the certified public accounting firm of Arthur Andersen LLP.

We wish to express our appreciation for the cooperation and assistance extended by officials and staff of the Hilo Medical Center.

Marion M. Higa
State Auditor

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Introduction

This financial audit of the Hilo Medical Center was conducted by the Office of the Auditor and the certified public accounting firm of Arthur Andersen LLP. The audit was conducted pursuant to Section 23-4, Hawaii Revised Statutes, which requires the State Auditor to conduct postaudits of the transactions, accounts, programs and performance of all departments, offices, and agencies of the State of Hawaii and its political subdivisions.

Background

Hilo Medical Center, formerly known as Hilo Hospital, is part of the Division of Community Hospitals of the Department of Health, State of Hawaii. The center began as a ten bed facility erected by the Republic of Hawaii in 1897. The County of Hawaii assumed direct control of the center in 1920. In 1970, the ownership and management of the center was transferred from the County of Hawaii to the State Department of Health where it remains today. To accomplish its mission of ensuring equal access to quality health care, the center is dedicated to providing the best health care services possible to the residents of Hawaii County.

The center sits on 20.4 acres of state-owned land, employs approximately 870 persons, and has an operating budget of approximately $64 million. Currently, the center has 274 licensed beds as follows:

Acute Care	166 Beds
Skilled Nursing Facility (SNF)	36 Beds
Intermediate Care Facility (ICF)	72 Beds
Total	274 Beds

Organization of the center

Hilo Medical Center is one of 13 facilities that are administered by the Division of Community Hospitals. The center is comprised of the following main departments:

- The Administration Office is responsible for overall administration and management of the center, development of policies and procedures, utilization review, and the establishment of goals and objectives.

- The Business Office provides accounting support, including financial management, maintenance of accounting records, and patient billings.

- Patient Care Services offers medical, surgical, ambulatory care, home care, psychiatric, and extended care services. The center also provides comprehensive support services, which aid in the proper diagnosis and treatment of patients. Some of these services are: dietary, health education, hemodialysis, laboratory, nuclear medicine, occupational therapy, physical therapy, respiratory therapy, and social services.

Objectives of the Audit

1. Report on the fair presentation of the financial statements of the center.

2. Assess the adequacy, effectiveness, and efficiency of the systems and procedures relating to the financial accounting, reporting, and internal controls of the center and to recommend improvements to such systems, procedures, and reports.

3. Determine whether expenditures and other disbursements have been made and all revenues and other receipts have been collected and accounted for in accordance with federal and state laws, rules and regulations, and policies and procedures.

Scope and Methodology

We audited the financial records and transactions and reviewed the related systems of accounting and internal controls of the center for the fiscal year July 1, 1994 to June 30, 1995, in accordance with generally accepted auditing standards as set forth by the American Institute of Certified Public Accountants and the standards for financial audits as set forth in the U.S. General Accounting Office's Government Auditing Standards (1994). Included in our audit were all fund types and account groups.

We also reviewed the center's transactions, systems, and procedures for compliance with applicable laws and regulations. The audit included a review of the center's accounting, reporting, and internal control structure. It also included a review of the center's forms, records, accounting, and operational procedures.

The independent auditors' opinion as to the fairness of the financial statements presented in Chapter 3 is that of Arthur Andersen LLP. The audit was conducted from May 1995 through December 1995. The work relating only to Chapter 3 was conducted from May 1995 through September 1995. The audit was conducted in accordance with generally accepted government auditing standards.

Chapter 2

Internal Control Practices

Internal controls are steps instituted by management to ensure that financial reporting objectives are met and resources are safeguarded. This chapter presents our findings and recommendations on the financial accounting and internal control practices and procedures of the Hilo Medical Center.

Summary of Findings

We found significant deficiencies in the center's financial accounting and internal control practices and procedures that resulted in four reportable conditions. Many of these deficiencies were brought to the center's attention in prior years but have not been corrected. Individually the four reportable conditions do not constitute a material weakness. Taken together, however, and partly because management has failed to correct these deficiencies, they constitute a material weakness in the management control structure of the center. These findings are summarized here.

a. The center's financial reporting system does not generate information or standard accounting reports that are accurate, timely, or useful to management.

b. The center's billing and collection system and existing procedures are not adequate to effectively capture, process, bill, and collect all patient charges on a timely basis.

c. Business office staff are not properly classified or adequately trained, and billing and collection functions are not sufficiently organized.

d. The center's information processing system has severe limitations that contribute to delays in billing and collecting patient accounts.

In addition to the reportable conditions described above, we found problems that affect the center's ability to manage costs and enhance revenues. These findings are summarized here.

a. The role of the Utilization Review department (UR) in managing cost needs to be expanded to benefit the center.

b. The center's agreements with others for laboratory, radiological, and kidney dialysis services are not adequately monitored. At least one contract contains terms that are potentially detrimental to the center.

c. The center's self-insured, workers' compensation program is poorly managed.

d. Patients waitlisted for long-term care may place a financial hardship on the center. It may soon have to turn away better paying patients because of limited availability of acute care beds.

Reportable Conditions Collectively Result in a Material Weakness

A reportable condition is defined as a significant deficiency in the design or operation of the management control structure which could adversely affect the center's ability to record, process, summarize, and report financial data in the financial statements consistent with the goals of management. A material weakness in the management control structure is the worst possible reportable condition and must be taken seriously. Our experience is that material weaknesses are rare in Hawaii's government agencies today.

Management controls have a pervasive effect on the center, and their absence can increase the risk of errors or irregularities in many critical financial statement accounts. A material weakness exists when controls are such that significant errors or irregularities may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions.

As a result of these reportable conditions, accounting records are not reconciled to determine whether account balances are correct, the financial activity for the year is improperly recorded, and financial transactions are not recorded in the center's financial records. Many of these problems could have been corrected with adjustments. However, such adjustments were not made and were of such magnitude that our certified public accountants have stated an exception to the fair presentation of the Hilo Medical Center's June 30, 1995 financial statements in conformity with generally accepted accounting principles.

In the following sections, we discuss the four reportable conditions and other findings related to the center's internal control structure.

The Financial Reporting System Is Inadequate to Effectively Manage Operations

Financial reports with numerous errors are useless to management. Errors and other problems identified with the center's financial processing are the result of a failure to accurately and timely process financial data, and constitute a failure to provide useful financial information to management. We also found a lack of proper budgeting and accountability for financial operations.

Financial processing is not accurate

The reports that are generated by the center's own accounting information system are plagued with errors. These errors and needed adjustments were identified by our certified public accountants during the course of the year-end financial audit. They should have been identified and corrected by the center's management. The significant errors and needed adjustments are included in the Independent Auditors' Report in Chapter 3. For example, the center failed to record an adjustment of approximately $9 million to write-off idle property, plant, and equipment to net realizable value, which resulted in an overstatement of assets by approximately $9 million. The failure to provide for approximately $2 million of potentially uncollectible accounts receivable means that the accounts receivable balance recorded in the financial statements is $2 million more than what is expected to be collected.

In addition, many necessary monthly financial calculations and analyses are performed only quarterly or annually. Examples of these necessary financial calculations and analyses are: recording of property additions; determining amounts to be received from third-party payors under contractual agreements such as Medicare, Medicaid, and the Hawaii Medical Service Association (HMSA); recording of accounts payable; calculating and recording depreciation expense; and recording all accrued liabilities, including liabilities for payroll and related benefits, vacations, and workers' compensation claims.

Accounting entries and financial reports should be prepared on a timely basis and reviewed by personnel with the appropriate financial accounting skills to identify errors and potential adjustments. The center should not leave it to the auditors to "find" errors and make the necessary adjustments at the end of the year.

Monthly financial reports are not prepared on a timely basis

Timely financial reports are essential for effective management of operations. They enable management to quickly identify problem areas or reporting errors that need correction. Monthly financial reports should normally take from two to three weeks to complete. It takes the center six to eight weeks to summarize monthly transactions and prepare financial reports through a process that is cumbersome and extremely labor intensive.

Reports do not provide adequate information

The center's information system can provide a number of monthly informative reports that detail various relevant operating statistics and other information. These reports include a balance sheet and statement of revenues and expenses, and summaries of key operating statistics. These reports are not provided to management for its analysis. The business office should prepare, analyze, and submit these reports to management, with accompanying explanations of significant variances from the prior year and the budget.

Reports should also include key statistical highlights in comparison with certain industry standards. These standards could include the number of admissions, the average length of a patient's stay, an average daily census, and occupancy percentages. Other operating standards such as ratios of employees to patients and operating margins could also be prepared.

The center does not have a system of financial accountability

The center's administration develops its annual operating budget using historical cost information with limited input from operating departments. Under the current financial reporting system, there is no accountability for budget overruns or operating inefficiencies. Operating budgets are not compared against actual operating results. Without this comparison, individual departments cannot be held accountable, and management cannot effectively control the operating costs of the center.

A budget is a plan converted into numbers—in this case, dollars. A good budget is reflective of sound planning. As part of the planning process, goals and expectations should be developed by department heads and department personnel, based on annual financial objectives.

The center's budget should be inputted into its accounting and financial reporting system. The system can then be used to measure actual operations against the budget. Management can compare results to the budget and can take actions if needed. Financial accountability is improved when monthly analyses of variances between actual and budgeted amounts are prepared by each department, and department heads are required and held accountable to explain and act upon significant variations. Financial accountability is crucial to effective operations of any entity. It is imperative for entities that are expected to function without taxpayer subsidies.

Financial accountability is essential to autonomy

The Department of Health believes the center can operate more effectively if independent, and autonomous of state government. However, the center owes the state general fund approximately $21 million for past central service and departmental expenses as required by Sections 36-27 and 36-30, Hawaii Revised Statutes. Central service expenses include such items as cash and debt management, accounting, and payroll services provided by other state departments. Departmental expenses include Department of Health administrative and support services costs. In addition, millions of dollars for buildings, improvements, and equipment have been financed by taxpayers.

Before autonomy can be achieved, these financial issues must be addressed: its ability to repay its $21 million debt to the state general fund and the purchase or rental of the facilities and equipment. Payments of this magnitude will require a significant positive cash flow.

Generating this kind of cash flow requires that the center be managed "with an eye towards the bottom line." That is, the center must operate similar to a profit-oriented enterprise, rather than an operation financed with taxpayers' subsidies. This will require a system of financial accountability covering all of the center's operations.

The Center's Billing and Collection System is Inadequate

The primary source of revenues for private, profit-oriented medical facilities is its billing and collections program. Therefore, the center must be able to properly bill for its services and ensure that amounts due are collected.

One indication of the efficiency and effectiveness of a hospital's billing and collection procedures, as well as a measure of its liquidity, is its *Days in Patient Accounts Receivable* (DAR). As of June 30, 1995, the center's DAR was approximately 100 days, which is twice the DAR for efficiently run hospitals. In addition, hospital collection practices should be designed to maximize collection of accounts receivable. In the center's history, more than six percent of its annual net revenues are deemed uncollectible. This percent compares unfavorably to the industry average of about three percent. If the center improved its collections to meet the industry average, millions of dollars could be collected and used to finance improvements and equipment, and/or repay the state general fund.

