Minnie Hamilton Health System

Financial and Compliance Report

December 31, 2011

ARNETT & FOSTER

Certified Public Accountants, P.L.L.C.

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ARNETT FOSTER
Certified Public Accountants, P.L.L.C.

INDEPENDENT AUDITOR'S REPORT ON THE FINANCIAL STATEMENTS AND SUPPLEMENTARY SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS AND OTHER SUPPLEMENTARY INFORMATION

To the Board of Directors
Minnie Hamilton Health System
Grantsville, West Virginia

We have audited the accompanying balance sheets of Minnie Hamilton Health System (the "System") as of December 31, 2011 and 2010, and the related statements of operations and changes in net assets and cash flows for the years then ended. These financial statements are the responsibility of the System's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the System's internal control over financial reporting. Accordingly, we express no such opinion. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Minnie Hamilton Health System as of December 31, 2011 and 2010, and the changes in its net assets and cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

In accordance with *Government Auditing Standards,* we have also issued our report dated April 26, 2012, on our consideration of Minnie Hamilton Health System's internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements and other matters for the year ended December 31, 2011. We issued a similar report for the year ended December 31, 2010, dated April 25, 2011, which has not been included with the 2011 financial and compliance report. The purpose of those reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing for each year, and not to provide an opinion on the internal control over financial reporting or on compliance. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audit for each year.

Our audit was conducted for the purpose of forming an opinion on the basic financial statements as a whole. The accompanying schedule of expenditures of Federal awards is presented for purposes of additional analysis as required by U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments and Non-Profit Organizations,* and is not a required part of the basic financial statements. Also, the accompanying schedule of non Federal awards is presented for purposes of additional analysis of the basic financial statements and is not a required part of such financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain other procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the schedule of expenditure of Federal awards and the schedule of non-Federal awards are fairly stated in all material respects in relation to the financial statements as a whole.

ARNETT & FOSTER, P.L.L.C.

Arnett + Foster, P.L.L.C.

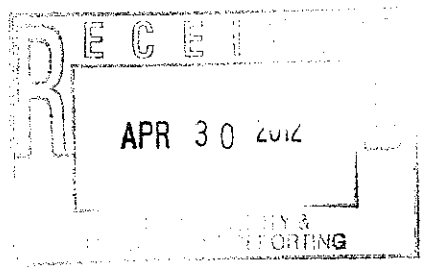
Charleston, West Virginia
April 26, 2012

MINNIE HAMILTON HEALTH SYSTEM

BALANCE SHEETS
December 31, 2011 and 2010

ASSETS	2011	2010
Current Assets		
Cash and cash equivalents	$ 586,206	$ 665,587
Patient receivables, net of allowance for doubtful accounts of $2,067,044 in 2011 and $2,400,506 in 2010	2,258,766	2,246,015
Grants receivable	55,860	25,257
Other receivable	-	76,978
Supplies inventory	116,548	121,204
Prepaid expenses and other assets	40,058	43,067
Estimated third-party payor settlements	63,572	-
Total current assets	3,121,010	3,178,108
Property and Equipment, net	3,354,978	3,535,640
Total assets	$ 6,475,988	$ 6,713,748

LIABILITIES AND NET ASSETS		
Current Liabilities		
Current maturities of long-term obligations	$ 433,980	$ 373,721
Accounts payable and accrued expenses	463,299	515,726
Employee compensation, payroll withholdings, and taxes payable	701,919	659,423
Deferred grant revenue	2,106	29,845
Estimated third-party payor settlements	-	124,458
Total current liabilities	1,601,304	1,703,173
Long-Term Obligations, net of current maturities	1,572,082	1,760,545
Total liabilities	3,173,386	3,463,718
Net Assets - Unrestricted	3,302,602	3,250,030
Total liabilities and net assets	$ 6,475,988	$ 6,713,748



See Notes to Financial Statements

MINNIE HAMILTON HEALTH SYSTEM

STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
Years Ended December 31, 2011 and 2010

	2011	2010
Unrestricted revenues, gains and other support		
Net patient service revenue	$ 15,028,538	$ 14,309,910
Federal, state and other grants	1,669,760	1,930,383
Contributions for operating expenses	53,935	6,499
Other operating revenue	364,762	316,242
Total revenues, gains and other support	17,116,995	16,563,034
Operating expenses		
Salaries and wages	9,819,833	9,010,642
Payroll taxes and benefits	1,469,641	1,279,798
Professional fees	932,982	1,089,820
Supplies and other expenses	2,216,357	1,943,003
Insurance	139,168	158,457
Utilities	290,385	282,366
Taxes	266,109	327,226
Interest	123,623	124,464
Depreciation and amortization	792,329	711,945
Provision for bad debts	1,028,633	1,320,232
Total expenses	17,079,060	16,247,953
Operating income	37,935	315,081
Non-operating revenue		
Interest	5,466	2,853
Rental income	9,171	15,002
Total non-operating revenue	14,637	17,855
Excess of revenues over expenses	52,572	332,936
Net assets, unrestricted - beginning of year	3,250,030	2,917,094
Net assets, unrestricted - end of year	$ 3,302,602	$ 3,250,030

