Minnie Hamilton Health System

Financial and Compliance Report

December 31, 2013

arnett foster toothman pllc

CPAs & Advisors

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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

Report on the Financial Statements

We have audited the accompanying financial statements of Minnie Hamilton Health System (the System), which comprise the balance sheets as of December 31, 2013 and 2012, and the related statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

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 from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

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, 2013 and 2012, 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.

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Other Matters

Other Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying schedule of expenditures of Federal awards for the year ended December 31, 2013, 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 2013 financial statements. Also, the accompanying schedule of non-Federal awards for the year ended December 31, 2013, is presented for purposes of additional analysis of the 2013 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 2013 financial statements. The information has been subjected to the auditing procedures applied in the audit of the 2013 financial statements and certain other procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the 2013 financial statements or to the 2013 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 2013 financial statements as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards,* we have also issued our report dated April 30, 2014, on our consideration of Minnie Hamilton Health System's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements and other matters for the year ended December 31, 2013. We issued a similar report for the year ended December 31, 2012, dated April 22, 2013, which has not been included with the 2013 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* in considering the System's internal control over financial reporting and compliance.

ARNETT FOSTER TOOTHMAN PLLC

Arnett Foster Toothman PLLC

Charleston, West Virginia
April 30, 2014

MINNIE HAMILTON HEALTH SYSTEM

BALANCE SHEETS
December 31, 2013 and 2012

ASSETS	2013	2012
Current Assets		
Cash and cash equivalents	$ 299,862	$ 763,659
Patient receivables, net of allowance for doubtful accounts of $2,311,117 in 2013 and $1,808,806 in 2012	3,352,376	2,407,588
Grants receivable	59,972	21,663
Estimated third-party payor settlements	94,226	-
Other receivables	636,839	-
Supplies inventory	140,151	120,449
Prepaid expenses and other assets	45,109	86,022
Total current assets	4,628,535	3,399,381
Property and Equipment, net	2,910,193	2,929,385
Other Assets	12,000	-
Total assets	$ 7,550,728	$ 6,328,766
LIABILITIES AND NET ASSETS		
Current Liabilities		
Note payable	$ 250,000	$ -
Current maturities of long-term obligations	482,934	456,771
Accounts payable and accrued expenses	1,161,505	369,687
Employee compensation, payroll withholdings, and taxes payable	929,468	769,532
Deferred grant revenue	37,635	50,341
Deferred revenue	475,000	-
Estimated third-party payor settlements	-	12,855
Total current liabilities	3,336,542	1,659,186
Long-Term Obligations, net of current maturities	948,269	1,117,161
Total liabilities	4,284,811	2,776,347
Net Assets - Unrestricted	3,265,917	3,552,419
Total liabilities and net assets	$ 7,550,728	$ 6,328,766

MINNIE HAMILTON HEALTH SYSTEM

STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
Years Ended December 31, 2013 and 2012

	2013	2012
Unrestricted revenues, gains and other support		
Net patient service revenue (net of contractual allowances and discounts)	**$ 16,840,983**	$ 16,378,796
Less: Provision for bad debts	**(1,967,273)**	(1,564,132)
Net patient service revenue	**14,873,710**	14,814,664
Federal, state and other grants	**1,672,592**	1,621,945
Contributions for operating expenses	**15,812**	755
Other operating revenue	**883,411**	522,046
Total revenues, gains and other support	**17,445,525**	16,959,410
Operating expenses		
Salaries and wages	**10,867,866**	10,105,329
Payroll taxes and benefits	**1,581,938**	1,540,517
Professional fees	**1,157,134**	1,015,662
Supplies and other expenses	**2,585,684**	2,465,399
Insurance	**126,130**	139,978
Utilities	**278,252**	277,957
Taxes	**341,333**	316,165
Interest	**94,348**	111,425
Depreciation and amortization	**708,026**	751,088
Total expenses	**17,740,711**	16,723,520
Operating income (loss)	**(295,186)**	235,890
Non-operating revenue		
Interest	**2,012**	7,255
Rental income	**6,672**	6,672
Total non-operating revenue	**8,684**	13,927
Excess (deficiency) of revenues over expenses	**(286,502)**	249,817
Net assets, unrestricted - beginning of year	**3,552,419**	3,302,602
Net assets, unrestricted - end of year	**$ 3,265,917**	$ 3,552,419