We found that there are significant delays in billing patients and third-party payors (Medicare, Medicaid, and insurers such as HMSA). Patients' bills are often erroneous and collection and follow-up efforts are unfocused. Furthermore, problems are exacerbated by lenient admitting practices and the center's inability to file claims electronically.

Patient billing processes are significantly delayed

Delays in sending bills result in delayed payments, or in some cases, rejected claims. Typically, patient bills are not generated and mailed until up to six or seven weeks after the patient is discharged. Ideally, patients and third-party payors should be billed within a few days after discharge. Delays in bill preparation and review and mailing processes are due to the following:

- Medical records are not up-to-date because physician attestation and diagnosis documentation is performed manually;

- The billing system requires the center to manually code bills with certain key information for third-party payors;
- The business office's review of bills prior to mailing them is not done in a timely manner;
- Billing procedures for long-term care patients is very time-consuming due to limitations of the center's automated billing system; and
- Billings for certain long-term care patients simply were not mailed for a significant period of time.

The center should consider electronically filing patient claims

The center files all patient claims manually, even though Medicare, Medicaid, HMSA and other organizations allow for electronic filing of claims. Electronic filing of these claims would significantly decrease the time from billing to collection, thereby increasing the center's cash flow.

Some of the third-party payors are imposing mandatory electronic filing requirements in the near future, with penalties for those who fail to comply. As pointed out in our prior report on the information system of the hospitals division, the advantages of electronic filing include cost savings and quicker claims payment.[1] Mandatory electronic filing requirements make it even more appropriate to implement an electronic claim system.

We have been informed that the center has been working on implementing electronic claims filing. The center should continue efforts to enhance its claims filing process.

Patients' bills include unsubstantiated charges

In order to produce patients' bills, departments rendering services to patients must submit charges to the business office. Charges for certain procedures require proper authorization and supporting documentation. The medical records department is responsible for assuring that there is proper documentation for all procedures and support for all patient charges. Lack of documentation to support patient charges can result in partial payment, delay of payment, or no payment.

We tested a representative sample of billings to patients and found an inordinate number of charges for which there was no supporting documentation. We found a number of instances of medications ordered and bills submitted for payment, but there was no documentation confirming that the medications had actually been administered to the patients. Another case revealed that there was no documentation of approval for admission of a patient. Two bills were produced for

surgeries though surgery reports were not provided. Two of the patient bills tested were rejected by the third-party payor due to improper preparation of the bills.

Lenient admitting practices hamper billing and collections

Medical insurance is a primary source of income to the center. If a patient does not have insurance, or if the patient's insurance does not cover the procedures to be performed, the center must then collect amounts due from the patient. When a patient is admitted to the center, steps must be taken to determine whether or not the patient has insurance that will help pay for the services to be provided.

Current admitting procedures do little to ensure that the patient's insurance coverage is current and will cover the procedures to be performed. When a patient is admitted to the center, patient information is gathered and a copy of the patient's insurance card is taken. Unless the insurance card requires pre-authorization for hospital services, no effort is made to verify insurance coverage at this time.

Also, the center's Utilization Review (UR) department does not review the reason or necessity of admitting a patient prior to the patient's admission. This review would help enable the center to determine if insurance will pay for the services to be provided. For example, some insurers will not pay for a hospital stay or treatment they deem unnecessary. The center should verify insurance coverage and have the UR department review the appropriateness of admissions prior to admitting patients.

Currently, the center's method of identifying gaps in insurance coverage is essentially one of waiting to see if insurance will pay the claim. If the charges are denied by the insurance company, the center then pursues payment of the entire amount from the patient. In the hospital's jargon, the amounts due from the patients are referred to as "self-pay accounts."

Self-pay accounts represent a significant collection problem

The balance due from self-pay accounts increased from $3.8 million in 1994 to $4.5 million by June 30, 1995. Of the $4.5 million, 60 percent, or approximately $2.7 million, is greater than 150 days old. One of the reasons for this increase is the center's failure to collect payments from patients either upon admission or upon discharge from the hospital.

In previous years, the center had a policy of collecting the estimated self-pay portion in cash, up-front, from the patient upon admission. This policy has been replaced with a policy to obtain promissory notes upon discharge from patients who have self-pay balances. However, this policy is not consistently enforced. As a result, patients with large balances due are discharged from the center without making payments and without a scheduled payment plan.

The first request for payment is when the patient receives a bill from the center. We pointed out significant delays in this process which, taken together with the failure to collect cash up-front or establish scheduled payment plans upon discharge, increase the likelihood that self-pay accounts receivable may not be collected. To minimize self-pay account collection problems, the center should calculate and collect the appropriate amount of cash during the admission process from patients who are likely to have a self-pay balance. Overpayments from patients should be monitored and refunded promptly. In addition, all patients should be required to sign a "promise to pay" form upon admission to facilitate later collection of balances.

Collection and follow-up efforts are not sufficient

At June 30, 1995 the center's patient accounts receivable amounted to approximately $35 million. Of this, the center expects that more than $18 million will not be collected. About $12 million of accounts receivable is over a year old, while another $7 million is greater than 150 days old. The center's collection efforts usually continue for one to four billing cycles (months), however, very little collection effort is made past that period.

To address the need for tighter collections, the center implemented an "accounts receivable task force" during the latter part of fiscal 1995. However, the focus was narrowly limited to selected patient accounts between 120 and 150 days old. Collection and follow-up efforts should be consistent and steps should be taken to collect receivables before they become old.

Patient accounts receivable are not thoroughly reviewed and analyzed

Quarterly, management reviews the center's accounts receivable by payor to estimate collectibility, but does not perform any other analytical review of its accounts receivable balance. To properly control patient accounts receivable and identify problem accounts in a timely manner, a thorough monthly analytical review of accounts receivable should be performed by the business office. Slow paying or delinquent accounts should be flagged for additional follow-up procedures. In addition, the accounts receivable performance for each third-party payor should be critically analyzed to provide the center with data by which prompt payment can be requested, especially when the payor is not meeting contract terms or government regulations.

Payments from third-party payors are not sufficiently reviewed

Because the center's standard charges often differ from amounts insurers and other third-party payors are contractually obliged to pay, third-party payors generally pay only a portion of the center's charges. The center

does not calculate the amount of charges expected to be collected from third-party payors when a bill is submitted to the third-party payor. As a result, the center does not know how much is actually due from third-party payors. When payments are received from the payors, the center does not review the payments for correctness. Instead, the center accepts whatever payments it receives and writes-off the differences and/or transfers the remaining balance to a "self-pay" category where it receives minimal follow-up.

The center should determine the amounts it expects to receive from third-party payors, compare payments received against those amounts, and follow-up when payments received differ from what was expected.

Year-end Medicare and Medicaid cost reports are not tracked

As a part of its agreements with Medicare and Medicaid, the center is required to file an annual cost report for audit purposes. The cost report represents an annual reconciliation between Medicare and Medicaid payments made to the center and amounts owed to the center based on actual costs incurred during the year. Cost reports are audited by agents of Medicare and Medicaid to determine whether they are correct. If cost reports filed are determined to be incorrect by the auditor, the hospital can be held liable to repay moneys to Medicare and Medicaid. Two cost reports have just been audited and two cost reports are still open (e.g. pending audit).

The two cost reports that were just audited have resulted in an unexpected $2.6 million payment due to Medicare and Medicaid. The financial records of the center had recorded a *balance due from* Medicare and Medicaid of $700,000. Because the center does not keep track of the status of the open cost reports, it must pay Medicare and Medicaid $2.6 million instead of receiving $700,000. Differences of this magnitude are severe and can cause problems with budgets and cash flow of the center.

Because of the potential impact of adjustments resulting from the audits of cost reports that are still open, the center should monitor the status of the audits of each open report. Monitoring the status of audits of open cost reports can provide management with a more accurate picture of the final settlement amount revealed by the audits. Cost report audit results should not surprise management. We have been informed also that an initial review of the two open cost reports indicate that the center may have to pay an additional $2.8 million for these open years.

Adjustments in the form of amounts due to or from Medicare and Medicaid are not unusual. However, the *magnitude* of these amounts due, as well as the surprise nature of the audit results, are unusual and need to be minimized.

Business Office Personnel Are Improperly Classified, Lack Adequate Training, and Some Functions Are Poorly Organized

Many of the problems noted in the areas of financial accounting and reporting and billings and collections might be avoided if the center's business office staff were properly classified, trained, and organized. We found that business office personnel lacked the requisite accounting and financial skills to prepare and review accounting records and that they have not been appropriately trained in health care financial management and analysis.

Health care financial management is a highly complex, specialized field that must adapt to changes in Medicare, Medicaid, and health care initiatives such as the burgeoning health maintenance organization (HMO) industry. The Hilo Medical Center is a $64 million operation requiring competent financial management. The center's business office positions should be properly classified and personnel should be trained to deal with the accounting, reporting, and billing functions unique to the health care industry.

Staff should be properly classified and trained

These staff problems are not new. In our 1992 report on the Division of Community Hospitals, we found that

> The business offices at the community hospitals are not staffed with enough appropriately trained personnel. They lack persons with backgrounds in financial management and analysis, persons familiar with practices specific to the hospital industry. Instead of patient account personnel typically used within the industry, offices are staffed by positions classified as "accountants."[2]

We find that the situation has not changed and our comment is even more relevant today. Patient revenues have more than doubled since 1990, to $64 million, and the need for specialized staff is immediate. In addition to the "accountants" referred to in our previous report, we now find that billing and collection positions are staffed with "clerks" who lack the appropriate knowledge of Medicare, Medicaid, and other third-party payor billing and collection practices, which have become exceedingly complicated and extensive.

We also note that the State of Hawaii position descriptions for accounting and billing and collection staff do not reflect appropriate educational or experience levels for these positions. For example, a billing/collection position is a clerk-typist II, which requires only a high school education and allows for no work experience. Additionally, none of the "accountant" positions specifically require work experience in the health care industry. All of these positions should set minimum qualifications of at least some college education and appropriate health care industry work

experience. Position classification and the State's pay scale prevent the center from attracting and hiring qualified personnel. These factors have contributed to the current situation.

Lack of training

In addition to inaccurate and untimely financial information, the lack of proper training has been a significant cause of delays in billing and collections. The center does not have a formal training program for the business office staff. Lack of training in the business office was also noted in our prior report on the community hospitals' information system.[3] We previously found that necessary accounting reports are not being prepared because staff are unsure about operating the system to produce accurate reports.[4]

The billing and collection staff's tasks are not organized efficiently

Billing and collections in the health care industry have become highly specialized because of the myriad of third-party payors and government regulations. Hospitals have found that best results are achieved when patient billing and collection functions are organized by payor-type, to address the specialized nature of each payor. We found that shifts in workload organization have contributed to the problems with billings and collections.