MINNIE HAMILTON HEALTH SYSTEM

STATEMENTS OF CASH FLOWS
Years Ended December 31, 2011 and 2010

	2011	2010
Cash Flows from Operating Activities		
Excess of revenues over expenses	$ 52,572	$ 332,936
Adjustments to reconcile excess of revenues over expenses to net cash provided by operating activities:		
Depreciation and amortization	792,329	711,945
Loss (gain) on sale and disposal of equipment, net	(14,000)	6,272
Provision for bad debts	1,028,633	1,320,232
Change in assets and liabilities:		
(Increase) decrease in patient receivables	(1,041,384)	(1,848,427)
(Increase) decrease in grant receivables	(30,603)	17,377
(Increase) decrease in supplies inventory	4,656	(3,708)
(Increase) decrease in prepaid expenses and other assets	3,009	17,858)
(Increase) decrease in other receivables	76,978	(76,978)
Increase (decrease) in accounts payable and accrued expenses	(9,931)	333,345
Increase (decrease) in estimated third-party payor settlements	(188,030)	83,136
Increase (decrease) in deferred revenue	(27,739)	(9,735)
Net cash provided by operating activities	646,490	884,253
Cash Flows from Investing Activities		
Purchase of property and equipment	(561,587)	(654,160)
Net cash used in investing activities	(561,587)	(654,160)
Cash Flows from Financing Activities		
Proceeds from long-term obligation	218,124	41,340
Principal payments on short-term obligations	(27,560)	-
Principal payments on long-term obligations	(354,848)	(365,467)
Net cash used in financing activities	(164,284)	(324,127)
Net (decrease) in cash and cash equivalents	(79,381)	(94,034)
Cash and cash equivalents		
Beginning	665,587	759,621
Ending	$ 586,206	$ 665,587
Supplemental Disclosure of Cash Flow Information		
Cash payments for interest	$ 123,623	$ 124,464
Supplemental Disclosure of Noncash Investing and Financing Activities		
Property and equipment acquired through incurrence of long-term obligations	$ 36,080	$ 227,313

MINNIE HAMILTON HEALTH SYSTEM

NOTES TO FINANCIAL STATEMENTS

Note 1. Nature of Organization and Significant Accounting Policies

Nature of organization: Minnie Hamilton Health System (the System) is a not-for-profit organization located in Grantsville, West Virginia, which provides acute medical services and outpatient services to citizens of Calhoun County and surrounding areas.

A summary of significant accounting policies follows:

Use of estimates: The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Significant estimates used in preparing these financial statements include those assumed in determining the allowance for doubtful accounts and in determining the due from/to third-party payors. It is at least reasonably possible that the significant estimates used will change within the next year.

Cash and cash equivalents: For purposes of reporting the statement of cash flows, the System considers all cash accounts, which are not subject to withdrawal restrictions or penalties, and all highly liquid debt instruments purchased with an original maturity of three months or less to be cash equivalents.

Patient accounts receivable: Patient accounts receivable are carried at the original charge less an estimate made for doubtful or uncollectible accounts. In evaluating the collectability of accounts receivable, the System analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. The allowance is based upon a review of the outstanding balances aged by financial class. Management uses collection percentages based upon historical collection experience to determine collectability. Management also review troubled, aged accounts to determine collection potential. For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the System records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts. Recoveries of accounts previously written off are recorded as a reduction to the provision for bad debt expense when received. Interest is not charged on patient accounts receivable.

Supplies inventory: Supplies inventory is stated at latest invoice cost, which approximates lower of cost (first-in, first-out method) or market.

Property and equipment: Property and equipment acquisitions are recorded at cost. Donated assets are recorded at fair value at the date of contribution. Depreciation is provided over the estimated useful lives of the respective assets using the straight-line method. Buildings and equipment under capital lease obligations are amortized using the straight-line method over the shorter period of the lease term or the estimated useful life of the asset. Amortization of capital lease assets is included in depreciation expense.

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support, and are excluded from the excess of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

During the year ended December 31, 2005, the System received emergency preparedness equipment acquired by the Calhoun County Commission and by the West Virginia Division of Homeland Security and Emergency Management through the expenditure of Federal financial assistance from the U.S. Department of Homeland Security. This equipment is considered to be owned by the System while it is used in authorized programs; however, the U.S. Department of Homeland Security has a reversionary interest in the equipment. Disposition of this equipment and the ownership of any proceeds resulting from dispositions is subject to Federal regulations and requirements.

Basis of presentation: Net assets and revenues, gains, and losses are classified based on donor imposed restrictions. Accordingly, net assets of the System and changes therein are classified and reported as follows:

Unrestricted - Resources over which the Board of Directors has discretionary control.

Temporarily restricted - Resources subject to donor imposed restrictions which will be satisfied by actions of the System or passage of time. There were no temporarily restricted net assets at December 31, 2011 and 2010.

Permanently restricted - Resources subject to donor imposed restrictions that are to be maintained permanently by the System. There were no permanently restricted net assets at December 31, 2011 and 2010.

The System has elected to present temporarily restricted contributions, which are fulfilled in the same time period, within the unrestricted net assets class.

Gifts of cash and other assets are presented as restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statement of operations as net assets released from restrictions.

Statements of operations: For purposes of display, transactions deemed by management to be ongoing, major or central to the provision of health care services are reported as revenues and expenses. Peripheral or incidental transactions are reported as nonoperating revenues and expenses.

Excess of revenues over expenses: The statement of operations includes excess of revenues over expenses. Changes in unrestricted net assets when existing, which are excluded from excess of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments other than trading securities, permanent transfers of assets to and from affiliates for other than goods and services, contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets).

Net patient service revenue: Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Grant revenue: Federal, state and other grant revenue resulting from exchange transactions are recognized by the System as related grant program expenses are incurred. Grant funds received in advance of the incurrence of related expenses are reflected as deferred revenue in the accompanying balance sheets.

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

Income taxes: The System is exempt from Federal and state income taxes under Section 501(c)(3) of the Internal Revenue Code and similar state statutes relating to not-for-profit organizations.

There is currently very little guidance in the IRS Code on what activities should be subject to unrelated business income tax (UBIT). The IRS has indicated that they are studying the issue and may issue additional guidance. As a result, at this time there is uncertainty regarding whether the System should pay income tax on certain types of net taxable income from activities that may be considered by taxing authorities as unrelated to the purpose for which the System was granted non-taxable status. In the opinion of management, any liability resulting from taxing authorities imposing income taxes on the net taxable income from activities deemed to be unrelated to the System's non-taxable status is not expected to have a material effect on the System's financial position or results of operations.

The System is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. The management of the System believes it is no longer subject to income tax examinations for years prior to 2008.

