BY THE U.S. GENERAL ACCOUNTING OFFICE

Report To The Secretary Of Health And Human Services

Hospital Links With Related Firms Can Conceal Unreasonable Costs And Increase Administrative Burden, Thus Inflating Health Program Expenditures

GAO reviewed five hospitals to identify transactions with organizations related to the hospitals by common ownership or control that had not been properly disclosed by the hospitals or identified by the intermediaries and that resulted in Medicare/Medicaid overpayments to the hospitals. Problems were identified in each hospital, and resulting excessive claims for payment quantified as of July 1982 totaled over $1.2 million. Related organization transactions not only conceal unallowable costs and increase Medicare/Medicaid reimbursements, but also increase the administrative burden on claims payors because of the need to identify and analyze such transactions. Because the transactions are often complex, Medicare and Medicaid paying agents miss some, and overpayments result.

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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-210190

The Honorable Richard S. Schweiker
The Secretary of Health and Human Services

Dear Mr. Secretary:

This is our report on how five selected hospitals were overpaid by the Medicare and Medicaid programs as a result of non-arm's-length transactions among the hospitals and organizations related to them by common ownership or control. The report discusses how hospitals that are part of complex multi-organization entities can use such transactions to inflate costs and reimbursements and conceal this from Medicare and Medicaid claims paying agents. Uncovering allowable costs associated with these transactions requires extensive auditing which, if done, increases program administration costs.

We are sending copies of this report to your Inspector General; the Administrator, Health Care Financing Administration; and other interested parties.

Sincerely yours,

Philip A. Bernstein
Director

REPORT TO THE SECRETARY
HEALTH AND HUMAN SERVICES

HOSPITAL LINKS WITH RELATED FIRMS CAN CONCEAL UNREASONABLE COSTS AND INCREASE ADMINISTRATIVE BURDEN, THUS INFLATING HEALTH PROGRAM EXPENDITURES

D I G E S T

The public and the Federal and State governments are concerned about the dramatic increase in the costs of providing health care to Government program beneficiaries. One reason for the rapid increase in costs is health care providers' dealing in non-arm's-length transactions with affiliated entities--called related organizations--that are under common ownership or control.

The Federal Medicare program reimburses hospitals for the reasonable cost of providing services to beneficiaries. Many States also reimburse for the reasonable cost under the Federal/State Medicaid program. When hospitals incur costs resulting from transactions with related firms, the reimbursement is generally limited to the lower of (1) the cost to the related firm or (2) the market value of the goods or services purchased.

Hospitals are required to file annual cost reports, and Medicare paying agents and State Medicaid agencies are responsible for auditing these reports and analyzing the transactions with related organizations to insure that reimbursement does not include unallowable profits for or excessive payments to affiliated entities.

GAO audited five hospitals in California and Nevada to identify non-arm's-length transactions and to determine the impact on Medicare and Medicaid. At each hospital, GAO

--determined who owned and/or controlled the hospital;

--reviewed the hospital's organizational structure, including its related organizations;

--identified non-arm's-length transactions between the related organizations;

--analyzed non-arm's-length transactions to determine the impact on Medicare and Medicaid;

--presented preliminary findings to the appropriate paying agents; and

--reviewed the cost report adjustments made by the intermediary and the recovery of overpayments. (See p. 4.)

RELATED ORGANIZATIONS GIVE HOSPITALS AN OPPORTUNITY TO INFLATE THEIR GOVERNMENT REIMBURSEMENT

While this limited review cannot be projected to the hospital industry as a whole, the findings nevertheless indicate that the Government pays more than the reasonable cost of health care for the elderly and poor. GAO's review at five hospitals showed that hospital owners can inflate their costs, and thereby their Government reimbursement, by dealing in non-arm's-length transactions with affiliated entities. Concealed related organizations and non-arm's-length transactions make identifying unallowable costs by the Medicare paying agents and States difficult.

The following examples illustrate how some hospitals inflated their costs by dealing in non-arm's-length transactions that were not adequately disclosed by the hospital or analyzed by its intermediary.

--By using a complicated set of transactions with a related pharmacy, North Las Vegas Hospital artificially increased intravenous solution costs by about 800 percent. This resulted in $215,000 in Medicare/Medicaid overpayments in 1979 and 1980. Additionally, as a result of GAO's review, the provider reduced its 1981 claim for reimbursement against the Government programs by over $440,000. (See p. 8.)

--Because the intermediary failed to apply the related organization guidelines fully, Medicare and Medicaid overpaid North Las Vegas Hospital $188,000 for therapy services in 1980 and 1981. (See p. 10.)