For this past fiscal year, clerks were assigned the responsibility for patient billings *according to the patient's last name*. For example, certain individuals bill all accounts for patients whose last names begin with the letters ranging from "A" to "N." During the same year, clerks who were assigned responsibility for collections and follow-up were assigned to patient accounts *by payor type* (i.e. Medicare, Medicaid, HMSA, etc.). Responsibilities for billings should correlate with that of follow-up and collections so that staff can develop expertise and to facilitate the exchange of information.

In an attempt to correlate these responsibilities, the business office has determined that both billings and collections will be coordinated by patient last name. Again, we state that best results are achieved when billing and collection responsibilities are organized by payor type, *not by patient name*.

The Information Processing System Has Severe Limitations

Our report on the information system of the community hospitals identified problems with the billing of long-term care patients because of computer limitations.[5] We now find that the problems seriously affect the center's ability to account for billings and to collect amounts due. We also find that the center has no disaster recovery plan to ensure that vital

information processing and billing capabilities are not irreparably lost in the event of a disaster. These problems are serious enough to be classified as a reportable condition.

The center's billing system is not appropriate for all of the center's operations

The new billing system installed at the center is specifically designed for acute care hospitals. A significant portion of the center's business, however, relates to long-term care patients whose accounts cannot be billed by the new system without significant manual effort. This required manual processing results in inefficiencies and further delays the overall billing process. These inefficiencies and delays have contributed to the growth of uncollectible accounts and need to be addressed and resolved as soon as possible.

System disaster recovery procedures are inadequate

Prior audit reports have noted that the center did not have a disaster recovery plan. In this audit, we found that the center still does not have a well-developed, written disaster recovery plan for its computer system. A disaster recovery plan is designed to ensure minimal interruption of information processing should a disaster at the center render its data processing useless.

A disaster recovery plan includes making back-up copies of system data and storing them in a secure, off-site location such as a safe deposit vault. It also identifies alternate computer facilities at which the back-up system can be installed and made operational. It further identifies key staff responsibilities for ensuring that the system back-up is current and agreements to use the alternate computer are intact. It serves as a reference tool for staff so that they understand their roles in installing and operating the back-up system as quickly as possible.

Without a written disaster plan, recovery from such an event could be unnecessarily slow or prolonged since resources and lines of authority are not clearly defined. In addition, delays in getting the system up would significantly affect the billing function and the cash flow of the center.

Other Problems Affect the Center's Ability to Contain Cost and Improve Revenues

In addition to the reportable conditions just discussed, we found a number of other problems at the center. These affect the center's ability to manage costs and enhance revenues and are discussed in the following sections.

The Role of Utilization Review in Managing Cost Can Be Expanded to Benefit the Center

Insurance plans normally pay for services based on standards for levels of treatment and lengths of stay. For example there is a standard length of stay for an appendectomy. Standard treatments would include surgery, post-operative recovery, nursing services, and medications for pain and inflammation. If a patient receives treatment or medication that is not included in the standards, or is kept in the hospital longer than the standard length of stay allowed under the insurance plan, the hospital will not be paid for the additional treatment and excess days.

In this event, each additional day that a patient occupies a semi-private room could result in lost revenues of up to hundreds of dollars. Also, the center may not be paid for services and medications provided. With 274 beds available, the potential for revenue loss and unchecked, unrecoverable costs is significant.

Utilization review (UR) is the review of a patient's course of treatment to assess the efficiency of the health care process and the appropriateness of decision-making related to the site of care, its frequency, and its duration. Utilization review can be conducted before admission, during the patient's stay, or after discharge. The review focuses on the type of service provided and the need for such service.

Effective utilization review can identify potential problems with patient treatment or length of stay. It can be used to identify possible cost savings by calling attention to treatments that are not normally required by the illness or surgery. Utilization review can also be used to point out the need for additional documentation from doctors to support non-standard treatments. In this case, the additional documentation may result in increased revenues from the insurers.

The center currently has one nurse assigned the responsibility for utilization review. The size of the medical center, its patient demographics, and its volume of business warrant additional resources to perform utilization review. The additional utilization review capabilities should benefit the center by reducing costs and increasing revenues and collections.

We understand that the center has recently added one additional staff member to assist with utilization review. We urge the center to continue efforts to strengthen the utilization review function.

Agreements for Laboratory, Radiological, and Kidney Dialysis Services Are Not Adequately Monitored

The center has contractual agreements with others to provide laboratory, radiological, and kidney dialysis services to its patients. The center is charged for each procedure performed at rates established in the contracts. The center then bills patients for these procedures at rates established by the third-party payors or in accordance with the center's policies.

We find that the center may be losing money on these agreements because the Division of Community Hospitals negotiated two contracts on behalf of the center that are potentially financially detrimental to the center. Additionally, the center does not reconcile invoices received for services to its own records of services requested and authorized. It also does not ensure that amounts billed to the center conform to the contract agreements. Amounts billed to patients are often less than payments made to the contractors.

The Division of Community Hospitals did not sufficiently evaluate the economics of laboratory and radiological contracts

The Division of Community Hospitals negotiated contracts for laboratory and radiological services for the Hilo Medical Center. In doing so, it agreed upon contract payment terms that are potentially detrimental to the center.

For example, the center must pay contractors 100 percent of amounts billed for laboratory and radiological services. However, the center generally receives only a fraction of these amounts from third-party payors. Depending on the agreements with the third-party payors, the center may be prevented from obtaining the balance from the patients. In addition, for certain laboratory services, the contractor's charge to the center is higher than the center's corresponding customary charge to the patient.

The center should be allowed to analyze and negotiate its own service contracts. In doing so, it should ensure that payments for services under the contract are fair in light of third-party payor practices and the center's fee structure.

The center does not reconcile services provided by contractors to services authorized

The center does not reconcile billings received from contractors to its own records to ensure that they are for services requested and authorized by the center. Nor does it ensure that charges for services conform to the contracts. The center has an obligation to pay for services that it has requested and authorized in accordance with the terms of the contract. Failure to ensure that payments are only for services requested and authorized, rendered, and billed to the center at contracted rates is a serious problem. The center should not pay for these services until it has verified that the procedures performed were requested and authorized, and that rates charged conform to the contractual agreements. Failure to

follow this practice may result in overpayments to contractors and an inability to collect for these services from patients and third-party payors.

Payments received do not cover the cost of contracted services

According to the center's accounting records, payments for kidney dialysis services exceeded amounts billed to patients by $110,000 during the year. This significant loss may be the result of several causes. These include the failure to ensure that payments were only for services requested and authorized; errors in billing patients; and third-party payments for the services may have been less than the cost to the center.

The center should not be paying for services that it cannot recover from patients or their insurers. In the case of kidney dialysis services, it should determine the causes of losing $110,000 and evaluate whether it should be paying for these services on behalf of its patients. It should also evaluate the contracts for laboratory and radiological services to determine whether contractors should bill patients and insurers directly for their services.

The Center's Self-Insured Workers' Compensation Program is Poorly Managed

The center is fully self-insured for workers' compensation claims. Claims are filed when one of the center's workers is injured on the job. The center generally pays all medical and rehabilitation expenses, a portion of the injured worker's base pay while out of work, disability expenses, and certain other costs. The center currently pays approximately $1.3 million a year in workers' compensation claims costs.

The center does not monitor the status of open claims

Once a claim is filed and recorded by the State Department of Labor, medical bills, salary, and other costs continue to be paid by the center without limit. Although each medical bill and payroll charge is reviewed prior to payment, no one is responsible for managing each case or trying to minimize the costs of these claims to the center. At a minimum, the center should have someone perform the following for workers' compensation claims:

- Evaluate the merit of each new claim and challenge claims that do not appear to be valid;
- Investigate the cause of each injury and ensure that future injuries can be prevented; and
- Work with the injured workers to rehabilitate them and get them back on the job as quickly as possible.

Proper monitoring of open workers' compensation claims and prevention of future claims minimizes the cost of self-insurance for these injuries. The lack of such monitoring has resulted in an enormous cost to the center, as discussed above.

The center does not have programs to minimize workers' compensation injuries

The center does not have programs in place to actively encourage safety on the job and thereby minimize the occurrence of workers' compensation injuries. Management should implement aggressive safety programs that reward workers for remaining injury-free. Each department head should be required to work with their staff to cooperatively develop a program and set goals to remain injury-free. Prevention of workers' compensation injuries will reduce the amount of payments that the center is required to make on behalf of injured workers under the current self-insurance plan.

Waitlisted Long-term Care Patients May Impact the Financial Viability of the Center

The center is licensed for 166 acute care beds and 108 long-term care beds. The center currently has between 50 to 60 long-term care patients occupying acute care beds because the long-term care units are full. These waitlisted patients are waiting to be moved to available long-term care beds. In the interim, their placement in the acute care setting can place a financial hardship on the center.

The increasing number of beds occupied by long-term care patients can have a negative financial impact on the center. Revenue for services provided to long-term care patients is generally from Medicare or Medicaid and barely covers the cost of providing the care. Congressional changes to Medicare and Medicaid may further reduce these revenues.

As long as the beds occupied by long-term care patients do not cause the center to have to turn away higher paying acute care patients, the financial impact of these long-term care patients is not severe. Should the center have to turn away better paying patients because of lack of beds, the financial impact on operations could be significant. During the year ended June 30, 1995, the center operated at near capacity. The increasing number of long-term care patients in the center indicates that it may reach full capacity and may have to turn away better paying patients.

Conclusions

Financial management practices at the Hilo Medical Center are deficient. Problems are such that the center is far from being capable of functioning effectively as an independent or autonomous entity. Problems are primarily the result of several layers of bureaucracy and inattention by the Division of Community Hospitals; State of Hawaii job classification and pay scales; and a failure to pay attention to important functions such as

utilization review, contract management, and the control of workers' compensation claims. Management must take steps to develop the staff and processes that are necessary to function independently.

Recommendations

1. The Division of Community Hospitals and the Hilo Medical Center should make a concerted effort to improve the center's accounting, reporting, billing, and information system functions. In doing so they should:

   a. identify and implement changes needed to improve accounting and financial reporting capabilities;

   b. take steps necessary to improve the billing and collections practices; and

   c. improve the information processing system and establish a disaster recovery plan for the information system.

2. The Division of Community Hospitals and the center should make it a priority to improve staff capabilities at the center. In doing so they should:

   a. develop proper job classifications and pay scales for needed personnel in the business office;

   b. identify and provide needed training; and

   c. properly organize the billing and collection processes.

3. The center should continue its efforts to improve the utilization review function.

4. The Division of Community Hospitals should cease negotiating contracts that are potentially financially detrimental to the center and allow the center to negotiate its own agreements.