Advertising expense: The System expenses advertising as it is incurred. Advertising expense was $47,921 and $36,379 for the years ended December 31, 2011 and 2010, respectively.

Subsequent events: The System has evaluated subsequent events through April 26, 2012, the date on which the financial statements were available to be issued.

Reclassification: Certain 2010 amounts have been reclassified to conform to the 2011 presentation The reclassification had no impact on previously reported net assets.

New or recent accounting pronouncements: In August 2010, the Financial Accounting Standards Board (FASB) issued Health Care Entities Topic 954 (Accounting Standards Update No. 2010-23) of the FASB Accounting Standards Codification *Measuring Charity Care for Disclosure*. The amended disclosure requirements are effective for fiscal years beginning after December 15, 2010 and must be applied retrospectively. Management's policy for providing charity care, as well as the level of charity care provided, shall be disclosed in the financial statements. Such disclosure shall be measured based on the provider's costs of providing charity care services. If costs cannot be specifically attributed to services provided to charity care patients (for example, based on a cost accounting system), management may estimate the costs of those services using reasonable techniques. The Hospital adopted the amended disclosure requirements on January 1, 2011. Note 7 reflects the amended disclosure requirements. Since the new guidance amends disclosure requirements only, its adoption did not impact the System's balance sheet, statement of operations, or cash flow statement.

Health Care Entities Topic 954 (Accounting Standards Update No. 2010-24) of the FASB Accounting Standards Codification *Presentation of Insurance Claims and Related Insurance Recoveries* is effective for fiscal years beginning after December 15, 2010. A health care entity should not net insurance recoveries for medical malpractice claims against a related medical malpractice claim liability. Additionally, the amount of the claim liability should be determined without consideration of insurance recoveries. A cumulative-effect adjustment should be recognized in opening net assets in the period of adoption if a difference exists between any liability and insurance receivables recorded as a result of application. Early application is permitted. The Hospital adopted Topic 954 (No. 2010-24) requirements

on January 1, 2011. Implementation of this standard did not materially impact the System's financial statements.

In July, 2011, the FASB issued Accounting Standards Update (ASU) 2011-07, Health Care Entities (Topic 954): *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities*. The amendments in this Update become effective for fiscal years ending after December 15, 2012 and must be applied retroactively. The amendments in this Update require certain health care entities to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). Additionally, those health care entities are required to provide enhanced disclosure about their policies for recognizing revenue and assessing bad debts. The amendments also require disclosures of patient service revenue (net of contractual allowance and discounts) as well as qualitative and quantitative information about changes in the allowance for doubtful accounts. The Hospital will adopt the amended requirements on January 1, 2012. Management does not believe this standard will have a material impact on the financial statements.

Note 2. Estimated Third-Party Payor Settlements

Estimated third-party payor settlements consist of amounts with the Medicare and Medicaid program for cost reports as follows:

	2011	2010
Due from/(to) third-party payors		
Disproportionate share	**$ 53,187**	$ 60,029
Due from/(to) third-party payors		
Medicare	**246,909**	37,000
Medicaid	**(236,524)**	(221,487)
	10,385	(184,487)
Total	**$ 63,572**	$ (124,458)

Medicaid Provider Tax Disallowance

The Centers for Medicare and Medicaid Services (CMS) has recently directed some local intermediaries to disallow the cost of provider taxes claimed in cost reports. Hospitals claimed the tax assessment as an allowable cost under the applicable regulations and the Provider Reimbursement Manual (PRM) sections. Hospitals have relied upon the fact that CMS approved applicable State Plan Amendments relating to the Provider Tax Assessments. The System paid the provider tax and included it as an allowable expense. The disallowance may be applied retroactively for several years and the impact could be significant, depending upon various factors. No provision for any potential liability has been recorded by the System. Management and various associations representing affected hospitals plan to appeal the disallowance. The ultimate outcome of the issue is unknown at this time.

Note 3. Property and Equipment

A summary of the components of property and equipment as of December 31, 2011 and 2010, is as follows:

	2011	2010
Building	$ 2,207,611	$ 2,162,611
Leasehold improvements	462,218	462,218
Equipment and furniture	5,983,969	5,462,801
	8,653,798	8,087,630
Less accumulated depreciation and amortization	5,298,820	4,551,990
Property and equipment, net	$ 3,354,978	$ 3,535,640

Capital lease assets at December 31, 2011 and 2010, included in property and equipment are as follows:

	2011	2010
Building and equipment	$ 531,576	$ 485,956
Less accumulated amortization	226,738	94,581
	$ 304,838	$ 391,375

Note 4. Line of Credit

The System had a $250,000 line of credit available at December 31, 2010 with interest at Wall Street prime plus 2%. There was no outstanding amount due at December 31, 2010. During 2011 the line of credit closed and was re-opened during February of 2012 at the same terms as above.

Note 5. Long-Term Obligations

A summary of long-term obligations is as follows:

	2011	2010
Calhoun County Building Commission Healthcare Facilities Refunding and Improvement Revenue Bonds (Minnie Hamilton Health System) Series 2006A, monthly principal payments of $25,979 including interest at 4.95%, maturing December 1, 2016, secured by substantially all System assets.	$ 1,315,680	$ 1,555,957
Note payable, bank, paid off in 2011.	-	75,351
Center for Rural Health, paid off in 2011.	-	55,579
Center for Rural Health, paid off in 2011.	-	75,800
Capital lease obligation, interest at 8.00% payable in 60 monthly installments of $6,423 with option to buy at end of lease at Fair Market Value. Secured by the equipment acquired under the obligation	172,556	237,510
Capital lease obligation, interest at 2.18% payable in 44 monthly installments of $2,767 with option to buy at end of lease at Fair Market Value. Secured by the equipment acquired under the obligation.	71,941	105,144

