Minnie Hamilton Health System

Financial and Compliance Report
December 31, 2017

Arnett Carbis Toothman llp
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, 2017 and 2016, 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, 2017 and 2016, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in Note 15 to the financial statements, the System has suffered recurring losses from operations and has a net capital deficiency. Management's plans to strengthen the System's operations and reduce the risks of future operating losses are also described in Note 15. The financial statements do not include any adjustments that might result from the outcome of this uncertainty. Our opinion is not modified with respect to this matter.

Other Matters

Other Information

Our audit was conducted for the purpose of forming an opinion on the financial statements as of and for the years ended December 31, 2017 and 2016, as a whole. The accompanying schedule of expenditures of federal awards, as required by Title 2 U.S. *Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), for the year ended December 31, 2017, is presented for purposes of additional analysis and is not a required part of the 2017 financial statements. Also, the accompanying schedule of non-federal awards for the year ended December 31, 2017, is presented for purposes of additional analysis of the 2017 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 2017 financial statements. The information has been subjected to the auditing procedures applied in the audit of the 2017 financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the 2017 financial statements or to the 2017 financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the 2017 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 October 15, 2018, 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, 2017. We issued a similar report for the year ended December 31, 2016, dated October 23, 2017, which has not been included with the 2017 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 Carbis Toothman LLP

Charleston, West Virginia
October 15, 2018

MINNIE HAMILTON HEALTH SYSTEM

BALANCE SHEETS
December 31, 2017 and 2016

	2017	2016
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	$ **707,657**	$ 435,902
Patient receivables, net of allowance for doubtful accounts of $2,590,413 in 2017 and $3,027,608 in 2016	**2,409,722**	2,485,990
Grants receivable	**-**	20,744
Supplies inventory	**164,292**	126,574
Prepaid expenses and other assets	**145,699**	75,006
Total current assets	**3,427,370**	3,144,216
PROPERTY AND EQUIPMENT, net	**1,957,354**	2,430,686
OTHER ASSETS	**43,632**	33,593
Total assets	$ **5,428,356**	$ 5,608,495
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Line of credit	$ **499,309**	$ 201,909
Current maturities of long-term obligations	**165,492**	360,891
Accounts payable and accrued expenses	**2,380,528**	1,323,101
Employee compensation, payroll withholdings, and taxes payable	**1,046,998**	1,020,751
Deferred revenue	**-**	166,451
Estimated third-party payor settlements	**1,744,479**	1,455,773
Total current liabilities	**5,836,806**	4,528,876
LONG-TERM OBLIGATIONS, net of current maturities	**112,823**	256,103
Total liabilities	**5,949,629**	4,784,979
NET ASSETS (DEFICIT) - UNRESTRICTED	**(521,273)**	823,516
Total liabilities and net assets	$ **5,428,356**	$ 5,608,495

See Notes to Financial Statements

MINNIE HAMILTON HEALTH SYSTEM

STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
Years Ended December 31, 2017 and 2016

	2017	2016
UNRESTRICTED REVENUES, GAINS AND OTHER SUPPORT		
Patient service revenue (net of contractual allowances and discounts)	$ 18,049,172	$ 18,767,096
Less: Provision for bad debts	(891,797)	(1,106,956)
Net patient service revenue	17,157,375	17,660,140
Federal, state and other grants	3,300,735	2,899,302
Contributions for operating expenses	11,538	25,899
Other operating revenue	538,246	852,879
Total revenues, gains and other support	21,007,894	21,438,220
OPERATING EXPENSES		
Salaries and wages	12,889,643	12,642,896
Professional fees	3,099,766	3,134,510
Supplies and other expenses	2,607,527	3,104,252
Payroll taxes and benefits	2,140,042	2,169,854
Depreciation and amortization	612,696	608,066
Utilities	382,156	353,765
Taxes	332,037	530,071
Insurance	187,097	218,521
Interest	121,613	60,156
Total expenses	22,372,577	22,822,091
Operating loss	(1,364,683)	(1,383,871)
NON-OPERATING REVENUE		
Interest	4,296	3,578
Rental income	15,598	11,872
Total non-operating revenue	19,894	15,450
Deficiency of revenues over expenses	(1,344,789)	(1,368,421)
Net assets unrestricted:		
Beginning of year	823,516	2,191,937
End of year	$ (521,273)	$ 823,516