5. The center should take steps to ensure that it is paying for contract services that are authorized and that conform to the contract.

6. The center should evaluate the need to continue its contracts to pay for radiological, laboratory, and kidney dialysis services for its patients.

7. The center should take steps necessary to effectively manage its workers' compensations claims.

8. The Division of Community Hospitals and the center should begin to develop plans to deal with the potential problems associated with its waitlisted patients.

Chapter 3

Financial Audit

This chapter presents the results of the financial audit of the Hilo Medical Center as of and for the fiscal year ended June 30, 1995. It includes the independent auditors' report and reports on the internal control structure and tests of compliance with laws and regulations. It also displays financial statements of all fund types and account groups administered by the center, together with explanatory notes.

Summary of Findings

In the opinion of Arthur Andersen LLP, based on their audit, except for certain accounting errors which have not been adjusted by the center as required by generally accepted accounting principles and not recording the proper liability for workers' compensation claims, the financial statements present fairly, in all material respects, the financial position of the center as of June 30, 1995, and the results of its operations and cash flows of its unrestricted funds for the year then ended in conformity with generally accepted accounting principles.

Arthur Andersen LLP noted certain matters involving the internal control structure and its operation that they considered to be reportable conditions, including a material weakness as defined in the report on the internal control structure. They also noted no instances of noncompliance with laws and regulations applicable to Hilo Medical Center.

ARTHUR ANDERSEN LLP

Independent Auditors' Report

The Auditor
State of Hawaii:

We have audited the following financial statements of the Hilo Medical Center (center):

Balance Sheet - All Fund Types and Account Groups - June 30, 1995 (Exhibit A);

Statement of Revenues and Expenses of Unrestricted Funds - for the year ended June 30, 1995 (Exhibit B);

Statement of Changes in Fund Balances - Unrestricted and Restricted Funds - for the year ended June 30, 1995 (Exhibit C); and

Statement of Cash Flows of Unrestricted Funds - for the year ended June 30, 1995 (Exhibit D).

These financial statements are the responsibility of the center's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with generally accepted auditing standards and the standards for financial audits contained in Government Auditing Standards (1994 revision) 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 audit provides a reasonable basis for our opinion.

The financial statements contained accounting errors which have not been adjusted by the center and which we believe are required by generally accepted accounting principles as of June 30, 1995. The net impact of not recording these adjustments is to overstate assets by approximately $9.2 million, understate liabilities by approximately $6.5 million, overstate unrestricted fund balance by approximately $10.6 million and overstate excess of revenues over expenses by approximately $5.1 million in the accompanying financial statements. The following is a summary of the nature and impact of such accounting errors and related unrecorded adjustments [(decreases) and increases in the respective account balances in 000's]:

Adjustment Description	Amount			
	Assets	Liabilities	Fund Balance	Excess of Revenues Over Expenses
Property, plant and equipment -- to write-off idle equipment. Generally accepted accounting principles require that property, plant and equipment be carried at the lower of cost or net realizable value. As more fully discussed in Note 4 to the financial statements, the center is carrying certain "idle equipment" of approximately $9.3 million, net, which we believe exceeds their current net realizable value. The "idle equipment" primarily relates to assets associated with the "old" hospital, which we believe were recorded in error. As of June 30, 1995 the center has not corrected this error.	$(9,307)	$ -	$(10,193)	$ 886
Property, plant and equipment -- to record capital lease assets and correct accounting for capital lease payments. Generally accepted accounting principles require that leases which meet the criteria of capital leases be recorded as assets, with a corresponding liability at the date of inception. In addition, capital lease payments should be applied against the principal balance of the lease obligation and should not be capitalized. Generally accepted accounting principles also require that the correction of material prior period accounting errors should be recorded to beginning fund balance.	2,434	2,779	(391)	46

Adjustment Description	Amount			
	Assets	Liabilities	Fund Balance	Excess of Revenues Over Expenses
Receivables -- to increase allowance for contractual adjustments and doubtful accounts. Generally accepted accounting principles require that receivables be carried at their net realizable value.	(2,200)	-	-	(2,200)
Property, plant and equipment - to correct payment for environmental cleanup costs. Environmental remediation costs that have no future benefit are required to be expensed in accordance with generally accepted accounting principles.	(299)	(59)	-	(240)
Current liabilities - to correct provider tax, estimated third party settlements and various unrecorded liabilities. Generally accepted accounting principles require that all liabilities be recorded on an accrual basis at period end.	44	3,739	-	(3,695)
Net patient service revenue - to record late-billed patient revenue. Generally accepted accounting principles require that net patient revenue be recorded on an accrual basis at period end.	180	-	-	180
Restricted fund balance - to record current year activity. Generally accepted accounting principles require that all activity in restricted funds be properly recorded to the respective fund balance.	-	-	5	(5)
Other miscellaneous adjustments	(37)		-	(37)
	$(9,185)	$6,459	$(10,579)	$(5,065)

As discussed in Note 10 , the center is fully self-insured for workers' compensation and disability claims. The center maintains a liability for the expected cost of open reported claims based on the historical cost information for closed claims. The liability recorded by the center using this methodology at June 30, 1995 was $875,000. Claims which have been incurred but not reported (IBNR) have not been considered in the center's liability analysis, nor have any actuarial estimates been used to determine the center's total workers' compensation liability. As a result, we were unable to satisfy ourselves as to the center's total workers' compensation liability as of June 30, 1995. During the year ended June 30, 1995, the center paid approximately $1.3 million in workers' compensation and disability expenses.

In our opinion, except for the impact of the matters discussed in the preceding two paragraphs above, the financial statements referred to above present fairly, in all material respects, the financial position of Hilo Medical Center as of June 30, 1995, and the results of its operations and cash flows of its unrestricted funds for the year then ended in conformity with generally accepted accounting principles.

As more fully discussed in Note 10, the State of Hawaii and various unnamed parties are defendants in a lawsuit claiming amounts owed for the occupation on certain Ceded Lands. The ultimate outcome of this litigation and its effect on Hilo Medical Center, if any, cannot be determined. Accordingly, no provision for any loss that may result from the resolution of this matter has been made in the accompanying financial statements.

Our audit was made for the purpose of forming an opinion on the basic financial statements taken as a whole. The supplemental information included in Schedules I to V is presented for purposes of additional analysis and is not a required part of the basic financial statements. This information has not been subjected to the auditing procedures applied in the audit of the basic financial statements and, accordingly, we express no opinion on it.

/s/Arthur Andersen LLP

Honolulu, Hawaii
September 6, 1995

ARTHUR ANDERSEN LLP

Independent Auditors' Report on Internal Control Structure Based on an Audit of the Financial Statements

The Auditor
State of Hawaii:

We have audited the financial statements of Hilo Medical Center as of and for the year ended June 30, 1995, and have issued our report thereon dated September 6, 1995. Such report is qualified with respect to accounting errors in the financial statements that have not been adjusted, and for the omission of a consideration of claims incurred but not reported (IBNR) in determining the recorded liability for workers' compensation claims.

We conducted our audit in accordance with generally accepted auditing standards and the standards for financial audits contained in Government Auditing Standards (1994 revision), 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.

In planning and performing our audit of the financial statements of the Hilo Medical Center for the year ended June 30, 1995, we considered its internal control structure in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide assurance on the internal control structure.

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

We noted certain matters involving the internal control structure and its operation that we consider to be reportable conditions under standards established by the American Institute of Certified Public Accountants. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control structure that, in our judgment, could adversely affect Hilo Medical Center's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements. The following reportable conditions are more fully described in Chapter 2:

1. The Hilo Medical Center's financial reporting system does not generate information or standard accounting reports that are necessary to effectively manage the operations of the Hilo Medical Center.

2. The Hilo Medical Center's billing and collection system and existing procedures are not adequate to effectively capture, process, bill and collect all patient charges on a timely basis.

3. Business office staff are not properly classified or adequately trained, and billing and collection functions are not sufficiently organized.

4. The Hilo Medical Center's information processing system has severe limitations that contribute to delays in billing and collecting patient accounts.

A material weakness is a reportable condition in which the design or operation of one or more of the specific internal control structure elements does not reduce to a relatively low level the risk that errors or irregularities in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions.

Our consideration of the internal control structure would not necessarily disclose all matters in the internal control structure that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses as defined above. However, we noted the following matter involving the internal control structure and its operation that we consider to be a material weakness as defined above. These conditions were considered in determining the nature, timing, and extent of the procedures to be performed in our audit of the financial statements of Hilo Medical Center for the year ended June 30, 1995.

The reportable conditions referred to above and described in more detail in Chapter 2, do not individually constitute a material weakness. However, many of these same conditions have been identified in prior years and have still not been corrected. As a result, these uncorrected conditions taken together reveal a material weakness in the overall management control environment. Management controls have a pervasive effect on the organization and their absence can increase the risk of errors or

irregularities in many critical financial statement accounts. The weaknesses in Hilo Medical Center's overall management controls include a lack of properly experienced, trained, and supervised personnel, failure to emphasize key internal accounting controls and failure to take timely corrective action. These management control weaknesses resulted in unreconciled accounts, improper postings of current year financial accounting activity and unrecorded transactions which resulted in material accounting errors and related proposed adjustments to the Hilo Medical Center's June 30, 1995 financial statements.

We also noted other matters involving the internal control structure and its operation that we have reported to the Auditor, State of Hawaii, and management of Hilo Medical Center, which are described in Chapter 2.

This report is intended for the information of the Auditor, State of Hawaii, and management of Hilo Medical Center. However, this report is a matter of public record and its distribution is not limited.

/s/Arthur Andersen LLP

Honolulu, Hawaii
September 6, 1995

ARTHUR ANDERSEN LLP

Independent Auditors' Report on Compliance Based on an Audit of the Financial Statements

The Auditor
State of Hawaii:

We have audited the financial statements of Hilo Medical Center as of and for the year ended June 30, 1995, and have issued our report thereon dated September 6, 1995. Such report is qualified with respect to accounting errors in the financial statements that have not been adjusted, and for the omission of a consideration of claims incurred but not reported (IBNR) in determining the recorded liability for workers' compensation claims.

We conducted our audit in accordance with generally accepted auditing standards and the standards for financial audits contained in Government Auditing Standards (1994 revision), issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

Compliance with laws, regulations, contracts and grants applicable to the Hilo Medical Center is the responsibility of the Hilo Medical Center's management. As part of obtaining reasonable assurance about whether the financial statements are free of material misstatement, we performed tests of the Hilo Medical Center's compliance with certain provisions of laws, regulations, contracts and grants. However, the objective of our audit of the financial statements was not to provide an opinion on overall compliance with such provisions. Accordingly, we do not express such an opinion.

This report is intended for the information of the Auditor, State of Hawaii, and management of Hilo Medical Center. However, this report is a matter of public record and its distribution is not limited.