See Notes to Financial Statements

MINNIE HAMILTON HEALTH SYSTEM

STATEMENTS OF CASH FLOWS
Years Ended December 31, 2013 and 2012

	2013	2012
Cash Flows from Operating Activities		
Excess (deficiency) of revenues over expenses	$ (286,502)	$ 249,817
Adjustments to reconcile excess (deficiency) of revenues over expenses to net cash provided by operating activities:		
Depreciation and amortization	708,026	751,088
Provision for bad debts	1,967,273	1,564,132
Change in assets and liabilities:		
(Increase) decrease in patient receivables	(2,912,061)	(1,712,954)
(Increase) decrease in grant receivables	(38,309)	34,197
(Increase) decrease in supplies inventory	(19,702)	(3,901)
(Increase) decrease in prepaid expenses and other assets	28,913	(45,964)
(Increase) decrease in other receivables	(636,839)	-
Increase (decrease) in accounts payable and accrued expenses	951,754	(25,999)
Increase (decrease) in estimated third-party payor settlements	(107,081)	76,427
Increase (decrease) in deferred revenue	462,294	48,235
Net cash provided by operating activities	117,766	935,078
Cash Flows from Investing Activities		
Purchase of property and equipment	(312,016)	(325,495)
Net cash used in investing activities	(312,016)	(325,495)
Cash Flows from Financing Activities		
Proceeds from long-term obligations	250,000	-
Principal payments on long-term obligations	(519,547)	(432,130)
Net cash used in financing activities	(269,547)	(432,130)
Net increase (decrease) in cash and cash equivalents	(463,797)	177,453
Cash and cash equivalents		
Beginning	763,659	586,206
Ending	$ 299,862	$ 763,659
Supplemental Disclosure of Cash Flow Information		
Cash payments for interest	$ 94,348	$ 111,425
Supplemental Disclosure of Noncash Investing and Financing Activities		
Property and equipment acquired through proceeds of long-term debt	$ 376,818	$ -

See Notes to Financial Statements

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.

The System's allowance for doubtful accounts for self-pay patients remained consistent at 85 percent of self-pay accounts receivable at December 31, 2013 and 2012. In addition, the System's self-pay write-offs remained consistent in fiscal year 2013 and 2012. The System has not changed its charity care or uninsured discount policies during 2013 or 2012.

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 (deficiency) 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, 2013 and 2012.

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, 2013 and 2012.

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 (deficiency) of revenues over expenses: The statement of operations includes excess (deficiency) of revenues over expenses. Changes in unrestricted net assets when existing, which are excluded from excess (deficiency) 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. Accounting principles generally accepted in the United States of America require the management of the System to evaluate tax positions taken by the System. Management has evaluated the System's tax positions and did not become aware of any course of action on services or events that might adversely affect the System's tax exempt status. Therefore, no provision or liability for income taxes has been included in the financial statements.

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 2010.

Advertising expense: The System expenses advertising as it is incurred. Advertising expense was $68,261 and $56,563 for the years ended December 31, 2013 and 2012, respectively.

Subsequent events: The System has evaluated subsequent events through April 30, 2014, the date on which the financial statements were available to be issued.

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:

	2013	2012
Due from third-party payors:		
Disproportionate share	$ -	$ 62,090
Due from/(to) third-party payors:		
Medicare	75,126	(42,139)
Medicaid	19,100	(32,806)
	94,226	(74,945)
Total	$ 94,226	$ (12,855)

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, 2013 and 2012, is as follows:

	2013	2012
Building	$ 2,375,133	$ 2,207,611
Leasehold improvements	462,218	462,218
Equipment and furniture	6,830,777	6,309,465
	9,668,128	8,979,294
Less accumulated depreciation and amortization	6,757,935	6,049,909
Property and equipment, net	$ 2,910,193	$ 2,929,385

Capital lease assets at December 31, 2013 and 2012, included in property and equipment are as follows:

	2013	2012
Building and equipment	$ 531,576	$ 531,576
Less accumulated amortization	431,100	327,966
	$ 100,476	$ 203,610

Note 4. Line of Credit

The System has a $250,000 line of credit with interest at 5%. The outstanding amount due at December 31, 2013 and 2012 was $250,000 and $0, respectively. The line of credit matures in September 2015.