	2011	2010
Capital lease obligation, interest at 10.13% payable in 60 monthly installments of $1,293 with bargain purchase option of $1 at end of lease. Secured by the equipment acquired under the obligation.	**22,613**	28,925
Note payable, bank, payable in monthly installments of $7,474 including interest at a fixed rate of 4.5%, maturing October 24, 2016, secured by the System's Glenville facilities and equipment.	**388,329**	-
Capital lease obligation, payable in 60 payments of $1,137, secured by the equipment acquired under the obligation.	**34,943**	-
	2,006,062	2,134,266
Less current maturities	**433,980**	373,721
Long-term obligations	**$ 1,572,082**	$ 1,760,545

Aggregate maturities of long-term obligations at December 31, 2011 are as follows:

	Capital Lease Obligation	Long-Term Debt
2012	$ 108,211	$ 325,769
2013	115,486	342,153
2014	60,716	359,124
2015	7,815	376,938
2016	9,015	300,025
Thereafter	810	-
	$ 302,053	$ 1,704,009

The System entered into an agreement with the Calhoun County Building Commission whereby the Commission issued on December 1, 2006, Calhoun County Building Commission Healthcare Facilities Refinancing and Improvement Bond, Series 2006A (Minnie Hamilton Health System). The purpose of this bond was to provide funds to finance certain improvements to and equipment for the Hospital, retire certain indebtedness, and pay certain costs of issuance and related costs.

Under the terms of the Bond Agreement and the bank note payable, the System is required to maintain certain financial and operational covenants. These covenant provisions include, among others, limitations on incurring additional debt and limitations on capital expenditures outside of the bond project. The agreements also require the System to satisfy certain measures of financial performance as long as the notes are outstanding. The System was in compliance with these covenants as of December 31, 2011.

Note 6. Donated Use of Facilities and Equipment from Calhoun County Building Commission

In 1996, the System entered into a lease arrangement with the Calhoun County Building Commission (the Commission) for use of the building and equipment that was utilized by Calhoun General Hospital, Inc. prior to its closing. The lease runs through December 2095. Under terms of the lease agreement, the System was to make monthly payments to the Commission in sufficient amounts for it to meet its debt service obligations on the facilities. After the Commission liquidated its debt obligations during 1999, lease payments were reduced to $1 per year for the remainder of the lease term.

As the present value of projected lease payments at the lease's inception was substantially less than the fair rental value of the facilities, a restricted donation of $771,818 was recognized by the System in 1996.

This amount represented the difference between the estimated fair rental value of the leased assets and the present value of the projected lease payments.

Note 7. Net Patient Service Revenue

The System has agreements with third-party payors that provide for payments to the System at amounts different from its established rates. For Medicare and Medicaid, the System is classified as a Critical Access Hospital and receives special reimbursement treatment. A summary of the payment arrangements with major third-party payors is as follows:

- **Medicare**

  Inpatient services and certain outpatient services rendered to Medicare program beneficiaries are paid based on a cost reimbursement methodology. Other outpatient services are paid based on fee schedules. The System is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the System and review thereof by the Medicare fiscal intermediary. The appropriateness of the admission of Medicare program beneficiaries is subject to an independent review by a peer review organization.

- **Medicaid**

  Inpatient services rendered to Medicaid program beneficiaries are reimbursed under a cost reimbursement methodology. The System is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the System and review thereof by the Medicaid program. Certain outpatient services are paid on a per visit rate. Other outpatient services are reimbursed based upon the lesser of the System's charge or predetermined fee schedule amounts.

- **Commercial Insurance Carriers**

  The System has also entered into payment agreements with certain commercial insurance carriers. The basis for payment to the System under these agreements include various discounts from established charges and capitated amounts per enrollee.

- **West Virginia Health Care Authority**

  The Legislature of the State of West Virginia has created the Health Care Authority (HCA) to regulate the System's gross patient revenue based on limitation orders compiled from rate schedules and budgets submitted by the System on a periodic basis. Under current state regulations, Critical Access Hospitals are exempt from the rate setting process.

A summary of gross and net patient service revenue for all payors is as follows:

	2011	2010
Gross patient service revenue	**$ 18,608,826**	$ 17,633,757
Provision for contractual adjustments	**(2,652,703)**	(2,677,176)
Charity care (charges forgone based on established rates)	**(927,585)**	(646,671)
	$ 15,028,538	$ 14,309,910

As a result of special provisions of the Omnibus Budget Reconciliation Act of 1987, the System qualifies as a disproportionate share hospital. As a result of qualifying for this designation, the System is entitled to supplemental Medicaid payments. Included in net patient revenues are Medicaid disproportionate share revenues of approximately $1,277,000 and $1,147,000 for 2011 and 2010, respectively.

The State of West Virginia Disproportionate Share Hospital (DSH) State Plan was amended to provide for a settlement process among participating hospitals. There is a Memorandum of Understanding between the Department of Health and Human Resources and the Bureau for Medical Services and the West

Virginia Hospital Association, effective January 1, 2012, for settlement of all DSH audits through 2010 with no cash settlement. It is at least reasonably possible that the final settled amounts will differ from the amounts received and those differences could be material. Management is unable to determine what those differences could be because the laws and regulations governing Medicaid DSH payments are complex and subject to interpretation. The System has estimated settlement amounts payable for years subject to cost settlement of $279,000, which is netted against the DSH amounts receivable of $332,187 for the quarterly payment due December 31, 2011.

As disclosed in Note 2 to the accompanying financial statements, the System has recorded amounts for cost report settlements with Medicare and Medicaid. The 2011 and 2010 net patient service revenue was increased by approximately $65,000 and $7,000, respectively, as a result of settlements at amounts different than originally estimated.

Charity Care

The System provides charity care to patients who are financially unable to pay for the health care services they receive. The System's policy is not to pursue collection of amounts determined to qualify as charity care if the patient has an adjusted income equal to or below 100% of the Federal Poverty Income levels. A sliding scale discount is applied for patients up to 300% of the Federal Poverty Guidelines. Accordingly, the System does not report these amounts in the net revenues or in the allowance for doubtful accounts. The estimated costs of providing charity care services are based on a calculation which applies a ratio of costs to charges to the gross uncompensated charges associated with providing care to charity patients. The costs of caring for charity care patients for the years ended December 31, 2011 and 2010 were approximately $851,000 and $596,000, respectively.