See Notes to Financial Statements

MINNIE HAMILTON HEALTH SYSTEM

STATEMENTS OF CASH FLOWS
Years Ended December 31, 2017 and 2016

	2017	2016
CASH FLOWS FROM OPERATING ACTIVITIES		
Deficiency of revenues over expenses	$ (1,344,789)	$ (1,368,421)
Adjustments to reconcile excess of revenues over expenses to net cash provided by operating activities:		
Depreciation and amortization	612,696	608,066
Provision for bad debts	891,797	1,106,956
Change in assets and liabilities:		
(Increase) decrease in patient receivables	(815,529)	(1,035,060)
(Increase) decrease in grant receivables	20,744	86,238
(Increase) decrease in supplies inventory	(37,718)	18,052
(Increase) decrease in prepaid expenses and other assets	(80,732)	18,333
Increase (decrease) in accounts payable and accrued expenses	1,083,674	807,136
Increase (decrease) in estimated third-party payor settlements	288,706	761,267
Increase (decrease) in deferred revenue	(166,451)	(126,451)
Net cash provided by operating activities	452,398	876,116
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of property and equipment	(130,460)	(199,164)
Net cash used in investing activities	(130,460)	(199,164)
CASH FLOWS FROM FINANCING ACTIVITIES		
Line of credit borrowings, net of repayments	297,400	201,909
Principal payments on long-term obligations	(347,583)	(759,121)
Net cash used in financing activities	(50,183)	(557,212)
Net increase in cash and cash equivalents	271,755	119,740
Cash and cash equivalents:		
Beginning	435,902	316,162
Ending	$ 707,657	$ 435,902
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash payments for interest	$ 121,613	$ 60,156
SUPPLEMENTAL DISCLOSURE OF NONCASH INVESTING AND FINANCING ACTIVITIES		
Property and equipment acquired through capital lease obligations	$ 8,904	$ 78,010

See 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 reviews 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 was 70% and 83% of self-pay accounts receivable at December 31, 2017 and 2016. The System has not changed it's charity care or uninsured discount polices during 2017 or 2016.

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 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, 2017 and 2016.

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, 2017 and 2016.

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.

Deficiency of revenues over expenses: The statement of operations includes deficiency of revenues over expenses. Changes in unrestricted net assets when existing, which are excluded from 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 2014.

Advertising expense: The System expenses advertising as it is incurred. Advertising expense was $14,493 and $27,307 for the years ended December 31, 2017 and 2016, respectively.

Subsequent events: The System has evaluated subsequent events through October 15, 2018, the date on which the financial statements were available to be issued.

New or recent accounting pronouncements:

Revenue Recognition: In May 2014, the FASB issued Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers*, which clarifies the principles for recognizing revenue and develops a common revenue standard for U.S. GAAP. This ASU attempts to remove inconsistencies and weaknesses in the current revenue recognition requirements, provides a more robust framework for addressing issues, improves comparability across entities and industries, provides more useful information to the users of the financial statements, and simplifies the preparation of financial statements by consolidating the number of requirements required to be referenced. Early adoption is not permitted. The guidance permits the use of either a retrospective or modified retrospective (cumulative effect) transition method. The System is currently evaluating the impact, if any, that adoption will have on it's December 31, 2019, financial statements.

Leases: In February 2016, the FASB issued ASU No. 2016-02, *Leases* (Topic 842), which supersedes FASB ASC Topic 840, Leases, and makes other conforming amendments to U.S. GAAP. ASU No. 2016-02 requires, among other changes to the lease accounting guidance, lessees to recognize most leases on balance sheet via a right-of-use asset and lease liability, and additional qualitative and quantitative disclosures. The System is currently evaluating the impact, if any, that adoption will have on its December 31, 2020, financial statements.