--By forming a separate hospital management company, the owners of Woodruff Community Hospital increased its reported costs and concealed them from the intermediary's easy scrutiny, thus making it difficult for the intermediary to determine if they were reasonable. (See p. 13.)

--Woodruff Community Hospital's related organizations contributed to the intermediary's overpaying the hospital during the year, in effect granting it a $500,000 interest-free loan. (See p. 16.)

--Mad River Community Hospital's equipment lease transactions with a related organization will increase hospital operating costs by $500,000 in 8 years. In 1979, the Government paid part of the additional costs. (See p. 22.)

--The intermediary overreimbursed Brookwood Hospital about $250,000 because the hospital did not properly disclose its non-arm's-length transactions, and the intermediary did not evaluate the hospital costs adequately. (See p. 26.)

Hospitals' use of affiliated entities gives their owners an opportunity to circumvent the Government intent to reimburse hospitals for the reasonable cost of health services. GAO had to invest considerable time and effort identifying the hospitals' related organizations and analyzing their transactions because each hospital had a different organizational structure. Without a similar emphasis on identifying related organizations and their non-arm's-length transactions, intermediaries are not likely to discover the impact of such transactions on Government reimbursement. (See pp. 37 and 38.)

The intermediaries responsible for the hospitals reviewed agreed with GAO's findings and are taking actions to recover the overpayments.

This report addresses only related organization transactions in hospitals, but other types of providers--nursing homes, home health agencies, renal dialysis facilities, cost-basis paid health maintenance organizations, and others--can be involved in such transactions. Because of the complexity of the issues surrounding the related organization reimbursement principle and its application, GAO is studying the principle as it relates to all types of providers. GAO intends to make recommendations in a report on that study addressing the overall related organization issue.

Contents

ABBREVIATIONS

AHMC	American Hospital Management Corporation
GAO	General Accounting Office
HCFA	Health Care Financing Administration
IV	intravenous
MPEC	Medical Properties and Equipment Company

CHAPTER 1

INTRODUCTION

In recent years much public interest has focused on the rapidly escalating costs for Medicare and Medicaid, the Government-financed health care programs for the elderly, disabled, and poor. One reason previously identified by us and others as leading to excessive program costs is the providers' use of entities related to them. Institutional health providers and their owners or controlling parties found that they could increase their reimbursement from the Government by forming closely related organizations involved in transactions with one another. Such arrangements can increase medical care costs and conceal abuses of the Government programs. The complex transactions between closely related organizations are difficult for the Government's claims paying agents to audit in order to determine the Government's appropriate share of costs.

COST REIMBURSEMENT SYSTEM

In most instances under Medicare and frequently under Medicaid, hospitals are reimbursed for the reasonable and necessary costs of providing health services to program beneficiaries. Medicare also pays nursing homes on a retrospective cost basis; however, in most States Medicaid pays nursing homes on a prospective cost-related basis. Medicare also pays privately owned, for-profit institutions a return on their capital investment used in providing Medicare services, and Medicaid also permits a profit factor in its rates. Program regulations require providers to maintain sufficient financial and statistical records to allow Government representatives to determine the costs payable under the programs.

The Department of Health and Human Services has contracted with private insurance companies such as Blue Cross to act as intermediaries for the Government. The Medicare intermediaries (1) reimburse providers, (2) audit the providers' cost reports and supporting documentation to insure that costs claimed for reimbursement are reasonable and allowable under the program, and (3) assist and advise providers on maintaining required fiscal records. Because Medicare providers select their intermediaries, commonly owned and controlled providers, or a provider and its home office, can have different intermediaries.

Under Medicare, intermediaries pay providers on an interim basis the estimated costs for serving program beneficiaries. The interim payments, usually made biweekly, are normally set at a percentage of the hospital's charges that from past experience

should equate to its reasonable costs. After the end of its fiscal year, the hospital submits a cost report, which is subject to intermediary audit to determine the correct reimbursement for the year. The intermediary then either pays the provider any additional amounts due or bills it for excess interim payments.

Under Medicaid, most States use a hospital reimbursement system and cost reimbursement principles similar to Medicare's. The State or a contractor called a fiscal agent pays the hospitals and makes retrospective settlements with them. Normally, Medicare and Medicaid have an agreement whereby one of them makes the audit for both programs.

In a number of States, Medicaid uses a different reimbursement system from Medicare's. However, an alternate Medicaid system is required to use cost reports and to selectively audit them to insure that the system results in reasonable payments.

The intermediaries and States use their discretion in deciding to what extent they audit the hospitals' cost reports.