/s/ Arthur Andersen LLP

Honolulu, Hawaii
September 6, 1995

Descriptions and Definitions

This section describes the financial statements, schedules, and definitions of technical terms used in this chapter.

Descriptions of financial statements and schedules

The following is a brief description of the financial statements audited by Arthur Andersen LLP and unaudited schedules which are attached at the end of this chapter.

Balance Sheet (Exhibit A). This statement presents assets, liabilities, and fund balances of all fund types used by the center.

Statement of Revenues and Expenses of Unrestricted Funds (Exhibit B). This statement presents revenues and expenses of unrestricted funds of the center.

Statement of Changes in Fund Balances (Exhibit C). This statement presents changes in fund balances for all fund types used by the center.

Statement of Cash Flows of Unrestricted Funds (Exhibit D). This statement summarizes cash flows of the unrestricted funds of the center.

Supplemental Schedule of Operating Expenses - Unaudited (Schedule I). This schedule details the salaries and wages, and supplies and other operating expenses of the center's departments.

Selected Center Statistics - Unaudited (Schedule II). This schedule presents various operating statistics of the center.

Supplemental Schedule of Reconciliation of Cash on Deposit with the State of Hawaii - Unaudited (Schedule III). This schedule presents a reconciliation of cash on deposit with the State of Hawaii, by fiscal year appropriation number.

Modified Cash Flow Report - Unaudited (Schedule IV). This schedule summarizes cash flows of the center by significant payer category.

Aging of Patient Accounts Receivable - Unaudited (Schedule V). This schedule presents the aging of patient accounts receivable of the center.

Definition of terms

Technical terms are used in the financial statements and in the notes to the financial statements. The more common terms and their definitions are as follows:

Appropriation. An authorization granted by the State Legislature permitting a state agency, within established fiscal and budgetary controls, to incur obligations and to make expenditures.

Allotment. An authorization by the director of finance to a state agency to incur obligations and to make expenditures pursuant to the appropriation made by the state Legislature.

Contractual Allowance. A contractual allowance is the difference between gross revenue charges at established rates for service and amounts received from third-party payors under contractual agreements, such as Medicare, Medicaid, and the Hawaii Medical Service Association (HMSA).

Encumbrance. An obligation in the form of a purchase order or contract which is chargeable to an appropriation, the incurring of which sets aside the appropriation for the amount of the obligation.

Expenditure. The actual disbursement of funds for the payment of goods delivered or services rendered, the obligation to pay for such goods or services having been incurred against authorized funds.

Notes to Financial Statements

Explanatory notes which are pertinent to an understanding of the financial statements and financial condition of Hilo Medical Center included in the scope of the audit are discussed in this section.

Note 1 - Description of organization

Hilo Medical Center (center), formerly known as Hilo Hospital, is part of the Community Hospitals Division of the Department of Health, State of Hawaii. The center began as a 10 bed facility erected by the Hawaiian Government in 1897. The County of Hawaii assumed direct control of the center in 1920. In 1970, the ownership and management of the center was transferred from the County of Hawaii to the Department of Health, State of Hawaii. Currently, the center has 274 licensed beds as follows:

Acute Care	166 Beds
Skilled Nursing Facility (SNF)	36 Beds
Intermediate Care Facility (ICF)	72 Beds
Total	274 Beds

The Department of Health, State of Hawaii, administers the operations and maintenance of the center and establishes the rates for services through the division. The division's central office oversees the activities of the center and maintains contact with state government agencies

responsible for budgeting, accounting, purchasing, and personnel. Through June 20, 1995, the State of Hawaii appropriated general funds for the difference between the center's receipts and expenditures and for certain improvement projects. Effective June 20, 1995, Act 211, Session Laws of Hawaii (the Act) established greater autonomy for the division, the community hospitals, and the center . The Act provides the division with greater flexibility in the use of its funds, reduces or eliminates the State's access to the division's special funds, eliminates certain State administrative charges to the Division, and establishes control over procurement, rate-setting and other business decisions at the division level. To date, autonomous operation of the center has not occurred.

Note 2 - Summary of significant accounting policies

Financial statement presentation. Except as discussed in the Independent Auditor's Report, the accompanying financial statements are presented in accordance with generally accepted accounting principles as promulgated in the audit guide published by the American Institute of Certified Public Accountants, "Audits of Providers of Health Care Services."

Allowance for doubtful accounts. The write-off of uncollectible accounts by the center is controlled by Section 40-82.5, of the Hawaii Revised Statutes. In accordance with Section 40-82.5, the center prepares and submits for the review of the State Attorney General a listing of all accounts considered uncollectible which have been delinquent for at least two consecutive years. Such accounts as the State Attorney General finds to be uncollectible are entered in a special record and deleted from the accounts receivable records of the center. The center is thus relieved from any further accountability for the approved uncollectible accounts.

Inventories. Inventories, consisting principally of supplies, are valued at the lower of cost (first-in, first-out method) or market.

Property, plant, and equipment. Property, plant, and equipment are recorded at cost or estimated fair market value at the date of donation. Donated buildings, equipment, and land are considered additions to the permanent capital of the center and, therefore, are credited directly to the unrestricted fund balance. Equipment under capital leases are recorded at the present value of future payments. Property, plant, and equipment are depreciated by the straight-line method over their estimated useful lives. Gains or losses on the sale of property, plant, and equipment are reflected in other operating revenues. Normal repairs and maintenance expenses are charged to operations as incurred. Land on which the center is situated is owned by the State of Hawaii and is being provided at no cost to the center.

Depreciation is computed under the straight-line method to amortize the cost of the assets over the following estimated useful lives:

	Life (Years)
Building and improvements	5 - 50
Major moveable equipment	5 - 20
Fixed equipment	5 - 20

Capital improvement projects are managed by the Department of Accounting and General Services. At completion of the project, the related costs are transferred to the appropriate property, plant, and equipment accounts and depreciated.

Accrued vacation and compensatory pay. The center has adopted the practice of fully accruing all vacation and compensatory pay at current salary rates. Vacation is earned at the rate of one and three quarters working days for each month of service. Vacation days may be accumulated to a maximum of ninety days.

Patients' safekeeping funds. Patients' safekeeping funds represent funds received, or property belonging to center patients that are held by the center in a fiduciary capacity as custodian. Receipts and disbursements of these funds are not reflected in the center's operations.

Net patient service revenue. Net patient service revenue is reported on an accrual basis in the period in which services are provided, at established rates, less contractual adjustments. In accordance with the Guide, revenues relating to charity care have been eliminated from revenue and accounts receivable.

Operating revenues include amounts to be received from Medicare and Medicaid programs. Receipts from Medicare and Medicaid may be more or less than the established billing rates of the center depending upon the nature of the service provided. The amounts are determined either by use of cost reimbursement formulas or predetermined rates. Differences are accounted for as contractual adjustments.

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. Inpatient nonacute services, certain outpatient services, and defined capital and medical education costs related to Medicare beneficiaries are paid based on a cost reimbursement methodology. The center's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization under contract with the center.

Medicaid. Inpatient and outpatient services rendered to Medicaid program beneficiaries are reimbursed under a cost reimbursement methodology. The center is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the center and audits thereof by the Medicaid fiscal intermediary.

HMSA. Inpatient and outpatient services rendered to HMSA subscribers are reimbursed at prospectively determined rates per day of hospitalization or procedure performed. The prospectively determined per-diem rates are not subject to retroactive adjustment.

The center has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the center under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Grants and donations. Restricted grants and donations are credited directly to the applicable fund balance. Resources restricted for specific operating purposes are transferred to the unrestricted fund and reflected as other operating revenues to the extent expended by the unrestricted fund during the year. Funds which are restricted for property expenditures are transferred from the restricted fund to the unrestricted fund to the extent expended within the year. Unrestricted grants and donations are recorded as nonoperating revenue.

Contributed services. Volunteers have made contributions of their time in furtherance of the center's services. The value of this contributed time is not reflected in these financial statements since it is not susceptible to objective measurement or valuation.

Note 3 - Receivables

The center's receivables as of June 30, 1995 are as follows:

Patient accounts receivable	$46,744,046
Less—Allowance for bad debts	(18,145,656)
Less—Allowance for contractual adjustments	(11,161,549)
Net patient accounts receivable	17,436,841
Other receivables	649,292
Total receivables	$18,086,133

Note 4 - Property, plant, and equipment

At June 30, 1995, property, plant, and equipment consisted of the following:

Property, plant and equipment:	
Buildings and improvements	$32,416,222
Idle equipment	23,141,639
Equipment	10,422,641
Land improvements	1,054,349
	67,034,851
Less—Accumulated depreciation	(32,429,534)
	34,605,317
Assets under capital leases:	
Equipment	1,731,717
Less—Accumulated amortization	(956,134)
	775,583
	$35,380,900

Generally accepted accounting principles require that property, plant and equipment be carried at the lower of cost or net realizable value. The center is carrying certain "idle equipment" of approximately $9.3 million, net, which exceeds their current net realizable value. The "idle equipment" primarily relates to assets associated with the "old" hospital, which were recorded in the accompanying financial statements in error. As of June 30, 1995, the center has not corrected this error. The accompanying financial statements do not include any adjustments for the write-down of these assets.

Note 5 - Capital lease obligations

The center leases machinery and equipment under capital leases which expire on various dates through June 1998. As of June 30, 1995, future minimum payments were as follows (in 000's):

1996	$315
1997	264
1998	135
Total future minimum payments	714
Less—Amount representing interest	36
Total capital lease obligations	678
Current portion	288
Noncurrent portion	$390

Generally accepted accounting principles require that leases which meet the criteria of capital leases be recorded as assets, with a corresponding liability at the date of inception. The center has not recorded certain capital lease obligations of approximately $2.8 million as of June 30, 1995. Accordingly, the capital lease obligation schedule above does not reflect amounts relating to these unrecorded leases.

Note 6 - Pension plan

Substantially all eligible employees of the center are members of the Employees' Retirement System of the State of Hawaii (ERS), a cost-sharing multiple employer, public employee retirement plan. The ERS provides retirement benefits as well as death and disability benefits. Prior to June 30, 1984, the plan consisted of only a contributory option. In 1984, legislation was enacted to add a new noncontributory option for members of the ERS who are also covered under Social Security. Persons employed in positions not covered by Social Security are precluded from the noncontributory option. The noncontributory option provides for reduced benefits and covers most eligible employees hired after June 30, 1984. Employees hired before that date were allowed to continue under the contributory option or to elect the net noncontributory option and receive a refund of employee contributions. All benefits vest after five and ten years of credited service under the contributory and noncontributory options, respectively.

Required employer contributions to the ERS are based on actuarially determined rates that should provide sufficient resources to pay member pension benefits when due. The funding method used to calculate the total employer contribution required is the frozen initial liability method, and includes amortization of the accrued unfunded liability of pension benefits and post-retirement benefits fixed at $470 million over a period of twenty-eight years beginning July 1, 1988. The State's policy is to fund its required contribution annually.