Note 5. Long-Term Obligations and Subsequent Event

A summary of long-term obligations is as follows:

	2013	2012
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 2016, secured by substantially all System assets.	$ 798,293	$ 1,063,383
Capital lease obligation, interest at 8.00% payable in 60 monthly installments of $6,423, maturing August 2014, with option to buy at end of lease at Fair Market Value. Secured by the equipment acquired under the obligation.	25,053	107,910
Capital lease obligation, interest at 2.18% payable in 44 monthly installments of $2,767, maturing February 2014, with option to buy at end of lease at Fair Market Value. Secured by the equipment acquired under the obligation.	8,158	40,007

	2013	2012
Capital lease obligation, interest at 10.13% payable in 60 monthly Installments of $1,293, maturing in 2014, with a bargain purchase option of $1 at end of lease. Secured by the equipment acquired under the obligation.	**4,568**	16,302
Note payable, bank, payable in monthly installments of $7,474 including interest at a fixed rate of 4.5%, maturing October 2016, secured by the System's Glenville facilities and equipment.	**237,913**	314,862
Note payable, The Center for Rural Health Development, Inc., payable in monthly installments of $3,786 including an interest rate which is fixed at 4.5% for the first 36 months, after which time it will go to a variable rate of Prime plus 1.25% for the remainder of the term, maturing February 2018, secured by equipment acquired under the obligation.	**170,427**	-
Note payable, interest at 5.43%, payable in 48 monthly installments of $4,065, maturing July 2017, secured by the equipment acquired under the obligation.	**159,308**	-
Capital lease obligation, interest at 14.36%, payable in 60 monthly installments of $1,137, maturing January 2017, secured by the equipment acquired under the obligation.	**27,483**	31,468
	1,431,203	1,573,932
Less current maturities	**482,934**	456,771
Long-term obligations	**$ 948,269**	$ 1,117,161

Aggregate maturities of long-term obligations at December 31, 2013 are as follows:

	Capital Lease Obligation	Long-Term Debt
2014	$ 44,553	$ 438,381
2015	7,815	460,238
2016	9,015	387,693
2017	3,879	72,304
2018	-	7,325
	$ 65,262	$ 1,365,941

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 not compliance with the minimum debt service coverage and maximum capital expenditures covenants as of December 31, 2013. Subsequent to year end, the System received a waiver of these covenants from the bank for the year ended December 31, 2013.

Subsequent Event - On January 28, 2014, the System entered into a note payable with the Calhoun County Bank for $600,540. The note entails 48 monthly payments of $13,862 and will mature in February 2018. The interest rate is fixed at 5% and is secured by all accounts receivables.

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 includes 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:

	2013	2012
Gross patient service revenue	**$ 21,266,734**	$ 20,053,282
Less provision for:		
Provision for contractual adjustments	**3,664,495**	2,749,334
Charity care (charges forgone based on established rates)	**761,256**	925,152
Bad debts	**1,967,273**	1,564,132
Net patient service revenue	**$ 14,873,710**	$ 14,814,664

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 $1,232,000 for 2013 and 2012, respectively.

The State of West Virginia Disproportionate Share Hospital (DSH) State Plan provides for a settlement process among participating hospitals. DSH audits through 2010 have been settled with no cash settlement. For fiscal 2011 and future years, settlements could occur. 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 approximately $349,000, which is netted against the DSH amounts receivable of $349,000 for the quarterly payment due December 31, 2013.

As disclosed in Note 2, the System has recorded amounts for cost report settlements with Medicare and Medicaid. The 2013 and 2012 net patient service revenue was increased (decreased) by approximately $(165,000) and $250,000, 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 200% 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, 2013 and 2012 were approximately $635,000 and $772,000, respectively. The System is the recipient of various grants that are used to offset the costs of providing charity care.

Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized during the years ended December 31, 2013 and 2012, from these major payor sources, is as follows:

2013	Third-Party Payors	Self-Pay	Total All Payors
Patient service revenue (net of contractual allowances and discounts)	$ 14,077,200	$ 2,763,783	$ 16,840,983

2012	Third-Party Payors	Self-Pay	Total All Payors
Patient service revenue (net of contractual allowances and discounts)	$ 13,956,206	$ 2,422,590	$ 16,378,796

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:

	2013	2012
Medicare	44%	41%
Medicaid	24%	21%
Other third-party payors	5%	11%
Private pay	27%	27%
	100%	100%

The System 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:

	2013			
	Total Expenses	Patient Care and Other Program Expense	Support Services	General and Administrative
Salaries and wages	$ 10,867,866	$ 8,792,255	$ 1,169,221	$ 906,390
Payroll taxes and benefits	1,581,938	1,279,810	170,193	131,935
Professional fees	1,157,134	469,242	71,732	616,160
Supplies and other expenses	2,585,684	1,645,244	487,839	452,601
Insurance	126,130	98,401	-	27,729
Utilities	278,252	-	-	278,252
Taxes	341,333	229,515	-	111,818
Interest	94,348	-	-	94,348
Depreciation and amortization	708,026	-	490,727	217,299
Total operating expenses	$ 17,740,711	$ 12,514,467	$ 2,389,712	$ 2,836,532

	2012			
	Total Expenses	Patient Care and Other Program Expense	Support Services	General and Administrative
Salaries and wages	$ 10,105,329	$ 8,243,616	$ 1,013,675	$ 848,038
Payroll taxes and benefits	1,540,517	1,256,706	154,531	129,280
Professional fees	1,015,662	434,730	50,719	530,213
Supplies and other expenses	2,465,399	1,557,888	407,357	500,154
Insurance	139,978	106,961	-	33,017
Utilities	277,957	-	-	277,957
Taxes	316,165	218,647	-	97,518
Interest	111,425	-	-	111,425
Depreciation and amortization	751,088	558,851	133,029	59,208
Total operating expenses	$ 16,723,520	$ 12,377,399	$ 1,759,311	$ 2,586,810

Note 10. Grant Funding

The composition of various grant related items included in the financial statements for the year ended December 31, 2013, are as follows:

	Revenue	Grants Receivable	Deferred Revenue
Federal Funding			
Community Health Systems Program	$ 1,148,612	$ -	$ 37,635
Small Provider Quality Improvement	78,337	-	-
Small Hospital Improvement Program	8,550	-	-
Heath Information Technology Extension	14,000	8,000	-
National Bioterrorism Hospital Preparedness	23,382	-	-
	1,272,881	8,000	37,635
State Funding			
Uncompensated Care	286,727	36,271	-
Mortgage Finance	36,024	3,344	-
West Virginia In-Person Assistance Program	12,357	12,357	-
West Virginia Health Care Authority	39,525	-	-
	374,633	51,972	-
Other Funding			
Highmark – Accountable Care Learning Center	15,683	-	-
West Virginia School Based Health Assembly	2,000	-	-
Parkersburg Area Community Foundation	5,000	-	-
Partners in Health	2,395	-	-
	25,078	-	-
	$ 1,672,592	$ 59,972	$ 37,635

The composition of various grant related items included in the financial statements for the year ended December 31, 2012, are as follows:

	Revenue	Grants Receivable	Deferred Revenue
Federal Funding			
Community Health Systems Program	$ 1,088,940	$ -	$ -
Small Provider Quality Improvement	121,663	21,663	-
National Bioterrorism Hospital Preparedness	29,308	-	-
	1,239,911	21,663	-
State Funding			
Uncompensated Care	285,179	-	-
Mortgage Finance	45,600	-	-
West Virginia Health Care Authority	50,000	-	49,341
	380,779	-	49,341
Other Funding			
Mountain Cap	777	-	-
American Cancer Society	478	-	-
Partners in Health	-	-	1,000
	1,255	-	1,000
	$ 1,621,945	$ 21,663	$ 50,341