COST REIMBURSEMENT TO RELATED ORGANIZATIONS

An objective of the Medicare and Medicaid programs is to reimburse providers that serve program beneficiaries for the reasonable cost of the services, although the methods used to arrive at this amount can vary in a State. Except for a return on equity allowed to for-profit organizations, Medicare does not pay providers a profit. Accordingly, Medicare regulations, which generally apply to Medicaid, require providers that purchase goods or services from commonly owned or controlled organizations to eliminate any profit realized by the supplier on sales to the provider. The portion of the net equity of the related organization used to provide the goods or services to the provider is included in the provider's net equity when payments for profit are computed for profitmaking providers. When filing their annual cost reports, providers are required to disclose any transactions with organizations related to them by common ownership or control and adjust the costs incurred in such non-arm's-length transactions to the cost of the related supplier. Costs incurred by a home office or parent organization are includable and reimbursable to the providers. However, the home office or parent organization must also file a report documenting these costs.

Generally, the Government will reimburse providers that purchase goods or services from related organizations for the

cost incurred by those organizations. This cost, however, cannot be more than the reasonable market price of comparable goods, services, or facilities. Reimbursement rules provide an exception to the related organization cost limitation when a provider and its related supplier meet all of the following conditions.

--The supplying organization is a bona fide separate organization.

--A substantial part of its business activity providing the same services as to the provider is with other nonrelated organizations and there is an open, competitive market for the services furnished by the organization.

--The services, facilities, or supplies are those that commonly are obtained from other organizations and are not usually furnished directly to patients by the provider.

--The charges to the provider are in line with the charges for such services, facilities, or supplies in the open market and are no more than the charges to others under comparable circumstances.

If a provider's related organization meets all of these conditions, the provider can be reimbursed the amount it paid. In such instances, the Government does not pay a return on the related organization's equity devoted to serving program beneficiaries.

THE MEDICARE/MEDICAID ANTI-FRAUD AND ABUSE AMENDMENTS

In 1977, the Congress enacted Public Law 95-142, the Medicare and Medicaid Anti-Fraud and Abuse Amendments, to control fraud and abuse against the Government health care programs. Reviews by us and others and congressional hearings disclosed that the practice of some nonprofit, tax-exempt organizations subcontracting with for-profit corporations owned or controlled by nonprofit providers' officers enabled funds to be diverted from the health financing programs. Testimony during congressional hearings also disclosed that adequately auditing some providers with complicated multiple entity organizational structures was expensive and time consuming.

Certain sections of Public Law 95-142 were intended to strengthen disclosure requirements and provide an additional

audit tool to intermediary and Government auditors to help control program payments involving related organizations.[1] The law requires providers to disclose on request the ownership of any subcontractor or supplier with whom the provider has annual business transactions of more than $25,000 and to provide full and complete information on any significant business transactions with wholly owned entities.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our review objectives were to identify providers involved in non-arm's-length transactions with related entities and to determine if they fully disclosed these transactions. Further, we wanted to determine the impact of non-arm's-length transactions on the Medicare and Medicaid programs and to identify any overpayments.

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[1]Section 3, "Disclosure of Ownership and Related Information," section 8, "Disclosure by Providers of Owners and Certain Other Individuals Convicted of Certain Offenses," and section 15, "Disclosure by Providers of the Hiring of Certain Former Employees of Fiscal Intermediaries."

We reviewed the following five hospitals in California and Nevada.

Hospital	Type of organization
North Las Vegas Hospital North Las Vegas, Nevada	For-profit. Member of a small chain owned by Huntington Health Services, Inc.
Woodruff Community Hospital Long Beach, California	For-profit. Owned by Belvue Enterprises, Inc., which in turn is owned by two physicians.
Mad River Community Hospital Arcata, California	For-profit. Owned by American Hospital Management Corporation.
Brookwood Hospital Santa Rosa, California	For-profit. Owned by Brookwood Hospital Management Corporation. Managed by A. E. Brim and Associates.
Eskaton American River Hospital Carmichael, California	Nonprofit. Member of a small chain, owned by Eskaton Corporation.

In California alone, there are about 600 acute care hospitals, including publicly owned county hospitals, university hospitals, church-affiliated hospitals, and other nonprofit hospitals. In addition, California has many for-profit hospitals that are owned by individuals, small corporations, or large chain organizations. A similar pattern of hospital ownership is found in Nevada, except that the total number of acute care hospitals is much smaller than in California.

In selecting the five hospitals, we concentrated on private, for-profit facilities with various organizational structures. We tried to select hospitals with a high volume of Government program business, avoiding facilities that had undergone extensive recent audits or investigations. We decided to include one nonprofit facility for contrast. Additionally, we did not select hospitals owned by large chain organizations because reviewing them would have required an inordinate amount of time and staff resources. Because of limited staff resources we did not select a projectable statistical sample of providers.