Note 8. Concentrations of Credit Risk

The System is located in Calhoun County, West Virginia. The System grants credit without collateral to its patients, most of whom are local residents and are insured under third party payor agreements. The mix of net receivables from the System's patients and third-party payors is as follows:

	2011	2010
Medicare	37%	46%
Medicaid	20%	16%
Other third-party payors	10%	11%
Private pay	33%	27%
	100%	100%

The Hospital maintains cash in demand deposit accounts with a Federally insured bank. At times the balances in these accounts may be in excess of Federally insured limits. In management's opinion, the amounts in excess of Federally insured limits do not pose a significant risk.

Note 9. Classification of Expenses

Operating expenses by functional category are as follows:

	2011			
	Total Expenses	Patient Care and Other Program Expense	Support Services	General and Administrative
Salaries and wages	$ 9,819,833	$ 7,941,052	$ 966,715	$ 912,066
Payroll taxes and benefits	1,469,641	1,188,462	144,679	136,500
Professional fees	932,982	401,112	43,449	488,421
Supplies and other expenses	2,216,357	1,423,407	382,975	409,975
Insurance	139,168	109,004	-	30,164
Utilities	290,385	-	-	290,385
Taxes	266,109	221,065	-	45,044
Interest	123,623	-	-	123,623
Depreciation and amortization	792,329	792,329	-	-
Provision for bad debts	1,028,633	1,028,633	-	-
Total operating expenses	$ 17,079,060	$ 13,105,064	$ 1,537,818	$ 2,436,178

	2010			
	Total Expenses	Patient Care and Other Program Expense	Support Services	General and Administrative
Salaries and wages	$ 9,010,642	$ 7,209,094	$ 925,263	$ 876,285
Payroll taxes and benefits	1,279,798	1,023,921	131,417	124,460
Professional fees	1,089,820	602,923	44,269	442,628
Supplies and other expenses	1,943,003	1,293,733	355,081	294,189
Insurance	158,457	125,946	-	32,511
Utilities	282,366	-	-	282,366
Taxes	327,226	237,930	-	89,296
Interest	124,464	-	-	124,464
Depreciation and amortization	711,945	711,945	-	-
Provision for bad debts	1,320,232	1,320,232	-	-
Total operating expenses	$ 16,247,953	$ 12,525,724	$ 1,456,030	$ 2,266,199

Note 10. Grant Funding

The composition of various grant related items included in the financial statements for the year ended December 31, 2011, are as follows:

	Revenue	Grants Receivable	Deferred Revenue
Federal Funding			
Community Health Systems Program	$ 1,044,365	$ 11,452	$ -
Community Health System	17,583	8,828	-
Small Provider Quality Improvement	100,000	-	-
Increased Demand for Services	25,577	-	-
National Bioterrorism Hospital Preparedness	30,414	-	-
	1,217,939	20,280	-
State Funding			
Uncompensated Care	273,789	-	-
School Based Mental Health	38,150	16,125	-
Mortgage Finance	45,600	-	-
Cancer Screening Accessibility	483	-	-
Rural Health System Program	48,688	-	-
	406,710	16,125	-
Other Funding			
WVU Foundation	1,057	-	-
Marshall University	7,291	-	-
Mountain Cap	1,744	-	777
American Cancer Society	7,270	-	329
Mid Ohio Valley Health Department	629	-	-
Northern West Virginia Rural Health Education Center	2,665	-	-
Partners in Health	13,605	8,605	1,000
WV Health Improvement Institute	850	850	-
Parkersburg Area Community Foundation	10,000	10,000	-
	45,111	19,455	2,106
	$ 1,669,760	$ 55,860	$ 2,106

The composition of various grant related items included in the financial statements for the year ended December 31, 2010, are as follows:

	Revenue	Grants Receivable	Deferred Revenue
Federal Funding			
Community Health Systems Program	$ 956,549	$ -	$ -
Community Health System	9,100	-	-
Rural Hospital Flexibility	10,000	-	-
Capital Improvement Program	320,011	-	-
Increased Demand for Services	102,310	-	-
National Bioterrorism Hospital Preparedness	21,779	-	-
	1,419,749	-	-
State Funding			
Uncompensated Care	395,749	-	-
School Based Mental Health	44,358	8,457	-
Mortgage Finance	46,992	-	-
Cancer Screening Accessibility	4,043	-	483
	491,142	8,457	483

	Revenue	Grants Receivable	Deferred Revenue
Other Funding			
WVU Foundation	2,268	-	1,057
Calhoun County Tobacco Coalition	2,416	-	-
Marshall University	6,858	-	7,291
Mountain Cap	479	-	2,521
American Cancer Society	723	-	7,399
Center for Rural Health Development	4,575	500	-
Mid Ohio Valley Health Department	653	-	629
Northern West Virginia Rural Health Education Center	1,300	1,300	-
Partners in Health	-	-	6,000
Sisters of St. Josephs	220	15,000	4,465
	19,492	16,800	29,362
	$ 1,930,383	$ 25,257	$ 29,845

Note 11. Medical Malpractice Claims

The System is insured with respect to medical malpractice risks under a claims made professional liability insurance policy. This arrangement provides coverage to the System for all asserted malpractice claims up to $1,000,000 for each occurrence and a $3,000,000 aggregate limit. Incidents occurring through December 31, 2011, may result in the assertion of a claim and other claims may be asserted arising from past services provided. Management is not aware of any claims that have been asserted or are unasserted at December 31, 2011. The System has a deductible of $50,000 for each occurrence.