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, 2013, 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, 2013. 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, 2013 that have initial or remaining lease terms in excess of one year are as follows:

2014	$ 62,265
2015	34,002
2016	30,825
2017	4,980
	$ 132,072

Total rental expense in 2013 and 2012 for all operating leases was approximately $199,000 and $221,000, 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 is based upon employee contributions not to exceed certain percentages of eligible compensation. Employer expense totaled approximately $193,000 and $162,000 for 2013 and 2012, respectively.

Note 15. Electronic Health Records (EHR)

The Health Information Technology for Economic and Clinical Health Act ("HITECH Act") was enacted into law on February 17, 2009 as part of the American Recovery and Reinvestment Act (ARRA). The HITECH Act includes provisions designed to increase the use of EHR by both physicians and hospitals. The System intends to comply with the EHR meaningful use requirements of the HITECH Act in time to qualify for the maximum available Medicare and Medicaid incentive payments. The System's compliance will result in significant costs including professional services focused on successfully designing and implementing EHR solutions along with costs associated with the hardware and software components of the project.

During the years ended December 31, 2013 and 2012, the System applied for and recognized in other revenue and support approximately $477,000 and $183,000, respectively, and recorded $593,000 and $0 in other receivables, respectively, related to Medicare and Medicaid EHR incentive payments. The System has recorded deferred revenue of $475,000 and $0 for the years ended December 31, 2013 and 2012, respectively, for the difference in the amounts of Medicare and Medicaid share of qualifying expenditures and the amounts amortized to income. Management determined the average useful life of the assets is five years; therefore, the expected incentive revenue will be recognized ratably over five years. The System intends to apply for additional funds in the coming years. Both the 2013 and 2012 funds and any future funds are dependent on reaching certain metrics and various stages of "meaningful use" as defined by the ARRA.

MINNIE HAMILTON HEALTH SYSTEM

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
Year Ended December 31, 2013

Federal Grantor/Pass-Through Grantor/Program or Cluster 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	-	$ 488,962
Health Centers Cluster			
Consolidated Health Centers Program	93.224	-	$ 634,798
Affordable Care Act (ACA) Grants for New and Expanded Services Under the Health Center Program	93.527	-	24,852
			659,650
Small HealthCare Provider Quality Improvement Program	93.912	G20RH19273	78,337
			1,226,949
Passed through:			
West Virginia Hospital Association:			
National Bioterrorism Hospital Preparedness Program, West Virginia Bureau for Public Health: (Disaster Preparedness)	93.889	WVHA - ASPR	11,575
West Virginia Primary Care Association:			
National Bioterrorism Hospital Preparedness Program, West Virginia Bureau for Public Health: (Threat Preparedness)	93.889	WVHA - Reserve	11,807
West Virginia Department of Health and Human Resources:			
Small Rural Hospital Improvement Grant Program Community Health Systems	93.301	G130638	8,550
			31,932
Passed through West Virginia Health Improvement Institute:			
American Recovery and Reinvestment Act of 2009 (ARRA), Heath Information Technology Regional Extension Center Program	93.718	WVRHITEC – 90RC0017/01	14,000
Total Expenditures of Federal Awards			$ 1,272,881

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, 2013

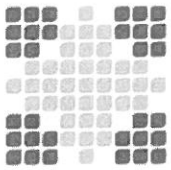
Note 1. Basis of Presentation

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.