Not-for-Profit Entities: On August 2016, the FASB issued Accounting Standards Update No. 2016-14 *Not-for-Profit Entities (Topic 958): Presentation of Financial Statements of Not-for-Profit Entities.* The amendments of this ASU change presentation and disclosure requirements for not-for-profit entities to provide more relevant information about their resources (and the changes in those resources) to donors, grantors, creditors, and other users. The amendments include qualitative and quantitative requirements in the financial statement presentation and disclosures regarding net asset classes, investment return, expenses, liquidity and availability of resources and presentation of operating cash flows. The System is currently evaluating the impact, if any, that adoption will have on its December 31, 2018, financial statements.

Statement of Cash Flow: In November 2016, the FASB issued ASU 2016-18, *Statement of Cash Flows* (Topic 230), which requires companies to include cash and cash equivalents that have restrictions on withdrawal or use in total cash and cash equivalents on the statement of cash flows. The System is currently evaluating the impact, if any, that adoption will have on its December 31, 2019, 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:

	2017	2016
Due (to) third-party payors:		
Medicaid disproportionate share	$ (2,254,195)	$ (1,662,097)
Due (from/(to) third-party payors:		
Medicare	397,848	(144,164)
Medicaid	111,868	350,488
	509,716	206,324
Total	$ (1,744,479)	$ (1,455,773)

Medicaid disproportionate share program settlement: On December 4, 2015 the West Virginia Department of Health and Human Resources (WVDHHR) received a letter ruling from the Region III office of the Center for Medicare and Medicaid Services (CMS) on the inclusion of the Hospital based rural health clinic cost in the Medicaid DSH calculation. The System has historically included the cost of hospital based rural health clinics (RHCs) within the Medicaid DSH calculation in accordance with policies established by the WVDHHR. The ruling from CMS states that although States have the flexibility to define the scope of "hospital services", a State cannot include the cost of a service not defined under its Medicaid State plan as a Medicaid inpatient or outpatient service. Based upon that interpretation, cost of operating the Hospitals RHCs will not be reimbursed as a part of the cost of uncompensated care. As of the date of this report, the WVDHHR has appealed that decision and is waiting for a ruling from CMS.

Therefore, at December 31, 2017, the Hospital estimated and recognized a payable for the Medicaid DSH cost based upon uninsured hospital based RHC cost for the years 2011 through 2017 of approximately $2,463,000. This estimated liability is included in the settlement amount above.

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. 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, 2017 and 2016, is as follows:

	2017	2016
Building	$ 2,427,431	$ 2,418,444
Leasehold improvements	462,218	462,218
Equipment and furniture	8,302,925	8,183,430
Construction in progress	145,746	145,746
	11,338,320	11,209,838
Less accumulated depreciation and amortization	9,380,966	8,779,152
Property and equipment, net	$ 1,957,354	$ 2,430,686

Capital lease assets at December 31, 2017 and 2016, included in property and equipment are as follows:

	2017	2016
Building and equipment	$ 686,920	$ 1,066,303
Less accumulated depreciation and amortization	356,514	506,348
	$ 330,406	$ 559,955

Note 4. Line of Credit

The System has a $500,000 line of credit with a variable interest rate of equal to the Prime Rate plus 2% (5.75% at December 31, 2017) and to be no less than 4.00%. The outstanding amount due for both years ended December 31, 2017 and 2016, was $499,309 and $201,909, respectively. The line of credit matures in April 2019.

Note 5. Long-Term Obligations and Subsequent Event

A summary of long-term obligations is as follows:

	2017	2016
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	$ **7,894**	$ 52,458
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	**-**	29,203
Note payable, bank, payable in monthly installments $13,862, including interest at a fixed rate of 5%, maturing February 2018, secured by the System's accounts receivable	**27,600**	188,065
Capital lease obligations, with interest ranging from 9.56%, to 10.50% payable in monthly installments of $702 to $13,324, maturing August 2018 to September 2020, secured by the equipment acquired under the obligation	**242,821**	347,268
Total	**278,315**	616,994
Less current maturities	**165,492**	360,891
Long-term obligations	$ **112,823**	$ 256,103

Aggregate maturities of long-term obligations at December 31, 2017 are as follows:

	Capital Lease Obligations			Long-Term
	Principal	Interest	Total	Debt
2018	$ 129,998	$ 11,847	$ 141,845	$ 35,494
2019	107,256	2,984	110,240	-
2020	5,567	52	5,619	-
	$ 242,821	$ 14,883	$ 257,704	$ 35,494

Subsequent Event

In June 2018, the System obtained a $1,000,000 promissory note from a financial institution. The note includes monthly principal and interest payments of $13,044 and matures in July 2026. The note has a variable interest rate calculated as the monthly average yield on United States treasury securities plus 3.00% with a floor of 4.00%. Proceeds from the note were used to pay off critical liabilities. The loan is secured by substantially all of the System's assets.

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

The System has 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 (CAH) and receives special reimbursement treatment.

CAHs receive payments on a reasonable cost basis, for inpatient and most outpatient services provided to eligible Medicare and Medicaid patients. Designation of the Hospital as a CAH reduces the risk of further cuts in payment rates for Medicare and Medicaid services.

A summary of the payment arrangements with major third-party payors is as follows:

- **Medicare**

  Inpatient acute care services and most outpatient services rendered to Medicare program beneficiaries are paid based on a cost reimbursement methodology. The System receives reimbursement at 101% of costs for Medicare inpatient, swing bed and outpatient services. 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 Hospital and audits thereof by the Medicare fiscal intermediary. The System's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization.

- **Medicaid**

  Inpatient and most outpatient 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 fiscal intermediary. Other outpatient services are reimbursed based upon the lesser of the System's charge or predetermined fee schedule amounts.

- **Managed Care and Other Commercial Insurance Carriers**

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

- **West Virginia Health Care Authority**

  During the current year, legislation was passed that eliminated rate regulation for West Virginia hospitals. The Health Care Authority may not reduce a hospital's rates for exceeding limits established by their rate orders effective July 1, 2016. Existing rate orders must still be complied with and failure to do so could result in other sanctions or penalties, in particular denial of certificate of need applications. The new law permits the Health Care Authority to impose fines for failure to comply with existing statutes and rules. However, the Authority has waived this requirement for Critical Access Hospitals.

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

	2017	2016
Gross patient service revenue	$ **25,737,828**	$ 27,495,272
Less provision for:		
Provision for contractual adjustments	**7,387,888**	8,419,156
Charity care (charges forgone based on established rates)	**300,768**	309,020
Bad debts	**891,797**	1,106,956
Net patient service revenue	$ **17,157,375**	$ 17,660,140

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 $921,308 and $1,100,258 for 2017 and 2016, 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 which is netted against the DSH amounts receivable for the quarterly payment due December 31, 2017.

As disclosed in Note 2, the System has recorded amounts for cost report settlements with Medicare and Medicaid. The 2017 and 2016 net patient service revenue was increased by approximately $83,000 and decreased by $156,000, 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, 2017 and 2016 were approximately $260,000 and $256,000, respectively. The System is the recipient of various grants and disproportionate share revenues 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, 2017 and 2016, from these major payor sources, is as follows:

2017	**Third-Party Payors**	**Self-Pay**	**Total All Payors**
Patient service revenue (net of contractual allowances and discounts)	**$ 16,888,141**	**$ 1,161,031**	**$ 18,049,172**

2016	Third-Party Payors	Self-Pay	Total All Payors
Patient service revenue (net of contractual allowances and discounts)	$ 17,504,596	$ 1,262,500	$ 18,767,096

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:

	2017	2016
Medicare	**44 %**	34 %
Medicaid	**24**	25
Other third-party payors	**19**	19
Private pay	**13**	22
	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:

	2017			
	Total Expenses	Patient Care and Other Program Expense	Support Services	General and Administrative
Salaries and wages	$ 12,889,643	$ 9,213,837	$ 1,410,778	$ 2,265,028
Payroll taxes and benefits	2,140,042	1,529,755	234,229	376,058
Professional fees	3,099,766	2,215,790	339,271	544,705
Supplies and other expenses	2,607,527	1,863,925	285,395	458,207
Insurance	187,097	133,742	20,478	32,877
Utilities	382,156	273,175	41,827	67,154
Taxes	332,037	237,348	36,342	58,347
Interest	121,613	86,932	13,311	21,370
Depreciation and amortization	612,696	437,970	67,060	107,666
Total operating expenses	$ 22,372,577	$ 15,992,474	$ 2,448,691	$ 3,931,412