The System's health professionals are also covered by the Federal Tort Claims Act and therefore, no professional liability insurance is necessary for services provided under the scope of the Community Health Center. Pursuant to Section 224 of the Public Health Service Act (PHS), 42 USC 233, the Federal Tort Claims Act covers alleged negligent medical care during the performance of official duties for Community Health Centers funded under Section 330 of the PHS Act. Under the Federal Tort Claims Act, the U.S. Government consented to be sued for any damage to property or for personal injury or death caused by the negligence or wrongful act or omission of Federal employees who were acting within the scope of their employment.

Note 12. Rental Expense

Leases that do not meet the criteria for capitalization are classified as operating leases with related rentals charged to operations as incurred.

Future minimum lease payments under operating leases as of December 31, 2011 that have initial or remaining lease terms in excess of one year are as follows:

2012	$ 120,409
2013	55,510
2014	43,361
2015	19,062
2016	15,885
	$ 254,227

Total rental expense in 2011 and 2010 for all operating leases was approximately $226,000 and $192,000, respectively.

Note 13. Health Care Legislation and Regulation

The health care industry is subject to numerous laws and regulations of Federal, state and local governments. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time. Management believes that the System is in compliance with fraud and abuse as well as other applicable government laws and regulations. If the System is found in violation of these laws, the System could be subject to substantial monetary fines, civil and criminal penalties and exclusion from participation in the Medicare and Medicaid programs.

Note 14. Retirement Plan

The System has a 401(k) retirement plan for eligible employees whereby the System may provide for a discretionary match contribution to employee contributions. The amount of the employer's discretionary contributions are based upon employee contributions not to exceed certain percentages of eligible compensation. Employer expense totaled approximately $147,932 and $0 for 2011 and 2010, respectively.

MINNIE HAMILTON HEALTH SYSTEM

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
Year Ended December 31, 2011

Federal Grantor/Pass-Through Grantor/Program Title	Federal CFDA Number	Pass-Through Entity Identifying Number	Federal Expenditures
U S. Department of Health and Human Services:			
Direct Awards:			
Consolidated Health Centers Program	93.224	-	$ 415,532
Consolidated Health Centers Program	93.224	-	628,833
American Recovery and Reinvestment Act – Grants to Health Center Programs, Integrated Services Department Initiative	93.703	-	25,577
Small HealthCare Provider Quality Improvement Program	93 912	G20RH19273	100,000
			1,169,942
Passed through West Virginia Department of Health and Human Resources:			
National Bioterrorism Hospital Preparedness Program, West Virginia Bureau for Public Health: (Disaster Preparedness)	93 889	WVHA - ASPR	10,690
National Bioterrorism Hospital Preparedness Program, West Virginia Bureau for Public Health (Threat Preparedness)	93.889	WVHA - Reserve	19,724
Small Rural Hospital Improvement Grant Program Community Health System	93 301	G110615	8,755
Small Rural Hospital Improvement Grant Program Community Health System	93.301	G120591	8,828
Total U.S. Department of Health and Human Services			47,997
Total Expenditures of Federal Awards			$ 1,217,939

See Notes to Schedule of Expenditures of Federal Awards

MINNIE HAMILTON HEALTH SYSTEM

NOTES TO SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
Year Ended December 31, 2011

Note 1. Basis of Presentation

The accompanying schedule of expenditures of Federal awards includes the Federal grant activity of Minnie Hamilton Health System and is presented on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America. The information in this schedule is presented in accordance with the requirements of OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Therefore, some amounts presented in this schedule may differ from amounts presented in, or used in the preparation of, the financial statements.

SCHEDULE OF NONFEDERAL AWARDS
Year Ended December 31, 2011

Grant Name	Reference or Grant #	Grant Program	Grant Period	Award Amount	Amount Drawn Down (Cumulative)	Amount Available	Grant Expenditures	Grants Receivable	Deferred Grant Revenue
Bureau of Public Health, Division of			07/01/10						
Primary Care	G110317	Uncompensated Care	06/30/11	$ 273,789	$ 273,789	$ -	$ 169,923	$ -	$ -
Bureau of Public Health, Division of			07/01/11						
Primary Care	G120199	Uncompensated Care	06/30/12	247,300	103,866	143,434	103,866	-	-
Bureau of Public Health, Division of		School Based Mental	07/01/10						
Primary Care	G110042	Health/Behavioral Health	06/30/11	42,250	42,250	-	22,025		-
Bureau of Public Health, Division of		School Based Mental	07/01/11						
Primary Care	G120105	Health/Behaviroal Health	06/30/12	16,125	16,125	-	16,125	16,125	-
Bureau of Public Health, Division of			07/01/10						
Primary Care	G110352	Mortgage Finance Funding	06/30/11	45,600	45,600	-	26,448	-	-
Bureau of Public Health, Division of			07/01/11						
Primary Care	G120305	Mortgage Finance Funding	06/30/12	45,600	19,152	26,448	19,152	-	-
Bureau of Public Health, Office of		Breast and Cervical Cancer							
Maternal, Child and Family Health	A090174	Screening Accessibility	06/30/11	6,083	6,083	-	483	-	-
Rural Health System Program	WVRHSP06	Collaborate	07/01/10	48,688	48,688	-	48,688	-	-
Total WVDHHR funding				725,435	555,553	169,882	406,710	16,125	-

(Continued)