MINNIE HAMILTON HEALTH SYSTEM

SCHEDULE OF NONFEDERAL AWARDS
Year Ended December 31, 2013

Grant Name	Ref #	Grant Program	Grant Period	Awarded Amount	Amount Drawn Down (Cumulative)	Amount Available	Grant Expenditures	Grant Receivable	Deferred Grant Revenue
Bureau of Public Health, Division of Primary Care	G130045	Uncompensated Care	07/01/12 06/30/13	$ 286,727	$ 286,727	$ -	$ 182,861	$ -	-
Bureau of Public Health, Division of Primary Care	G140115	Uncompensated Care	07/01/13 06/30/14	247,300	67,595	179,705	103,866	36,271	-
Bureau of Public Health, Division of Primary Care	G130015	Mortgage Finance Funding	07/01/12 06/30/13	45,600	45,600	-	26,448	-	-
Bureau of Public Health, Division of Primary Care	G140334	Mortgage Finance Funding	07/01/13 06/30/14	22,800	6,232	16,568	9,576	3,344	-
Total West Virginia Department of Health and Human Resources				602,427	406,154	196,273	322,751	39,615	-
West Virginia Health Care Authority	2013-WVRHSP-07	Crisis - Equipment	3/13/13 - 6/30/13	5,993	5,993	-	5,993	-	-
West Virginia Health Care Authority	2013-WVRHSP-04	Crisis - Equipment	10/10/12 - 1/31/13	33,532	33,532	-	33,532	-	-
West Virginia Primary Care Association	N/A	Outreach	10/01/13 - 03/31/14	52,840	-	52,840	12,357	12,357	-
Partners in Health	N/A	Outreach	2011-2013	15,000	15,000	-	1,395	-	-
Partners in Health	N/A	Outreach	2011-2012	1,000	1,000	-	1,000	-	-
Highmark WV	N/A	Primary Care	5/2013 - 5/2014	15,683	15,683	-	15,683	-	-
West Virginia School Based Health A ssembly	N/A	School Based	9/20/13 - 12/5/13	2,000	2,000	-	2,000	-	-
Parkersburg Area Community Foundation	N/A	Community	12/31/2013	5,000	5,000	-	5,000	-	-
Total Other Funding				131,048	78,208	52,840	76,960	12,357	-
Total Nonfederal Awards				**$ 733,475**	**$ 484,362**	**$ 249,113**	**$ 399,711**	**$ 51,972**	-



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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, in accordance with the 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, the financial statements of Minnie Hamilton Health System (the System), which comprise the balance sheet, as of December 31, 2013, and the related statements of operations and changes in net assets, and cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated April 30, 2014.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the System's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances 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. Accordingly, we do not express an opinion on the effectiveness of the System's internal control.

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 System's financial statements will not be prevented, or detected and corrected on a timely basis. *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.

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 material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified. We did identify a certain deficiency in internal control over financial reporting, described in the accompanying schedule of findings and questioned costs as item 13-01, which we consider to be a significant deficiency in internal control over financial reporting.

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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 Findings

The System's response to findings identified in our audit are described in the accompanying Corrective Action Plan. The System's response was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on it.

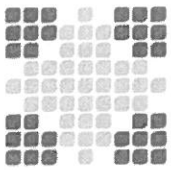
Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the System's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the System's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

ARNETT FOSTER TOOTHMAN PLLC

Arnett Foster Toothman PLLC

Charleston, West Virginia
April 30, 2014



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INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE FOR EACH MAJOR FEDERAL PROGRAM AND REPORT ON INTERNAL CONTROL OVER COMPLIANCE

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

Report on Compliance for Each Major Federal Program

We have audited Minnie Hamilton Health System's (the System) compliance with the types of compliance requirements described in the *OMB Circular A-133 Compliance Supplement* that could have a direct and material effect on each of the System's major federal programs for the year ended December 31, 2013. The System's major federal programs are identified in the summary of auditor's results section of the accompanying Schedule of Findings and Questioned Costs.

Management's Responsibility

Management is responsible for compliance with the requirements of laws, regulations, contracts, and grants applicable to its federal programs.

Auditor's Responsibility

Our responsibility is to express an opinion on compliance for each of the System's major federal programs based on our audit of the types of compliance requirements referred to above. 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 on compliance for each major federal program. However, our audit does not provide a legal determination of the System's compliance.

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Opinion on Each Major Federal Program

In our opinion, the System complied, in all material respects, with the types of 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, 2013.

Report on Internal Control Over Compliance

Management of the System is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered the System's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine our auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over 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. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

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 material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses, as defined above. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on requirements of OMB Circular A-133. Accordingly, this report is not suitable for any other purpose.