Consequently, the results of our review cannot be extrapolated to the hospital industry in the two States or to the industry in general.

Finally, we selected hospitals we suspected of dealing with related organizations based on reports and discussions with numerous organizations and agencies. We reviewed information filed with State regulatory agencies, intermediaries, and State audit agencies, and ownership and control disclosures pursuant to section 3 of Public Law 95-142 filed with the Health Care Financing Administration (HCFA) regional office.

Following this selection process, we visited each hospital and gathered information about its related organizations and the non-arm's-length transactions involved. We analyzed these transactions and submitted our findings to the intermediary responsible for auditing the hospital. We asked the intermediary to confirm our findings and determine the impact on Medicare and Medicaid. We also discussed our findings with HCFA officials.

Whenever possible, we attempted to coordinate the intermediary's analysis of our findings with its plan to audit the hospital. Generally, our findings were available to the intermediary before its audit. The final phase of our review consisted of reviewing and evaluating the intermediaries' workpapers and responses to our findings and their actions taken to recoup any overpayments identified as a result of our work.

In determining whether transactions represented non-arm's-length dealings, we used the Medicare related organization reimbursement principles discussed earlier. We are not sure that we identified all of the related organization transactions that occurred at the hospitals reviewed.

Our work was done in accordance with generally accepted Government audit standards.

CHAPTER 2

NORTH LAS VEGAS HOSPITAL USED COMPLEX ACCOUNTING TO CONCEAL RELATED ORGANIZATION PROFITS

At North Las Vegas Hospital, the use of a complex accounting method involving related organizations was a significant factor enabling the provider to be reimbursed for more than allowable costs. The accounting method inflated the hospital's costs while artificially decreasing the related pharmacy's profits, which in turn increased Medicare and Medicaid payments to the hospital. In addition, the intermediary failed to apply the related organization guidelines fully to limit related organization costs to the reasonable market price, thereby increasing ancillary service reimbursement. The total effect was overreimbursement to the provider by about $290,000 for 1979 and 1980. In addition, a reduction in Government program costs of about $555,000 for 1981 was effected by decreasing claimed costs before the intermediary made settlement.

BACKGROUND

North Las Vegas Hospital is a 99-bed acute care hospital in North Las Vegas, Nevada. The hospital is operated by North Las Vegas Hospital, Inc., a wholly owned subsidiary of Huntington Health Services, Inc., a publicly held company.

Huntington, the parent corporation, owns about 20 separate corporations that provide acute care, nursing care, or ancillary services or own and operate housing facilities for the disabled and elderly. Appendix I lists Huntington Health Services' affiliates and business activities.

Each subsidiary maintains its own accounting records, but at the end of each accounting period, the activities of each division (for example, acute or intermediate care) are combined. At the end of the fiscal year, all activities are consolidated into one set of financial statements.

Several organizations related to and controlled by Huntington provide services under Government programs. Because a full review of Huntington's complex organizational arrangements would require much time and audit effort, we selected the North Las Vegas Hospital, Inc., the North Las Vegas Hospital Pharmacy, Inc., and Medical Rehabilitation Services, Inc., for our review. We selected North Las Vegas Hospital because it is one of the few for-profit acute care hospitals in Nevada and it has a high Medicare and Medicaid utilization. Additionally, we believed that a review of the hospital and its relationship to the

two other Huntington organizations would help alert the intermediary and Government agencies to problems that may exist in similar related organizational arrangements.

COMPLEX ACCOUNTING FOR INTRAVENOUS SOLUTION AT NORTH LAS VEGAS HOSPITAL

A complex method of accounting for intravenous (IV) solution, implemented by North Las Vegas Hospital and North Las Vegas Hospital Pharmacy, resulted in an overpayment of about $215,000 for fiscal years 1979 and 1980. Additionally, as a result of our review, the provider reduced its fiscal year 1981 claim for reimbursement against the Government programs by about $441,000.

Under Medicare regulations, the hospital and pharmacy are related organizations because both are owned and controlled by Huntington Health Services. The hospital can claim reimbursement only for the actual costs of providing pharmacy services. However, by using a complex accounting method, the provider circumvented the regulations limiting reimbursement to allowable costs.

Beginning in December 1978, the hospital established a "drug additive program" for IV solutions. The procedure adopted involves the hospital's selling IV solutions to the related pharmacy for labeling, storage, adding of drugs if necessary, and dispensing to patients. A summary of the procedures and complex accounting transactions allowing the hospital and its parent company to profit excessively from selling IV solutions follows.