	2016			
	Total Expenses	Patient Care and Other Program Expense	Support Services	General and Administrative
Salaries and wages	$ 12,642,896	$ 10,314,314	$ 1,332,424	$ 996,158
Payroll taxes and benefits	2,169,854	1,770,208	228,679	170,967
Professional fees	3,134,510	1,443,340	46,887	1,644,283
Supplies and other expenses	3,104,252	2,257,126	449,661	397,465
Insurance	218,521	108,468	-	110,053
Utilities	353,765	-	353,765	-
Taxes	530,071	-	-	530,071
Interest	60,156	-	-	60,156
Depreciation and amortization	608,066	420,342	86,474	101,250
Total operating expenses	$ 22,822,091	$ 16,313,798	$ 2,497,890	$ 4,010,403

Note 10. Grant Funding

The composition of various grant related items included in the financial statements for the year ended December 31, 2017, are as follows:

	Revenue	Grants Receivable	Deferred Revenue
FEDERAL FUNDING			
Community Health Systems Program	$ 3,093,598	$ -	$ -
Small Hospital Improvement Program	2,210	-	-
Public Health and Social Emergency Fund	9,000	-	-
Breast Cancer Learning Community Project	39,305	-	-
Health Infrastructure Investment Program	1,500	-	-
	3,145,613	-	-
STATE FUNDING			
Uncompensated Care	135,122	-	-
Rural Health Systems Program	10,000	-	-
	145,122	-	-
OTHER FUNDING			
Delta Dental Community Care Foundation	10,000	-	-
	10,000	-	-
	$ 3,300,735	$ -	$ -

The composition of various grant related items included in the financial statements for the year ended December 31, 2016, are as follows:

	Revenue	Grants Receivable	Deferred Revenue
FEDERAL FUNDING			
Community Health Systems Program	$ 2,537,374	$ -	$ -
Small Hospital Improvement Program	18,528	-	-
Public Health and Social Emergency Fund	1,500	-	-
Health Infrastructure Investment Program	145,746	-	-
	2,703,148	-	-
STATE FUNDING			
Uncompensated Care	136,942	20,744	-
Mortgage Finance	4,662	-	-
Oral Disease Prevention Project	9,500	-	-
Rural Health Systems Program	10,000	-	-
	161,104	20,744	-
OTHER FUNDING			
Delta Dental Community Care Foundation	10,000	-	-
Parkersburg Area Community Foundation	15,050	-	-
Marshall University Research Corporation	10,000	-	-
	35,050	-	-
	$ 2,899,302	$ 20,744	$ -

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, 2017, 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, 2017. The System has a deductible of $40,000 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, 2017 that have initial or remaining lease terms in excess of one year are as follows:

2018	$	204,719
2019		185,265
2020		169,360
2021		169,360
2022		169,360
Thereafter		5,334,839
	$	6,232,903

Total rental expense in 2017 and 2016 for all operating leases was approximately $227,700 and $235,500, 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 $239,000 and $275,000 for 2017 and 2016, respectively.

Note 15. Management Plans

- Minnie Hamilton Health System (the System) experienced losses in 2015 through 2017 due to decreased patient revenues and increased expenses. Additionally, the System had a net asset deficit as of the year ended December 31, 2017. DSH settlement liabilities and assuming emergency response duties in the county only compounded the losses and negative cash flows. These issues forced management to take action in order to improve the System's financial stability. Actions taken subsequent to the year ended December 31, 2017, include carrying out non-profitable program closures, implementing reduction in workforce, and implementing realignment in workforce that will helped eliminate operating losses and improve cash flow. Without increasing staffing levels, the System has also started new services such as wound care, chronic care management and nephrology in 2018. Management will closely monitor these new services but feel they have the potential to be profitable to the System.

- EMS services have been difficult to manage profitably. Many options have been tried over the last several years. In July 2018, management worked with the Calhoun County EMS on a plan to begin to transfer operations of EMS back to the county. Beginning in October 2018, all transport services will be performed by Calhoun County EMS.