The center's payroll for employees covered by the plan was approximately $25,326,000 for fiscal 1995. The payroll for all of the center's employees was approximately $26,553,000 for fiscal 1995. Contributions made to the ERS by the center for 1995 were approximately $3,147,000. These contributions represented 12.4 percent of covered payroll.

Ten-year historical trend information showing the ERS' progress in accumulating sufficient assets to pay benefits when due is presented in the ERS' annual report.

Measurement of assets and actuarial valuations are made for the entire ERS and are not separately computed for individual participating employers such as the center. The disclosures required by GASB Statement No. 5 are presented in the ERS; Comprehensive Annual Financial Report (CAFR). The following data is provided as of June 30, 1994, for the entire ERS from the disclosures contained in the CAFR for the year then ended, the most recent available (in 000's):

Pension benefit obligation	$6,999,301
Net assets available for benefits (at cost)	5,409,623
Unfunded pension benefit obligation	$1,589,678

The pension benefit obligation is a standardized measure of the present value of credited projected pension benefits, adjusted for the effects of projected salary increases, estimated to be payable in the future as a result of members' service to date.

The entire ERS' actuarially determined employer contribution requirements were met as of June 30, 1994.

Note 7 - Post-retirement health care and life insurance benefits

In addition to providing pension benefits, the State provides certain health care and life insurance benefits for retired employees of the center. Contributions are based upon negotiated collective bargaining agreements, and are funded by the State as accrued. The center had 32 retirees eligible to receive benefits as of June 30, 1995. The center's share of the expense for post-retirement health care and life insurance benefits for the year ended June 30, 1995 was approximately $345,000.

Note 8 - Estimated third party settlements

As part of providing care to Medicare and Medicaid patients, the center is required to file cost reports annually. Cost reports reconcile payments received from payers to amounts due to the center, based on actual costs incurred.

The center is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the center and audits thereof by the Medicare and Medicaid fiscal intermediary. The center's Medicare and Medicaid cost reports have been final audited by the fiscal intermediary through June 30, 1993.

Generally accepted accounting principles require that all liabilities be recorded on an accrual basis at period end. At June 30, 1995, the center has not recorded certain estimated third-party settlements payable of approximately $4.1 million.

Note 9 - Commitments

Clinical Laboratories Of Hawaii, Inc. contract. The center has an agreement with Clinical Laboratories of Hawaii, Inc. (CLH) to provide technical pathological and laboratory services to the center at certain defined rates per procedure. The agreement expires in June 1997. The center incurred approximately $4.8 million in 1995 for these services, which is reflected in Other Professional Services in the accompanying financial statements. CLH bills third-party payers separately for the professional component of laboratory services, in compliance with Medicare and Medicaid regulations. CLH also pays the center rent for the space it occupies and reimburses the center for supplies, laundry, and the direct payroll cost of the center's employees used in CLH's operations. Rental income from CLH for 1995 was approximately

$397,000 and is included in Other Operating Revenue. Reimbursements for supplies and payroll costs received by the center in 1995 amounted to approximately $923,000 and are reflected in Other Professional Services.

Hawaii Radiologic Associates contract. In 1993, the center entered into an agreement with Hawaii Radiologic Associates (HRA) to provide technical CT scan, nuclear medicine, ultrasound and mammography services to the center at certain defined rates per procedure. The agreement expired on June 30, 1995, but has been renewed through June 30, 1997, with substantially the same terms. The center incurred approximately $1.6 million in 1995 for these services, which is reflected in Other Professional Services in the accompanying financial statements. HRA bills patients separately for the professional component of laboratory services, in compliance with Medicare and Medicaid regulations. HRA also pays the center rent for the space it occupies and reimburses the center for supplies and laundry used in HRA's operations. Rental income from HRA for 1995 was approximately $176,000 and is included in Other Operating Revenue. Reimbursements for supplies and laundry costs are reflected in Other Professional Services.

Operating lease commitments. The center has entered into various short-term operating leases for hospital equipment. The annual obligation under these leases is approximately $640,000.

Sick leave. Accumulated sick leave as of June 30, 1995, was approximately $5,934,000. Sick leave accumulates at the rate of 14 hours for each month of service, as defined, without limit. Sick pay can be taken only in the event of illness and is not convertible to pay upon termination of employment. As a result, no liability for sick pay is recorded in the accompanying financial statements.

Note 10 - Contingencies

Professional liability. The center maintains professional and general liability insurance with a private insurance carrier up to a $5 million limit per claim. The Attorney General, State of Hawaii, advises that any judgments rendered against the center in excess of the center's professional liability coverage as a result of pending or threatened litigation will require special legislative appropriations and will not be charged against the center's appropriations.

Ceded Lands. The State Attorney General has reported that an action has been filed by the Office of Hawaiian Affairs (OHA) against the State of Hawaii and various unnamed parties claiming the State's alleged failure to properly account for and pay to OHA monies due to OHA, under Article XII of the Hawaii State Constitution and Chapter 10 of the Hawaii Revised Statutes, for occupation by the State on certain ceded

lands. The case is still in its initial stages and such claim exceeds $10,000,000 and is probably less than $100,000,000. The State is vigorously contesting this case and denies that any monies are owed.

It has been alleged, but without certainty, that Hilo Medical Center may be situated on ceded lands. The ultimate outcome of this litigation and its effect on Hilo Medical Center, if any, cannot be determined. Accordingly, no provision for any liability that may result from the resolution of this litigation has been made in the financial statements.

Workers' compensation self-insurance liability. The center is fully self-insured for workers' compensation and disability claims. The center pays a portion of wages for injured workers (as required by law), medical bills, judgments as stipulated by the State of Hawaii, Department of Labor, and other costs. The center also provides treatment for injured workers directly using its own facilities. The center maintains a liability for the expected cost of open reported claims, based on the historical cost information for closed claims. The liability recorded by the center using this methodology at June 30, 1995 was $875,000. Claims which have been incurred but not reported (IBNR) have not been considered in the center's liability analysis, nor have any actuarial estimates been used to determine the center's total workers' compensation liability. Accordingly, the total workers' compensation liability as of June 30, 1995, cannot be determined. During the year ended June 30, 1995, the center paid approximately $1.3 million in workers' compensation and disability expenses.

Note 11 - Central service and departmental administrative expenses

In accordance with Section 36-27 and 36-30, Hawaii Revised Statutes (HRS), Hilo Medical Center was subject to overhead expenses for State of Hawaii central service and departmental administrative expenses. Effective June 20, 1995, Act 211, Session Laws of Hawaii 1995 retroactively exempted the center from the provisions of these sections to July 1, 1993. Accordingly, no overhead expenses were recorded for the year ended June 30, 1995. In addition, approximately $2.9 million due to the State for fiscal 1994 overhead expenses was forgiven and is reflected as a reduction in Fiscal and Administrative Services at June 30, 1995.

Note 12 - Fuel spill

In October 1992, approximately 1,500 gallons of diesel fuel overflowed from an underground tank at the center and contaminated the surrounding soil. During 1995, the center with the assistance of the State Department of Accounting and General Services (DAGS) began a voluntary tank removal and remediation program in order to comply with applicable state and federal environmental regulations. DAGS engaged a consultant to determine the total cost to remove and close the underground steel tanks, remediate the soil, and install new tanks. The center's estimate of the

total cost of the project is approximately $355,000. Approximately $240,000 of the cost relates to the remediation process. The remaining amount primarily represents the cost of installing new tanks. The center paid approximately $300,000 to DAGS during 1995 for this project. The center's management believes the remediation process will be adequate to comply with all federal, state, and local laws and no further liability with respect to the fuel spill or underground steel tanks is anticipated.

Note 13 - Hilo family practice clinic

On July 1, 1994, the center entered into an agreement with the University of Hawaii, John A. Burns School of Medicine (UH) to establish a family practice residency program at the "old" hospital site. The program was authorized by Section 4 of Act 347 (1993) and is intended to improve the quality of primary care in the Hilo community. The center agreed to reimburse UH for the operating expenses of the program for one year, up to $635,000. In 1995, the center reimbursed the program approximately $576,000, which is included in Nonoperating Expense in the accompanying financial statements.

HILO MEDICAL CENTER

BALANCE SHEET -- JUNE 30, 1995

ASSETS

UNRESTRICTED FUNDS:	
Current Assets-	
Cash on hand	$ 52,769
Cash on deposit with the State of Hawaii	6,995,636
Total cash	7,048,405
Receivables, net (Note 3)	18,086,133
Inventories	895,343
Total current assets	26,029,881
Property, Plant and Equipment, net (Note 4)	35,380,900
Total unrestricted funds	61,410,781
RESTRICTED FUNDS:	
Patient trust accounts	45,120
Cash on deposit with the State of Hawaii	22,232
Total restricted funds	67,352
	$ 61,478,133

The accompanying notes are an integral part of this balance sheet.

HILO MEDICAL CENTER

BALANCE SHEET - JUNE 30, 1995

LIABILITIES AND FUND BALANCES

UNRESTRICTED FUNDS:	
Current Liabilities-	
Accounts payable	$ 1,661,645
Accrued salaries and wages	383,740
Accrued vacation	2,252,483
Capital lease obligations - current portion (Note 5)	287,963
Estimated third party settlements, net (Note 8)	1,536,557
Workers' compensation payable (Note 10)	875,000
Total current liabilities	6,997,388
Due to State of Hawaii	21,438,423
Capital lease obligations - noncurrent portion (Note 5)	389,636
Security deposits	10,671
Total liabilities	28,836,118
Commitments (Note 9)	
Contingencies (Note 10)	
Fund balance	32,579,324
Total Unrestricted Funds	61,415,442
RESTRICTED FUNDS:	
Patients' safekeeping deposits	45,120
Fund balance	17,571
Total restricted funds	62,691
	$ 61,478,133

The accompanying notes are an integral part of this balance sheet.

Exhibit B

HILO MEDICAL CENTER

STATEMENT OF REVENUES AND EXPENSES OF UNRESTRICTED FUNDS

FOR THE YEAR ENDED JUNE 30, 1995

OPERATING REVENUES:	
Net patient service revenue	$ 64,378,422
Other operating revenues:	
Rental income	828,654
Cafeteria	228,029
Other	212,114
	1,268,797
Total operating revenues	65,647,219
OPERATING EXPENSES:	
Nursing services	19,465,212
Other professional services (Note 9)	15,477,751
Fiscal and administrative services (Note 11)	11,111,058
General services	6,581,680
Depreciation and amortization	2,889,724
Provision for uncollectible accounts	2,354,204
Total operating expenses	57,879,629
INCOME FROM OPERATIONS	7,767,590
NONOPERATING EXPENSE:	
Net transfers to other State of Hawaii hospitals and Division of Community Hospitals	(1,226,397)
Hilo Family Practice (Note 13)	(575,735)
Total nonoperating expense	(1,802,132)
EXCESS OF REVENUES OVER EXPENSES	$ 5,965,458

The accompanying notes are an integral part of this financial statement.