The hospital purchases the IV solution from a pharmaceutical manufacturer at $1.53[1] per bottle under an agreement that includes a provision for a quantity discount and a 10-percent rebate to be paid annually. The $1.53 is recorded on the hospital's books as a cost of goods sold. The hospital transfers the IV solution to the pharmacy at a charge of $20 per bottle. This transaction is recorded by the hospital as a $20 receivable from the pharmacy and a $20 sale. When a patient receives an IV solution, the patient is charged $25 and the hospital records revenue of $25 and a patient receivable of $25. No corresponding entry is made on the pharmacy books. At the end of each month, the hospital transfers half of the $25 ($12.50) to the

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[1]The $1.53 cost is calculated from the hospital's cost of $18.36 per case of 12 bottles of IV solution. This price does not reflect the quantity discount or 10-percent rebate available to the hospital.

pharmacy and records an additional $12.50 in cost of goods sold. The net result on the hospital's books is that the original cost of $1.53 is artificially increased by $12.50 (a 50-percent split of the $25 received from the patient) to $14.03 in the reported costs for one bottle of IV solution. In short, the $1.53 cost per bottle is overstated by about 800 percent.

Additionally, the manner in which the transaction is recorded on the pharmacy books increases reimbursement to the hospital. In effect, the cost of $20 a bottle to the pharmacy minus the $12.50 receipt creates a loss of $7.50 on the pharmacy books. By creating an artificial loss for IV solutions on the pharmacy books, the pharmacy reduced the amount of profit from sale of other drugs to the hospital. Because intercompany profits are supposed to be eliminated, the artificial loss on IV solution resulted in actual pharmacy profits on its dealings with the hospital not being eliminated from the hospital's cost report.

To determine the effect on Medicare and Medicaid, we requested that the intermediary review provider costs and equity for fiscal years 1979-81. In its reviews, the intermediary found that the total hospital costs, including private patient costs for 1979 and 1980, were overstated by about $515,000. The intermediary calculated that the effect on the Government programs for the 2 years was over $215,000. In addition, for 1981, the provider decreased its recorded pharmacy costs by $676,516, of which the intermediary computed that $441,137 applied to Government programs. These changes are summarized in the following table:

North Las Vegas Hospital IV Solution Cost
Impact on the Government Programs

	1979	1980	1981	Total
IV solution cost overstatement:				
Due Medicare	$25,113	$127,812	$361,055	$513,980
Due Nevada Medicaid	3,137	23,077	80,082	106,296
Decrease to return on equity:				
Due Medicare	3,524	27,360	(a)	30,884
Due Nevada Medicaid	389	4,905	(a)	5,294
Total	$32,163	$183,154	$441,137	$656,454

a/Additional program savings will be realized from reduction to return on equity after the 1981 home office cost report is incorporated and the hospital's cost report is settled.

INADEQUATE APPLICATION OF RELATED ORGANIZATION REIMBURSEMENT GUIDELINES

Another related organization problem at North Las Vegas Hospital was the intermediary's failure to apply the related organization reimbursement guidelines fully. The intermediary did not apply the guidelines fully because it determined that Medical Rehabilitation Services, Inc., which supplies inhalation therapy, was a related organization[2] and, consequently, reduced the hospital's allowable cost to the related supplier's cost. However, the intermediary did not limit the hospital's cost to the lower of the related supplier's cost or the market value. This failure to apply market value salary equivalency guidelines resulted in excess Medicare and Medicaid payments of about $188,000 for 1980 and 1981.

Medical Rehabilitation Services, Inc., provides inhalation therapy services under an agreement with North Las Vegas Hospital. Through the 1980 hospital cost report, the hospital's intermediary had designated Medical Rehabilitation Services as a related organization. In accordance with this designation the intermediary had reimbursed the hospital for Medical Rehabilitation Services' costs for providing services plus a return on its equity capital but had not limited the cost by applying guidelines for respiratory therapist salaries. These guidelines, which were implemented December 1, 1978, set hourly rates, by State, to be used in calculating allowable cost.

In August 1981, we asked the intermediary to determine the effect on Government reimbursement amounts of failing to apply salary equivalency guidelines. The intermediary determined that failing to apply the guidelines for 1980 resulted in substantial overpayments. Also, by applying the guidelines to the 1981 cost report, the intermediary made a tentative adjustment that further reduced allowable program costs. As a result, the intermediary is taking steps to decrease Medicare and Medicaid reimbursement by about $188,000 for the 2 years. The intermediary's calculations are summarized as follows:

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[2]The hospital filed its cost reports treating Medical Rehabilitation Services as an unrelated organization based on a March 1977 Federal district court decision that that entity was exempt from the related organization cost limitations. The decision--District of Columbia (USDC), Case #76-0764, applicable to Community Hospital of Huntington Park, another Huntington hospital--was binding for only 1 year.