- The implementation of a new inventory management program began in 2017 but was not fully functional until August of 2018. The new system is interfaced with their software vendor and has improved operations by allowing management to better perform cost evaluations and initiate cost savings.

- Management is conducting charge master and payer reviews to improve reimbursements. In 2018, management refinanced outstanding debt. The proceeds were used to pay off outstanding tax liens and payments. The System has also hired a new revenue cycle manager and chief financial officer in 2018. Both have had a significant impact on improving operations and providing timely and accurate reporting. Management believes it will be able to timely submit their Single Audit Reporting Package to the Federal Audit Clearinghouse with in nine months after its fiscal year end.

- Management has undertaken other initiatives to improve financial performance in addition to the above items. Management believes these initiatives in total will result in improved financial performance and cash flow.

MINNIE HAMILTON HEALTH SYSTEM

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
Year Ended December 31, 2017

Federal Grantor/Pass-Through Grantor/Program or Cluster Title	Federal CFDA Number	Pass-through Entity Identifying Number	Passed Through to Subrecipients	Federal Expenditures
U.S. Department of Health and Human Services:				
Direct Awards:				
Health Centers Cluster				
Health Center Program (Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Public Housing Primary Care)	93.224	-	$ -	$ 493,083
Affordable Care Act (ACA) Grants for New and Expanded Services Under the Health Center Program	93.527	-	-	2,600,515
Health Centers Cluster Total			-	3,093,598
Grants for Capital Development in Health Centers	93.526	-	-	2,210
Total Direct Awards			-	3,095,808
Passed through:				
West Virginia Department of Health and Human Resources:				
Small Rural Hospital Improvement Grant Program	93.301	-	-	9,000
Building Capacity of the Public Health System to Improve Population Health through National, Nonprofit Organizations	93.424	G170777	-	39,305
Healthcare Education Foundation of West Virginia:				
Public Health and Social Emergency Fund	93.003	-	-	1,500
Total Indirect Awards			-	49,805
Total Expenditures of Federal Awards			$ -	$ 3,145,613

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, 2017

Note 1. Basis of Presentation

The accompanying schedule of expenditures of federal awards (the "Schedule") includes the Federal award activity of Minnie Hamilton Health System under programs of the federal government for the year ended December 31, 2017. The information in this Schedule is presented in accordance with the requirements of Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Because the Schedule presents only a selected portion of the operations of Minnie Hamilton Health System, it is not intended to and does not present the financial position, changes in net assets, or cash flows of Minnie Hamilton Health System.

Note 2. Summary of Significant Accounting Policies

Expenditures reported on the Schedule are reported on the accrual basis of accounting. Such expenditures are recognized following, Uniform Guidance, wherein certain types of expenditures are not allowable or are limited as to reimbursement.

Note 3. Indirect Cost Rate

Minnie Hamilton Health System has elected to not use the 10 percent de minmis indirect cost rate as allowed under the Uniform Guidance. No indirect costs are charged to the programs.

MINNIE HAMILTON HEALTH SYSTEM

SCHEDULE OF NONFEDERAL AWARDS
Year Ended December 31, 2017

Grant Name	Ref #	Grant Program	Grant Period	Awarded Amount	Amount Drawn Down (Cumulative)	Amount Available	Grant Expenditures	Grant Receivable	Deferred Grant Revenue
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES									
Bureau of Public Health, Division of Primary Care	G170367	Uncompensated Care	7/1/2016 6/30/2017	$ 141,440	$ 141,440	$ -	$ 82,037	$ -	$ -
Bureau of Public Health, Division of Primary Care	G180361	Uncompensated Care	7/1/2017 6/30/2018	126,397	53,085	73,312	53,085	-	-
Recruitment and Retention Community Project (RRCP)	G170465	Loan Repayment Program	10/1/2016 6/30/2017	10,000	10,000	-	10,000	-	-
Recruitment and Retention Community Project (RRCP)	G180496	Loan Repayment Program	10/1/2017 6/30/2018	20,000	-	20,000	-	-	-
Total State Awards				297,837	204,525	93,312	145,122	-	-
Delta Dental Community Care Foundation	N/A	Working Poor Grant Program	2017	10,000	10,000	-	10,000	-	-
Total Other Funding				10,000	10,000	-	10,000	-	-
Total Nonfederal Awards				$ 307,837	$ 214,525	$ 93,312	$ 155,122	$ -	$ -

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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, 2017, 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 _____, 2018.