MINNIE HAMILTON HEALTH SYSTEM

SCHEDULE OF NONFEDERAL AWARDS (Continued)
Year Ended December 31, 2011

Grant Name	Reference or Grant #	Grant Program	Grant Period	Award Amount	Amount Drawn Down (Cumulative)	Amount Available	Grant Expenditures	Grants Receivable	Deferred Grant Revenue
WVU Foundation	2V123R - CIS	Cancer Prevention	04/16/07	3,500	3,500	-	1,057	-	
Marshall University	N/A	Research	09/01/09 10/1/2009	3,032	3,032	-	291	-	-
Marshall University	N/A	Dental	9/30/2010 08/01/10	25,200	25,200	-	7,000	-	-
Mountain Cap	N/A	Outreach	07/31/11 2009	3,000	3,000	-	1,744	-	777
American Cancer Society	N/A	Cancer Prevention	2010 12/31/07	7,487	7,487	-	2,667	-	-
American Cancer Society	N/A	Cancer Prevention	12/31/08	7,500	7,500	-	4,028	-	329
American Cancer Society	N/A	Cancer Prevention	12/31/08	1,000	1,000	-	375	-	-
American Cancer Society	N/A	Cancer Prevention	12/31/11	200	200	-	200	-	-
Mid-Ohio Valley Health Department	N/A	Outreach - Prevention	05/31/08	2,250	2,250	-	629	-	-
Sisters of St Joseph Charitable Fund	N/A	Equipment	10/31/09	15,000	15,000	-	-	-	-
Northern WV Rural Health Center	N/A	Education Services	2010-2011	3,965	3,965	-	2,665	-	-
Partner's in Health	N/A	Prevention	2010-2011	14,985	5,000	-	13,605	8,605	-
Partner's in Health	N/A	Insurance	2010-2011	1,000	1,000	-	-	-	1,000
WV Health Improvement Institute	N/A	Outreach	12/31/11	1,500	1,500	-	850	850	-
Parkersburg Area Community Foundation	N/A	Community	12/31/11	10,000	10,000	-	10,000	10,000	-
Total other funding				99,619	89,634	-	45,111	19,455	2,106
Total Nontederal Awards				$ 825,054	$ 645,187	$ -	$ 451,821	$ 35,580	$ 2,106

ARNETT FOSTER
Certified Public Accountants, P.L.L.C.

INDEPENDENT AUDITOR'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

To the Board of Directors
Minnie Hamilton Health System
Grantsville, West Virginia

We have audited the financial statements of Minnie Hamilton Health System, (the System) as of and for the year ended December 31, 2011, and have issued our report thereon dated April 26, 2012. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

Internal Control Over Financial Reporting

Management of the System is responsible for establishing and maintaining effective internal control over financial reporting. In planning and performing our audit, we considered the System's internal control over financial reporting as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the System's internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the System's internal control over financial reporting.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over financial reporting that might be deficiencies, significant deficiencies, or material weaknesses. We did not identify any deficiencies in internal control over financial reporting that we consider to be material weaknesses, as defined above. However, we identified a deficiency in internal control over financial reporting, described in the accompanying schedule of findings and questioned costs as item 11-01 that we consider to be a significant deficiency in internal control over financial reporting. *A significant deficiency* is a deficiency, or combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Compliance and Other Matters

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

The System's response to the finding identified in our audit is described in the accompanying schedule of findings and questioned costs. We did not audit the System's response and, accordingly, we express no opinion on it.

This report is intended solely for the information and use of management, Board of Directors, others within the Organization, the West Virginia Department of Health and Human Resources and other state and Federal agencies and is not intended to be and should not be used by anyone other than these specified parties.

ARNETT & FOSTER, P.L.L.C.

Arnett + Foster, P.L.L.C.

Charleston, West Virginia
April 26, 2012

ARNETT & FOSTER
Certified Public Accountants, P.L.L.C.

INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE WITH REQUIREMENTS THAT COULD HAVE A DIRECT AND MATERIAL EFFECT ON EACH MAJOR PROGRAM AND INTERNAL CONTROL OVER COMPLIANCE IN ACCORDANCE WITH OMB CIRCULAR A-133

To the Board of Directors
Minnie Hamilton Health System
Grantsville, West Virginia

Compliance

We have audited the compliance of Minnie Hamilton Health System (the System) with the types of compliance requirements described in the U S. Office of Management and Budget (OMB) Circular A-133, *Compliance Supplement* that could have a direct and material effect on each of its major federal programs for the year ended December 31, 2011. The System's major federal program is identified in the summary of auditor's results section of the accompanying Schedule Of Findings And Questioned Costs Compliance with the requirements of laws, regulations, contracts, and grants applicable to its major federal program is the responsibility of the System's management. Our responsibility is to express an opinion on the System's compliance based on our audit.

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States; and OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Those standards and OMB Circular A-133 require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about the System's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion. Our audit does not provide a legal determination of the System's compliance with those requirements.

In our opinion, Minnie Hamilton Health System complied, in all material respects, with the compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended December 31, 2011.

Internal Control Over Compliance

Management of Minnie Hamilton Health System is responsible for establishing and maintaining effective internal control over compliance with the requirements of laws, regulations, contracts, and grants applicable to federal programs. In planning and performing our audit, we considered the System's internal control over compliance with the requirements that could have a direct and material effect on a major federal program in order to determine our auditing procedures for the purpose of expressing our opinion on compliance in accordance with OMB Circular A-133, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the System's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a Federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a Federal program will not be prevented, or detected and corrected, on a timely basis.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be deficiencies, significant deficiencies, or material weaknesses We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses, as defined above.

This report is intended solely for the information and use of management, Board of Directors, others within the Organization, the West Virginia Department of Health and Human Resources and other state and Federal agencies and is not intended to be and should not be used by anyone other than these specified parties.

ARNETT & FOSTER, P.L.L.C.

Arnett + Foster, P.L.L.C.

Charleston, West Virginia
April 26, 2012

MINNIE HAMILTON HEALTH SYSTEM

SCHEDULE OF FINDINGS AND QUESTIONED COSTS
Year Ended December 31, 2011

I. SUMMARY OF AUDITOR'S RESULTS

Financial Statements

Type of auditor's report issued: Unqualified

Internal control over financial reporting:

- Material weakness(es) identified? ____yes __X__no
- Significant deficiency(ies) identified? __X__yes ____none reported

Noncompliance material to financial statements noted? ____yes __X__no

Federal Awards

Internal Control over major programs:

- Material weakness(es) identified? ____yes __X__no
- Significant deficiency(ies) identified? ____yes __X__none reported

Type of auditor's report issued on compliance for major programs: Unqualified

Any audit findings disclosed that are required to be reported in accordance with Section 510(a) of Circular A-133? ____yes __X__no

Identification of major programs:

CFDA Number	Name of Federal Program	Amount Expended
	U.S. Department of Health and Human Services	
	Direct award:	
93.224	Consolidated Health Centers Program (IDS)	$ 415,532
93.224	Consolidated Health Centers Program (CIP)	628,833
		$ 1,044,365

Dollar threshold used to distinguish between type A and type B programs: $ 300,000

Auditee qualified as low-risk auditee? __X__yes ____no

MINNIE HAMILTON HEALTH SYSTEM

SCHEDULE OF FINDINGS AND QUESTIONED COSTS (Continued)
Year Ended December 31, 2011

SECTION II. FINANCIAL STATEMENT FINDINGS

Significant Deficiency in Internal Control over Financial Reporting

11-01 CLINIC ACCOUNTS RECEIVABLE

Criteria or Specific Requirement

A&F noted that at December 31, 2011 the Clinic accounts receivable was not reconciled and allowance calculation not fully complete.

Condition and Cause

The reason for the lack of reconciliation and allowance calculation is due to the fact that in March of 2010 the Clinic switched over to a new electronic health records systems (from CPSI to Nextgen) and issues have taken place with this transition. There is more than one issue with the new Nextgen billing system that has not been corrected. One issue is that the Nextgen system is not interfaced with the general ledger. Another issue is that the Nextgen system adds the per encounter rate (reimbursement rate) directly to the original patient charge already in the system. Additionally, System management noted instances where the Nextgen system did not foot correctly. These issues make it difficult for the accounting department to reconcile to the general ledger as manual reconciliation adjustments must be made continuously throughout the year. Given these untimely issues, the Clinic accounts receivable account on the general ledger was not reconciled at December 31, 2011 and accounts receivable subsidiary detail was not and could not be provided to the auditors. In order to reconcile accounts receivable, the auditors had to review the entire year's charges less receipts activity.

Effect

Clinic net accounts receivable at December 31, 2011, is approximately $990,000 and represents 43% of total net patient accounts receivable. Management was able to reconcile the net patient accounts receivable at year end; however, significant adjustments were necessary to reconcile the accounts because accurate system reports were not available on a monthly basis.

Recommendation

We recommend that management work directly with Nextgen to correct the system in order to be fully interfaced with the general ledger and to be more compatible with billing cycle and trial balance completeness.

Views of Responsible Officials and Planned Corrective Actions

See Auditee's Corrective Action Plan.

SECTION III. FINDINGS AND QUESTIONED COSTS FOR FEDERAL AWARDS

No matters were reported

MINNIE HAMILTON HEALTH SYSTEM

AUDITEE'S SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS
Year Ended December 31, 2011

10-01 ACCOUNTS RECEIVABLE RESERVE CALCULATIONS

Criteria or Specific Requirement

A&F noted that at December 31, 2010 the Clinic accounts receivable was not reconciled and allowance calculation not fully complete.

Condition and Cause

The reason for the lack of reconciliation and allowance calculation is due to the fact that in March of 2010 the Clinic switched over to a new electronic health records systems (from CPSI to Nextgen) and issues have taken place with this transition. There is more than one issue with the new Nextgen billing system that has not been corrected. One issue is that the Nextgen system is not interfaced with the general ledger. Another issue is that the Nextgen system adds the per encounter rate (reimbursement rate) directly to the original patient charge already in the system. Additionally, System management noted instances where the Nextgen system did not foot correctly. These issues make it difficult for the accounting department to reconcile to the general ledger as manual reconciliation adjustments must be made continuously throughout the year. Given these untimely issues the Clinic accounts receivable account on the general ledger was not reconciled at December 31, 2010 and accounts receivable subsidiary detail was not and could not be provided to the auditors. In order to reconcile accounts receivable the auditors had to review the entire year's charges less receipts activity.

Effect

Clinic net accounts receivable at December 31, 2010, is approximately $596,000 and represents 27% of total net patient accounts receivable. Management was able to reconcile the net patient accounts receivable at year end; however, significant adjustments were necessary to reconcile the accounts because accurate system reports were not available on a monthly basis.

Recommendation

We recommend that management work directly with Nextgen to correct the system in order to be fully interfaced with the general ledger and to be more compatible with billing cycle and trial balance completeness.

Corrective Action Taken or Planned

Management was not able to resolve the Clinic accounts receivable reconciliation and allowance calculation in 2011. The finding was repeated for the year ended December 31, 2011.

AUDITEE'S CORRECTIVE ACTION PLAN

December 31, 2011

MINNIE HAMILTON HEALTH CARE CENTER, INC
d.b a., Minnie Hamilton Health System

CORRECTIVE ACTION PLAN
YEAR ENED DECEMBER 31, 2011

Reportable Conditions of Internal Control:

11-01 Clinic Accounts Receivable

Criteria or Specific Requirement
A&F noted that at December 31, 2011 the Clinic account receivables were not reconciled and allowance calculation not fully complete.

Corrective Action Taken or Planned:
Contact personnel are Stephen Whited COO/CFO and Roger Jarvis, Controller. The interface of NextGen billing system with the general ledger system of CPSI began in May 2011, the General Ledger accounts were created as required for the interface to be accomplished but many outstanding issues still remain as of yearend. When sample tests were performed, the posting methods of the two systems (NextGen – daily posting, CPSI – monthly posting) caused a complication that has not been resolved. Many meetings with NextGen have not resolved these issues, and the COO/CFO, along with the CIO are scheduling meetings with NextGen at their corporate office to reconcile these issues. The completion date is for the full implementation is August 31, 2012.

When completed, the COO/CFO and Controller will be able to complete the monthly reconciliation and allowance calculation of clinic accounts receivable in a more efficient and timely manner.

The COO/CFO and Controller will continue to create reports that will help the balancing and reconciliation process of the clinic accounts receivables. These reports will be ran no less than monthly, to ensure a reasonable amount of time for the COO/CFO and Controller to complete monthly financial statements.

Singed _____

Title _COO/CFO_____

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