	1980	1981 (note a)	Total
Due Medicare	$66,956	$101,223	$168,179
Due Medicaid	7,025	13,102	20,127
Total adjustment due	$73,981	$114,325	$188,306

a/Intermediary computed tentative adjustment.

The intermediary determined that no overpayments occurred in 1979 because the costs did not exceed the salary equivalency guidelines.

INTERMEDIARY AND PROVIDER CORRECTIVE ACTION

The intermediary confirmed that the complex accounting method used to record IV solution transactions contributed to an overstatement of costs on the hospital's books and an understatement of the related pharmacy's profit--which was eliminated on the hospital cost report. To correct this in the future, the hospital revised its method of accounting for IV solution and, for the 1981 cost report, voluntarily decreased its IV solution costs by $676,516. The intermediary allocated the decrease in costs as follows:

Medicare	$361,055
Medicaid	80,082
Private patients	235,379
Total reduction	$676,516

Additional program savings, resulting from adjustments to the hospital's equity, will be identified when the intermediary settles the 1981 cost report.

The intermediary allowed the hospital to treat Medical Rehabilitation Services, Inc., as an exempt organization in filing its 1981 cost report. However, the intermediary determined that the hospital's inhalation therapy costs were not reasonable according to the salary equivalency guidelines. Consequently, the intermediary estimates that an adjustment will result in decreasing the allowable costs by about $139,000. The intermediary allocated the estimated reduction as follows:

Medicare	$101,223
Medicaid	13,102
Private patients	25,175
Total	$139,500

CHAPTER 3

RELATED MANAGEMENT FIRM INFLATED WOODRUFF COMMUNITY HOSPITAL'S COSTS

The owners of Woodruff Community Hospital set up a management firm, and the hospital contracted with it for management services. As a result of the non-arm's-length dealings, the hospital's management costs allocated to Medicare were inflated above allowable costs by about $84,000 in cost reporting years 1979 and 1980.

The hospital also made excessive payments to a physician for utilization review services and claimed excessive costs totaling $24,000 from Medicare and Medicaid. In addition, the intermediary overpaid the hospital and then granted it what amounted to an interest-free loan of $500,000 because the intermediary did not evaluate the hospital and its related organizations as one economic unit.

BACKGROUND

Woodruff Community Hospital, a 99-bed acute care hospital, is a corporation, wholly owned by Belvue Enterprises, Inc., which is in turn owned by two physicians. The physicians also own the hospital building, other investments, and 80 percent of another organization that owns a medical building. In addition, the physicians are partners in a medical practice. They each own part of the management company that manages the hospital and their other business. Appendix III diagrams the various entities affiliated with Woodruff Community Hospital and the transactions between them.

Woodruff Community Hospital provides health care services to Medicare and Medicaid beneficiaries and private patients. In addition, Belvue Enterprises provides ancillary services to the hospital under contract, and the physician owners provide services directly to patients. In fiscal year 1980, over 60 percent of the hospital's services were provided to Medicare and Medicaid program beneficiaries.

We selected Woodruff Community Hospital because (1) a high proportion of its health care services are provided under the Government programs, (2) it is a small hospital that would not require extensive effort to audit, and (3) its cost reports had not been extensively audited in recent years.

REORGANIZING HOSPITAL MANAGERS UNDER A SEPARATE ENTITY RESULTED IN EXCESSIVE REIMBURSEMENT CLAIMS

The owners of Woodruff Community Hospital established a separate management company that employs them and a key hospital management official to manage the hospital. This action and the resulting non-arm's-length transactions between the hospital and the management company have resulted in increased operating costs and increased reimbursement claims. If the intermediary had not scrutinized the management services and compensation, this arrangement could have cost the Medicare and Medicaid programs about $84,000 in excess reimbursements in fiscal years 1979 and 1980.

By operating through a related management company and other related organizations, the provider removed the hospital management costs from the intermediary's easy scrutiny, making it more difficult for the intermediary to evaluate their allowability. Without our assistance in identifying and analyzing the activities of all the related entities, the intermediary might have overpaid the provider.

In 1978 the owners of Woodruff Community Hospital and the hospital's administrator formed Long Beach Medical Management, Inc., and contracted with it to manage the hospital. The hospital administrator told us that this organization was formed because at that time the owners of Woodruff also owned another hospital and wanted to have the same management team manage both hospitals. However, even after the other hospital was sold in 1979, the owners continued to manage Woodruff through the related management company.