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 was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control 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 deficiencies in internal controls, described in the accompanying schedule of findings and questioned costs as findings 2017-01 and 2017-02 that we consider to be significant deficiencies.

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*.

Minnie Hamilton Health System's Response to Findings

Minnie Hamilton Health System's response to the findings identified in our audit are described in the accompanying schedule of findings and questioned costs. Minnie Hamilton Health System's response was not subjected to the audit 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 Cardis Toothman LLP

Charleston, West Virginia
October 15, 2018

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INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE FOR EACH MAJOR FEDERAL PROGRAM AND REPORT ON INTERNAL CONTROL OVER COMPLIANCE REQUIRED BY THE *UNIFORM GUIDANCE*

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 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, 2017. 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 the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirement, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and the Uniform Guidance 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.

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, 2017.

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 the 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 the Uniform Guidance, 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. We did identify a certain deficiency in internal control over compliance, as described in the accompanying schedule of findings and questioned costs as item 2017-03, that we consider to be a significant deficiency.

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 the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

Arnett Carbis Toothman LLP

Charleston, West Virginia
October 15, 2018

MINNIE HAMILTON HEALTH SYSTEM

SCHEDULE OF FINDINGS AND QUESTIONED COSTS
Year Ended December 31, 2017

SECTION I. SUMMARY OF INDEPENDENT AUDITOR'S RESULTS

Financial Statements

Type of auditor's report issued on whether the financial statements audited were prepared in accordance with accounting principles generally accepted in the United States of America:	Unmodified		
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?	X yes	_____	none reported
Type of auditor's report issued on compliance for major programs:	Unmodified		
Any audit findings disclosed that are required to be reported in accordance with Section 2 CFR 200.516(a)?	_____ 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:	
	Health Centers Cluster:	
93.224/93.527	Health Center Program (Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Public Housing Primary Care) and Affordable Care Act (ACA) Grants for New and Expanded Services Under the Health Center Program	$ 3,093,598

Dollar threshold used to distinguish between type A and type B programs:	$ 750,000		
Auditee qualified as low-risk auditee?	_____ Yes	X no	

SECTION II. FINANCIAL STATEMENT FINDINGS

17-01 Account Reconciliations

Criteria or Specific Requirement

Effective internal controls to complete timely reconciliations of subsidiary records with general ledger control accounts to be properly performed under appropriate supervision and review throughout a financial reporting period.

Condition and Cause

We observed the System did not timely reconcile the subsidiary records for some significant general ledger accounts (i.e. accounts receivable, federal and state grant schedule, contractual and bad debt allowances, accounts payable, property and equipment, and accrued expenses accounts) during the year ended December 31, 2017. Subsidiary records for the federal and non-federal grant programs were properly maintained during the year to ensure accurate grant compliance financial reporting; however, the System did not reconcile those subsidiary records in a timely fashion to the general ledger control accounts to ensure accurate entity level financial reporting until several months after the related financial reporting periods had concluded.

During the fiscal 2017 year, there were significant changes in accounting systems and turnover of the controller. This resulted in delays in the significant general ledger accounts.

Effect

Lack of reconciliation between subsidiary records and the general ledger could have resulted in a misstatement of grant receipts and expenditures and revenue on the financial statements that would not have been detected in a timely manner. Also consequent to this condition, the System experienced a delay in completing the audit and created inefficiencies for the System's staff and audit team. The lack of timely reporting causes difficulties in management and board decision making as well which could have an adverse effect on the operations of the System.

Recommendation

We recommend that management put in place a better process of reconciling all significant general ledger accounts and implement a timeline and list of duties to ensure the System achieves timely reporting of monthly and annual reports.