Exhibit C

HILO MEDICAL CENTER

STATEMENT OF CHANGES IN FUND BALANCES

FOR THE YEAR ENDED JUNE 30, 1995

UNRESTRICTED FUNDS:	
Balance, beginning of year	$ 26,613,866
Excess of revenues over expenses	5,965,458
Balance, end of year	$ 32,579,324
RESTRICTED FUNDS:	
Balance, beginning of year	$ 17,571
1995 activity	-
Balance, end of year	$ 17,571

The accompanying notes are an integral part of this financial statement.

Exhibit D

HILO MEDICAL CENTER

STATEMENT OF CASH FLOWS OF UNRESTRICTED FUNDS

FOR THE YEAR ENDED JUNE 30, 1995

CASH FLOWS FROM OPERATING ACTIVITIES:	
Income from operations	$ 7,767,590
Adjustments to reconcile income from operations to net cash provided by operating activities:	
Depreciation and amortization	2,889,724
Provision for uncollectible accounts	2,354,204
Hilo Family Practice Expense	(575,735)
Nonoperating transfers to other State of Hawaii hospitals and Division of Community Hospitals	(1,226,397)
Decrease (increase) in:	
Receivables	(7,076,650)
Inventories	337,377
Increase (decrease) in:	
Accrued vacation	(199,537)
Estimated third-party payer settlements	1,866,997
Accounts payable	212,570
Workers Compensation payable	(3,000)
Accrued salaries and wages	62,179
Due to State of Hawaii	(1,301,781)
Net cash provided by operating activities	5,107,541
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:	
Acquisition of capital assets	(1,191,132)
Payments on capital lease obligations	(396,961)
Net cash used in capital and related financing activities	(1,588,093)
NET INCREASE IN CASH	3,519,448
CASH, beginning of year	3,528,957
CASH, end of year	$ 7,048,405

The accompanying notes are an integral part of this financial statement.

HILO MEDICAL CENTER

SUPPLEMENTAL SCHEDULE OF OPERATING EXPENSES

FOR THE YEARS ENDED JUNE 30, 1995 AND 1994

(UNAUDITED)

	1995				1994			
	Salaries and Wages	Supplies and Other Expenses	Total	Percent of Total Expenses	Salaries and Wages	Supplies and Other Expenses	Total	Percent of Total Expenses
NURSING SERVICES:								
Medical	$ 2,711,136	$ 305,154	$ 3,016,290	5.2%	$ 2,407,713	$ 409,630	$ 2,817,343	4.5%
Operating room	1,589,286	1,915,833	3,505,119	6.1%	1,697,507	2,089,636	3,787,143	6.0%
Surgical	1,594,287	219,400	1,813,687	3.1%	1,520,474	348,166	1,868,640	3.0%
Intermediate care	1,642,768	276,943	1,919,711	3.3%	1,617,772	303,830	1,921,602	3.0%
Intensive	1,047,871	298,955	1,346,826	2.3%	954,290	375,563	1,329,853	2.1%
Emergency room	1,312,537	440,594	1,753,131	3.0%	989,670	361,623	1,351,293	2.1%
Skilled nursing care	1,114,606	145,819	1,260,425	2.2%	1,277,256	83,730	1,360,986	2.2%
Nursing administration	1,399,186	39,480	1,438,666	2.5%	1,133,889	24,106	1,157,995	1.8%
Obstetrics	759,642	312,852	1,072,494	1.9%	717,676	260,102	977,778	1.6%
Nursery	602,059	48,878	650,937	1.1%	665,090	57,256	722,346	1.1%
Pediatrics	505,334	78,372	583,706	1.0%	482,461	73,767	556,228	0.9%
Psychiatrics	975,900	27,266	1,003,166	1.7%	925,011	29,108	954,119	1.5%
Delivery room	51,381	8,749	60,130	0.1%	55,424	68,614	124,038	0.2%
Recovery room	8,728	17,830	26,558	-	-	27,879	27,879	-
Surgical - short stays	-	14,366	14,366	-	-	24,820	24,820	-
	15,314,721	4,150,491	19,465,212	33.6%	14,444,233	4,537,830	18,982,063	30.0%
OTHER PROFESSIONAL SERVICES:		-						
Central services	887,619	729,454	1,617,073	2.8%	693,479	(213,052)	480,427	0.8%
Laboratory	4,861	4,784,171	4,789,032	8.3%	-	3,399,686	3,399,686	5.4%
Radiology	597,054	2,339,442	2,936,496	5.1%	568,255	2,353,857	2,922,112	4.6%
Pharmacy	518,772	1,583,277	2,102,049	3.6%	475,142	1,573,908	2,049,050	3.2%
Medical records	433,028	89,790	522,818	0.9%	392,498	198,356	590,854	0.9%
Home health	749,741	105,753	855,494	1.5%	707,192	88,696	795,888	1.3%

	1995				1994			
	Salaries and Wages	Supplies and Other Expenses	Total	Percent of Total Expenses	Salaries and Wages	Supplies and Other Expenses	Total	Percent of Total Expenses
Anesthesiology	409,819	427,936	837,755	1.4%	256,961	376,500	633,461	1.0%
Occupational therapy	278,321	6,582	284,903	0.5%	303,949	12,456	316,405	0.5%
Respiratory therapy	347,539	368,550	716,089	1.2%	296,398	209,604	506,002	0.8%
Physical therapy	262,198	26,560	288,758	0.5%	285,735	13,464	299,199	0.5%
Blood bank	-	196,894	196,894	0.3%	-	196,618	196,618	0.3%
Social services	244,320	3,198	247,518	0.4%	240,530	2,843	243,373	0.4%
Electrocardiology	-	-	-	-	-	16,985	16,985	-
Speech therapy	-	54,171	54,171	0.1%	2,996	47,941	50,937	0.1%
Ambulance	10,036	433	10,469	-	-	5,512	5,512	-
Electroencephalography	-	18,232	18,232	-	-	19,856	19,856	-
	4,743,308	10,734,443	15,477,751	26.7%	4,223,135	8,303,230	12,526,365	19.8%
GENERAL SERVICES:								
Plant operations	572,604	1,733,590	2,306,194	4.0%	556,438	1,661,104	2,217,542	3.5%
Dietary	1,218,993	802,238	2,021,231	3.5%	1,173,994	776,356	1,950,350	3.1%
Housekeeping	1,046,081	107,942	1,154,023	2.0%	1,001,463	112,442	1,113,905	1.8%
Laundry and linen	472,475	198,032	670,507	1.2%	427,001	123,892	550,893	0.9%
Security	-	393,650	393,650	0.7%	-	415,990	415,990	0.7%
Employee housing	-	11,389	11,389	-	-	35,467	35,467	0.1%
Automobile service	-	24,686	24,686	-	-	18,640	18,640	-
	3,310,153	3,271,527	6,581,680	11.3%	3,158,896	3,143,891	6,302,787	10.1%
FISCAL AND ADMINISTRATIVE SERVICES:								
Employee benefits	-	8,419,928	8,419,928	14.5%	-	7,796,144	7,796,144	12.4%
Fiscal and administrative	2,425,335	265,795	2,691,130	4.6%	2,344,781	8,104,675	10,449,456	16.6%
	2,425,335	8,685,723	11,111,058	19.2%	2,344,781	15,900,819	18,245,600	29.0%
DEPRECIATION AND AMORTIZATION	-	2,889,724	2,889,724	5.0%	-	2,361,712	2,361,712	3.7%
PROVISION FOR UNCOLLECTIBLE ACCOUNTS	-	2,354,204	2,354,204	4.1%	-	4,629,369	4,629,369	7.3%
								*0.1%
Total	$ 25,793,517	$ 32,086,112	$ 57,879,629	100.0%	$ 24,171,045	$ 38,876,851	$ 63,049,896	100.0%

* All ratios not specified total .1%

HILO MEDICAL CENTER

SELECTED CENTER STATISTICS

FOR THE YEARS ENDED JUNE 30, 1995 AND 1994

(UNAUDITED)

	1995	1994
NUMBER OF LICENSED BEDS:		
Acute	166	166
SNF	36	36
ICF	72	72
Total licensed beds	274	274
NUMBER OF NURSING UNITS	12	12
OCCUPANCY:		
Patient days and percent of occupancy:		
Acute:		
Days	56,914	50,514
Percent	94%	84%
Long-term:		
Days	37,214	37,896
Percent	94%	96%
Total:		
Days	94,128	93,088
Percent	94%	93%
SUNDRY PATIENT DATA:		
Admissions:		
Acute	9,025	8,942
Long-term	109	96
Total admissions	9,134	9,038
Newborn Deliveries	1,272	1,324
Discharges:		
Acute	8,606	8,990
Long-term	491	75
Total discharges	9,097	9,065

	1995	1994
MEALS SERVED - PATIENTS	247,255	306,109
AVERAGE DAILY CENSUS	258	255
AVERAGE LENGTH OF STAY (days)	10	*
POUNDS LAUNDERED	1,460,354	1,313,104
AVERAGE TOTAL OPERATING REVENUES PER PATIENT DAY	$649	$635
AVERAGE TOTAL COST PER PATIENT DAY	$615	$588
DEPARTMENTAL DATA:		
Surgical Procedures	8,554	8,406
Radiological examinations	20,192	48,718
Laboratory tests	192,577	171,140
Emergency room registrations	24,168	23,645
Home health services	15,011	13,393
Pharmacy prescriptions filled	*	*
Physical therapy	9,059	8,863
Occupational therapy treatments	34,459	30,673
Occupational therapy visits	31,457	33,401
Operations (number of minutes)	415,727	418,152
EKG EXAMINATIONS	7,290	10,658
ANESTHETICS GIVEN	5,188	5,640

* Medical center statistic is not available

SCHEDULE III

HILO MEDICAL CENTER

SUPPLEMENTAL SCHEDULE OF RECONCILIATION OF CASH ON DEPOSIT

WITH THE STATE OF HAWAII

AS OF JUNE 30, 1995

(UNAUDITED)

	Appropriation Symbol	
SPECIAL FUNDS	S-95-350H	$ 6,028,173
	S-94-350H	540,303
	S-93-350H	452,887
	S-92-350H	7,151
PRIVATE TRUST FUND	T-95-914H	22,794
PATIENTS' SAFEKEEPING FUNDS	T-95-996H	45,120
		7,096,428
CASH DEPOSIT AND DISBURSEMENTS IN TRANSIT		(33,440)
Total cash on deposit with State of Hawaii		$ 7,062,988
UNRESTRICTED FUNDS		$6,995,636
RESTRICTED FUNDS		67,352
		$ 7,062,988

SCHEDULE IV

HILO MEDICAL CENTER

MODIFIED CASH FLOW REPORT

FOR THE YEAR ENDED JUNE 30, 1995

(UNAUDITED)