The management company's sole function was to manage Woodruff, Belvue Enterprises (the hospital's home office), and other related entities. Most of the company's revenue comes from Woodruff. The management company's three owners and Woodruff's associate administrator were the company's only employees in 1980. The management company, Woodruff, and Belvue Enterprises records showed that in 1980 these four individuals received a total of $449,835 in salary and benefits. Of this total, $180,896 was allocated to Woodruff on its Medicare cost report and $37,346 to Belvue Enterprises on its home office cost report.

Our preliminary review of the provider's management costs raised questions as to (1) how reasonable some of the costs were and (2) whether costs were properly distributed among the various related entities. Consequently, we asked the intermediary to review the appropriateness of costs claimed by the hospital.

The intermediary audited the hospital, including management costs allocated to the hospital and the other related entities. The transactions between the hospital and those entities made it difficult for the intermediary to accurately determine and allocate costs. However, using documentation we provided, the intermediary was able to determine and allocate substantially lower management costs than the hospital had claimed. The documentation we provided included analyses of the related entities and was considerably more extensive than data the intermediary had gathered in the previous year's audit.

To calculate the amount of allowable management costs, the intermediary had to determine and combine the various costs incurred by all three entities--the hospital, the home office, and the management company. Next it had to determine reasonable amounts of compensation allowable under the programs. Then it had to allocate the compensation to the various related organizations. The table in appendix IV shows the total amounts paid, the amount claimed on the provider's cost reports, and the amount allowed by the intermediary for fiscal year 1980. The three organizations as a group accounted for claimed costs of $218,242 on the hospital and home office cost report. As a result of its review, the intermediary adjusted the costs to $88,744, a decrease of about $130,000. These adjustments amounted to total Medicare and Medicaid savings of over $74,000 for 1980. The intermediary also reopened and adjusted the prior year's cost report, which should amount to another $10,000 savings to Medicare and Medicaid when the cost report is settled.

In summary, the transactions between the management company, the hospital, and the other related entities made the intermediary's audit of management costs much more difficult. Without benefit of the information provided by us, the intermediary might not have discovered the excessive costs.

PROVIDER'S FAILURE TO MAKE PRUDENT DEALS RESULTED IN EXCESSIVE CLAIMS

Woodruff Community Hospital's contract with a physician for utilization review services resulted in $24,000 in excess reimbursement claims to the Government programs during a 2-year period. These excess claims occurred because the provider's operating practices varied considerably from what Medicare regulations define as reasonable. By applying reasonable cost guidelines, the intermediary determined that the hospital paid more than reasonable amounts for utilization review services.

In 1978, the hospital engaged a physician to act as the chairman of its utilization review committee and perform utilization review functions. The hospital compensated the physician $2,600 per month, $2,000 paid directly to him and $600 to an automobile lessor for a Porsche. The intermediary became aware of the arrangement during its audit of the 1979 cost report but failed to question whether the fee was reasonable. However, we later questioned the reasonableness of the agreement, which was still effective in 1980 and 1981.

Because Woodruff did not have the necessary records to support the fees, the intermediary reviewed their reasonableness. Although the hospital estimated that the physician spent about 2 hours per day on utilization review functions, hospital personnel could not document the specific services or the number of cases he reviewed. Accordingly, the intermediary used HCFA guidelines to determine the allowable cost. The guidelines used include (1) an hourly rate for physician services, (2) a percentage of cases referred for utilization review, and (3) an estimate of the time it takes to review one case.

Based on the guidelines, the intermediary calculated the allowable fees for utilization review. For 1980, the allowable fees amounted to approximately $10,000, which was about $20,000 less than the provider claimed. The intermediary reopened the 1979 cost report and similarly computed allowable fees. For 1979, the reasonable fees amounted to approximately $9,000, which is about $17,000 less than the amount originally claimed and paid. The following table shows the estimated decrease in Medicare and Medicaid reimbursements:

Fiscal year	Amount claimed	Estimated allowable amount	Estimated unallowable costs	Estimated excessive cost allocated to Medicare	Estimated excessive cost allocated to Medicaid	Total
1980	$30,000	$ 9,950	$20,050	$10,573	$2,091	$12,664
1979	26,350	8,681	17,669	9,294	1,979	11,273
Total	$56,350	$18,631	$37,719	$19,867	$4,070	$23,937

RELATED ORGANIZATIONS CONTRIBUTED TO THE INTERMEDIARY'S OVERPAYING AND GIVING THE HOSPITAL AN INTEREST-FREE LOAN

For fiscal year 1980, the intermediary overpaid Woodruff Community Hospital about $500,000. An important cause of the overpayment was the hospital's involvement in complex financial transactions with its related organizations. Woodruff's operating costs include substantial amounts paid to related organizations; consequently, its costs as recorded in its accounting records exceeded allowable costs for Government reimbursement. Woodruff's intermediary did not correctly apply a formula designed to reduce gross costs to allowable costs under Medicare in determining the hospital's interim reimbursement rate for 1980. The interim rate used, which was based on the hospital's financial records, caused the overpayment.