Corrective Action Taken or Planned

Management agrees with the auditor's recommendation and reconciliations will be completed on a monthly basis going forward.

17-02 Depreciation of Capital Lease Assets

Criteria or Specific Requirement

Effective internal controls over capitalizing appropriate capital assets additions and then depreciating over an appropriate useful life.

Condition and Cause

We observed the System entered into capital leases in past years and recorded the respective assets in the general ledger but failed to depreciate the assets over their useful life. This has caused accumulated depreciation and depreciation and amortization expense to be understated by $106,500.

Effect

Lack of proper depreciation could cause property and equipment to be overstated and a decrease in depreciation expense.

Recommendation

We recommend that management develop policies and procedures to track the capitalization and depreciation of assets purchased or acquired through capital leases. We also recommend management perform a property and equipment observation to ensure all equipment has been properly capitalized or disposed of on the general ledger and sub-ledger.

Corrective Action Taken or Planned

Management agrees with the auditor's recommendation and will develop procedures to ensure all capitalized assets are properly being depreciated.

SECTION III. FINDINGS AND QUESTIONED COSTS FOR FEDERAL AWARDS

Programs: Health Centers Cluster: Health Center Program (Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Public Housing Primary Care) and Affordable Care Act (ACA) Grants for New and Expanded Services Under the Health Center Program

CFDA Numbers: 93.224 and 93.527

Federal Agencies: U.S. Department of Health and Human Services

Passed-Through Entities: N/A

Award Number: N/A

Award Year: Various

Compliance Requirement: Reporting

Questioned Costs: None

Criteria: As required by Section 200.512 of the Uniform Guidance, Minnie Hamilton Health System must submit their Single Audit Reporting Package to the Federal Audit Clearinghouse no later than nine months after its fiscal year end.

Condition and Context: The federal reporting deadline for Minnie Hamilton Health System' Single Audit Reporting Package was September 30, 2018; however, Minnie Hamilton Health System did not issue their Single Audit Reporting Package until October 2018.

Effect: Minnie Hamilton Health System are not in compliance with the reporting deadline administered by the Federal Audit Clearinghouse.

Cause: Minnie Hamilton Health System had delays in reconciling balance sheet accounts and turnover within executive management and accounting department. Minnie Hamilton Health System also implemented new electronic health records system, which lead to delays in getting accurate accounting records.

Recommendation: It is recommended that Minnie Hamilton Health System file their Single Audit Reporting Package timely with the Federal Audit Clearinghouse going forward.

View of Responsible Officials: Minnie Hamilton Health System agrees with the finding. See Note 15 for Management's Plans.

MINNIE HAMILTON HEALTH SYSTEM

AUDITEE'S SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS
Year Ended December 31, 2017

Findings Required to be Reported by Government Auditing Standards:

16-01 Account Reconciliations

Condition and Cause

We observed the System did not timely reconcile the subsidiary records for grant receivable and revenue with the related general ledger control accounts during the year ended December 31, 2017. Subsidiary records for the federal and non-federal grant programs were properly maintained during the year to ensure accurate grant compliance financial reporting; however, the System did not reconcile those subsidiary records in a timely fashion to the general ledger control accounts to ensure accurate entity level financial reporting until several months after the related financial reporting periods had concluded.

During the fiscal 2017 year, there were significant changes in personnel in the accounting department including the controller and chief financial officer. This resulted in delays in the grant receivable and revenue subsidiary records being reconciled with the related general ledger control accounts.

Recommendation

We recommend that management reconcile grant receivable and revenue accounts with supporting subsidiary records as part of the normal monthly accounting routines.

Current Status

Management was not able to resolve the reconciling issues during the current year. The finding was repeated for the year ended December 31, 2017.

Walker, Angela D

From: Jonathan Bucher, CFO <jonathan.bucher@mhhs.healthcare>
Sent: Monday, October 22, 2018 9:44 AM
To: Walker, Angela D
Subject: Minnie Hamilton FS17 FINAL
Attachments: Minnie Hamilton FS17 FINAL.pdf

Good morning Angela,

I've attached the 2017 audited financials.

Please let me know if you need anything else in order to remove MHHS from the debarred list.

Thanks!