RECEIPTS:	
HMSA	$ 17,604,581
Medicare	15,287,606
Medicaid	12,337,249
Other third-party payers	7,646,476
Patient payments	3,354,006
Others	4,549,505
TOTAL RECEIPTS	60,779,423
TOTAL EXPENDITURES AND ENCUMBRANCES	58,189,371
EXCESS OF RECEIPTS OVER EXPENDITURES AND ENCUMBRANCES	2,590,052
TRANSFER TO THE DIVISION ADMINISTRATION	(1,164,716)
PRIOR YEAR REVERSION	66,708
UNENCUMBERED CASH BALANCE, June 30, 1994	3,339,831
UNENCUMBERED CASH BALANCE, June 30, 1995	$ 4,831,875

SCHEDULE V

HILO MEDICAL CENTER

AGING OF PATIENT ACCOUNTS RECEIVABLE

AS OF JUNE 30, 1995 AND 1994

(UNAUDITED)

	1995	1994
CURRENT	$ 16,866,144	$ 23,738,357
31-60 DAYS	4,628,166	4,265,580
61-90 DAYS	2,987,136	1,960,850
91-120 DAYS	2,578,396	2,557,099
121-150 DAYS	1,202,344	2,818,968
OVER 151 DAYS	18,481,860	15,152,133
Gross patient accounts receivable	46,744,046	50,492,987
Less:		
Allowance for doubtful accounts	(18,145,656)	(16,517,000)
Allowance for contractual adjustments	(11,161,549)	(20,822,802)
Net patient accounts receivable	$ 17,436,841	$ 13,153,185

Notes

Chapter 2

1. Hawaii, The Auditor, *Audit of the Information System of the Division of Community Hospitals*, Honolulu, October 1995, p. 10.

2. Hawaii, The Auditor, *Study of the Division of Community Hospitals*, Report No. 92-6, Honolulu, January 1992, p. 23.

3. Hawaii, The Auditor, *Audit of the Information System of the Division of Community Hospitals*, Report No. 95-21, Honolulu, October 1995, p. 14.

4. Ibid., p. 14.

5. Ibid., p. 9.

Responses of the Affected Agencies

Comments on Agency Responses

We transmitted a draft of this report to the Department of Health on January 3, 1996. A draft of the report was transmitted also to the Hilo Medical Center. A copy of the transmittal to the Department of Health is included as Attachment 1. A similar letter was sent to the Hilo Medical Center. The Department of Health, in consultation with the Hilo Medical Center, responded for both, and that response is included as Attachment 2.

The department concurs with our findings and says it is taking steps to implement many of our recommendations. The department believes that many of the problems noted can be better dealt with if the Hilo Medical Center were authorized to operate autonomously. It states it expects to submit a proposal to the 1996 Legislature to convert the operations of the community hospitals into an autonomous and independent public corporation. Pending any legislative approval of a conversion proposal, the department is taking steps to make improvements. We are pleased that the department is not relying solely on a decision on its autonomy proposal before taking corrective actions.

ATTACHMENT 1

STATE OF HAWAII
OFFICE OF THE AUDITOR
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917

MARION M. HIGA
State Auditor

(808) 587-0800
FAX: (808) 587-0830

January 3, 1996

COPY

The Honorable Lawrence H. Miike
Director of Health
Department of Health
Kinau Hale
1250 Punchbowl Street
Honolulu, Hawaii 96813

Dear Dr. Miike:

Enclosed for your information is copy number 9 of our draft report, *Financial Audit of the Hilo Medical Center*. We ask that you telephone us by Friday, January 5, 1996, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Tuesday, January 16, 1996.

The Hilo Medical Center, Governor, and presiding officers of the two houses of the Legislature have also been provided copies of this draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Marion M. Higa

Marion M. Higa
State Auditor

Enclosures

BENJAMIN J. CAYETANO
GOVERNOR OF HAWAII

LAWRENCE MIIKE
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P.O. BOX 3378
HONOLULU, HAWAII 96801

In reply, please refer to:
File:

January 16, 1996

BK-96-011

RECEIVED
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OFC. OF THE AUDITOR
STATE OF HAWAII

Ms. Marion Higa, State Auditor
Office of the Legislative Auditor
465 South King Street, Room 500
Honolulu, Hawai'i 96813

Dear Ms. Higa:

We have received your draft of "Financial Audit of Hilo Medical Center" and would like to thank you and your staff for some extremely helpful and compelling areas of concern which can serve as a guide for improvements at Hilo Medical Center (HMC).

We will take your audit as a challenge and guide toward improvements. The findings represent a painful litany of facts, some of which have been noted in previous reports including your legislative auditor's report of 1992, the 1994 report by the National Association of Public Hospitals, and the 1995 Legislative Auditor's report on the Hospital Information System. It is frustrating that many of the findings reoccur so often in study after study and note that part of the reason for this is that our basic organizational structure does not yield a full range of efficient and easily taken corrective actions simply because of impediments of the larger bureaucratic structure within which the hospitals are a part. To this end, the Division is currently proposing the most major reorganization of the hospital division since Statehood and will be presenting to the 1996 Legislature a proposal to convert the DCH into a public corporation for community hospitals, this corporation hopefully to become the most autonomous, most exempt, and most independent State agency of its kind.

We will follow up on the points that you have made in your report and expect that a great many improvements will be forthcoming as we proceed.

In a specific response to the eight recommendations from Chapter 2 of your audit, here are some abbreviated comments:

Recommendation 1-a states that the DCH needs to identify and implement changes to improve accounting and reporting capabilities. Prior to this Legislative Auditor's audit, HMC had outlined what changes were needed to improve accounting and financial reporting capabilities. This was subsequently confirmed by the Financial Management Work Group of the Transition Committee which has been organized to plan the conversion of the DCH into the proposed public corporation as guided by ACT 266, 1994. The systems requirements include, but are not limited to a banking-cash management system; a materials management system with accounts payable; purchasing, requisitioning, and inventory control; general accounting with general ledger, consolidations, financial reporting, budgeting and accounts receivable; payroll and human resource system and finally, a cost accounting/product line management system.

The Financial Management Work Group is currently in the process of determining which of these systems should receive priority as it is obvious that the DCH cannot undertake the enormous and expensive task of converting all of these required systems to what the DCH would want in an ideal world.

Recommendation 1-b states that we should take steps necessary to improve billing and collections practices. Steps are being taken to improve the billing and collections practices. Deloitte and Touche has just returned a proposal to improve our billing and collections efforts and we are in the process of contracting with them to provide services which will not only reduce our accounts receivables but also train our staff to follow the best practices in this area amongst our four acute care hospitals. In addition, some temporary assignment of key personnel is in process to strengthen the supervision in this area.

Recommendation 1-c states that we should improve the information processing system and establish a disaster recovery plan for the information system. The Information Systems Work Group of the Transition Committee has determined that an improved information processing system should be fully integrated and include six major functions; patient management, patient care, ancillary systems, patient accounting, general financial information and decision making. The system should be centralized, preferably at one site, to optimize existing resources. Staffing needs to be

expanded in certain skilled positions such as systems analysts, programming and personal computer specialists in order to accomplish this task.

A disaster recovery plan is partially completed so that data will not be lost but the need for an alternate processing site is still desirable. Maui can serve as the alternate processing site, given some funds to expand the hardware system, i.e., additional disk storage capabilities.

Recommendation 2-a states that we should develop proper job classifications and pay scales for the business office. Proper job classifications and pay scales prevent us from attracting and hiring qualified personnel, as noted by the audit. This is a systemic problem which is likely to continue under the State's personnel and civil service system.

We will renew a longstanding request for position upgrade and implement a plan for new leadership within the business office.

Recommendation 2-b states that we should identify and provide training. The recently awarded RFP to utilize private collection agencies includes provision for training of staff in the collections effort. We intend to take full advantage of that provision in the contract, as well as the training expected from the Deloitte and Touche contract for accounts receivable reduction.

Recommendation 2-c states that we should properly organize for billing and collection processes. A change in supervisory assignment will be our first step toward improving the billing and collection effort. The person assigned has been delegated the authority to make any operational or procedural change that will improve cash collections provided that the changes are done within the confines of the civil service rules and bargaining unit contracts.

Recommendation 3 states that we should continue to improve the utilization review function. We agree that we should continue to improve the utilization review function. The next level of performance improvement will require more medical staff buy-in and better clinical support information from an improved data processing system.

Recommendation 4 states that the Division of Community Hospitals should cease negotiating contracts that are potentially detrimental to HMC and allow HMC to negotiate its own agreements. The Division of Community Hospitals has, for several months, authorized the individual facilities to negotiate its own agreements except for medical malpractice insurance. It is acknowledged that negotiations best remain in the hands of the operating people.

Recommendation 5 states that HMC should ensure that it is paying for contract services that are authorized and conform to the contract. It is agreed that HMC should ensure it is paying for authorized contract services and that they conform to contract. HMC will develop a formal contract monitoring function for contracts we negotiate.

Recommendation 6 states that HMC should evaluate the need to continue its contracts for radiological, laboratory, and kidney dialysis services. HMC will evaluate the need to continue to contract for radiological, laboratory, and kidney dialysis services by exploring the consequences of converting to some alternative arrangement in each of these areas. We would note, however, that many private hospitals utilize contracts in these specialized service areas. Given the difficulties of recruitment and acquiring specialized technical personnel and equipment these services require and the Neighbor Island locations of most of our facilities, we face tremendous challenges if we try to provide these services within our administrative system.

Recommendation 7 states that we should effectively manage our workers' compensation claims. In this area, HMC has made considerable progress with an estimated savings of $231,769 for the six-month period from July 1, 1995 to December 31, 1995. In addition, assuming that the current savings continue and that future recommendations yield benefits as anticipated, HMC expects to save an additional estimated $619,282 during the 1996 calendar year.

HMC will submit a proposal for improved management of the workers' compensation claims, along the lines already started at one of our Maui facilities. This will include but not limited to hiring skilled staff, hiring an outside claims management consultant, utilizing more of our in-house services, and contracting with an investigator for suspected fraud cases.

Recommendation 8 states that DCH and HMC should begin to develop plans to deal with waitlisted patients. HMC will ask the DCH to restate the acute bed waitlist priority issue and present the medical executive committee with a waitlist crisis avoidance program. It should be noted that 120 long-term care beds are currently under construction directly across the street from HMC and expected to open in April, 1996. This will have an immediate favorable impact on our waitlist problem.

In closing, this critical report is a valid review of the problems of HMC struggling to improve itself within a system with built-in obstacles but in hopes of more positive organizational circumstances within which to grow given the possibilities of the proposed public corporation for community hospitals.

Thank you again for allowing us to comment on this audit. Your final recommendations will be carefully considered and actively followed up.

Sincerely,

BERTRAND KOBAYASHI, Ph.D.
Deputy Director for Community Hospitals