ARNETT FOSTER TOOTHMAN PLLC

Arnett Foster Toothman PLLC

Charleston, West Virginia
April 30, 2014

MINNIE HAMILTON HEALTH SYSTEM

SCHEDULE OF FINDINGS AND QUESTIONED COSTS
Year Ended December 31, 2013

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	$ 488,962
	Health Centers Cluster:	
93.224	Consolidated Health Centers Program	634,798
93.527	Affordable Care Act (ACA) Grants for New and Expanded Services Under the Health Center Program	24,852
		659,650
		$ 1,148,612

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, 2013

SECTION II. FINANCIAL STATEMENT FINDINGS

Significant Deficiency in Internal Control over Financial Reporting

13-01 CLINIC ACCOUNTS RECEIVABLE

Criteria or Specific Requirement

We noted that at December 31, 2013 the Clinic accounts receivable allowance calculation was not fully complete due to the Systems software being unable to produce reliable aging and subsidiary accounts receivable reports.

Condition and Cause

The reason for the difficulties in reconciling Clinic accounts receivable and calculating the allowance 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 subsidiary detail was not and could not be provided to the auditors. In order to test the reconciliation of accounts receivable, the auditors had to review the entire year's charges less receipts activity.

Effect

Clinic net accounts receivable at December 31, 2013, is approximately $1,107,000 and represents 33% of total net patient accounts receivable. Management was able to reconcile the net patient accounts receivable at year end; however, significant adjustments were necessary throughout the year 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, 2013

12-01 CLINIC ACCOUNTS RECEIVABLE

Criteria or Specific Requirement

We noted that at December 31, 2012 the Clinic accounts receivable allowance calculation was not fully complete due to the Systems software being unable to produce reliable aging and subsidiary accounts receivable reports.

Condition and Cause

The reason for the difficulties in reconciling Clinic accounts receivable and calculating the allowance 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 subsidiary detail was not and could not be provided to the auditors. In order to test the reconciliation of accounts receivable, the auditors had to review the entire year's charges less receipts activity.

Effect

Clinic net accounts receivable at December 31, 2012, is approximately $911,000 and represents 38% of total net patient accounts receivable. Management was able to reconcile the net patient accounts receivable at year end; however, significant adjustments were necessary throughout the year 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 2013. The finding was repeated for the year ended December 31, 2013.

SECTION III. FINDINGS AND QUESTIONED COSTS FOR FEDERAL AWARDS

No matters were reported.

AUDITEE'S CORRECTIVE ACTION PLAN

December 31, 2013

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

CORRECTIVE ACTION PLAN
YEAR ENDED DECEMBER 31, 2013

Reportable Conditions of Internal Control:

13-01 Clinic Accounts Receivable

Criteria or Specific Requirement
AFT noted that at December 31, 2013 the Clinic account receivables allowance calculation was not fully complete due to the systems software, NextGen, being unable to produce reliable aging and subsidiary A/R reports.

Corrective Action Taken or Planned:
Contact personnel is Kyle Pierson, CFO. The interface of NextGen billing system with the general ledger system of CPSI began in May 2011, and after sample tests were performed, the posting methods of the two systems (NextGen – daily posting, CPSI – monthly posting) caused irresolvable complications. Many meetings with NextGen did not resolve the issues. Once Kyle Pierson started in November 2012, Minnie Hamilton representatives have been in constant contact with NextGen representatives to resolve the reporting issues. It has become the consensus among senior management at Minnie Hamilton that the issues with NextGen are not feasibly resolvable. As such, Minnie Hamilton has begun the process of investigating options to consolidate the entire health system under one software provider. MHHS has held meetings with their hospital vendor, CPSI, to view their upcoming clinic software, expected to be released in the summer of 2014. The hospital has involved both senior management and providers in the process to insure a smooth transition to their next software vendor.

When completed, the entire health system will be interfaced and provide a more accurate accounts receivable subsidiary ledger, aging, and collection reports.

The CFO 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 CFO to complete monthly financial statements.

Signed _____

Title CFO

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