To avoid requiring providers to wait until the end of their cost reporting year to receive payment, the Medicare program authorizes intermediaries to make interim payments to providers biweekly based on the estimated costs they incur in serving program beneficiaries. These interim payments normally equal a percentage of the hospital's billed charges based on the ratio of costs to charges in previous cost reporting years, but the payments may be revised quarterly if necessary.

In June 1980, the intermediary revised Woodruff's interim payment rate from 67 to 76 percent of charges based on information filed by the hospital. However, in computing the new rate, the intermediary did not adjust the provider's current costs to exclude substantial payments to related entities as reflected in the adjustments to the prior year's cost report. If the intermediary had adjusted the hospital's financial information to exclude unallowable related organization costs and ancillary service costs, it might have avoided overpaying the hospital.

Based on the new 76-percent interim rate, the intermediary paid the hospital a retroactive lump sum of $386,000 in July 1980. The payment was made to correct for presumed underpayments through April 1980. For later payments, the intermediary adjusted the rate to 77 percent to allow for inflation. As a result, the intermediary overpaid the hospital more than $500,000 for the year ended September 30, 1980. Upon reviewing the hospital's cost report, the intermediary determined the amount overpaid and requested repayment on November 3, 1980.

The intermediary allowed Woodruff Community Hospital to repay the $500,000 overpayment over an extended period because it concluded that the hospital could not repay the amount in a lump sum. The intermediary's decision deprived the Medicare trust

fund of over $41,000 in interest income[1] because it did not evaluate the financial condition of the hospital and its related organizations as one economic unit. Had the intermediary made such an analysis, it could have reasonably required the hospital to repay the overpayment in a lump sum.[2]

Medicare regulations require intermediaries to collect overpayments on a timely basis. The intermediary can use discretion in determining the most appropriate repayment method--lump sum payment, set-off, or extended repayment schedule. In this case, the intermediary granted the provider a 12-month repayment schedule on January 30, 1981.

The intermediary approved the repayment schedule based on the hospital's (1) financial statements for its fiscal year 1980, (2) financial statements for the 5 months ended November 30, 1980, and (3) actual or projected monthly cash flow for its fiscal years 1980 and 1981. The intermediary concluded that the provider was unable to repay the overpayment in a lump sum and, therefore, needed a repayment schedule. Otherwise, the intermediary concluded, it would have to place the provider on 100-percent claim deduction, which

> "* * * could have precipitated such actions as the provider going out of business, filing bankruptcy and therefore limiting the collectibility of the remaining overpayment balance, or forcing the provider to borrow the money and repay the overpayment on a lump sum basis at a going interest rate of approximately 19%."

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[1]Based on the average interest rate for 3-month Treasury bills for the October 1980-July 1981 period, we estimate that the Medicare Hospital Insurance Trust Fund lost over $41,000 in interest because the funds were retained by the hospital instead of being immediately returned to the trust fund. Woodruff Community Hospital still owed $156,514 of this amount on July 23, 1981. In addition, on September 23, 1981, as a result of additional work, the intermediary billed Woodruff an additional $302,915 due on the fiscal year 1980 cost report. On October 15, 1981, based on a tentative review, the intermediary billed Woodruff $62,836 on the fiscal year 1981 cost report. The intermediary granted Woodruff another extended repayment schedule--$33,250 per month for 11 months.

[2]Section 117 of the Tax Equity and Fiscal Responsibility Act of 1982 requires providers to pay interest on the amount of overpayment outstanding more than 30 days after a final determination of overpayment is made. This provision should help alleviate the "interest-free loan" problem in the future.

Another reason the intermediary decided to opt for the repayment schedule was its concern that the interest expenses the provider would incur to fund a lump-sum repayment would be partly reimbursed by Medicare. The intermediary further noted that the provider had been involved in an extended repayment arrangement before and had met the schedule in a timely manner.

We believe that the intermediary did not adequately analyze the hospital's ability to reimburse Medicare for the erroneous overpayment. The intermediary's chief mistake was treating the hospital as a single financial entity. In reality, Woodruff is only a part of a larger economic entity, and its financial condition should have been evaluated in that context. (See app. III for an organization chart of Woodruff Community Hospital and it affiliated organizations.)

To more realistically determine the provider's ability to repay Medicare, we believe the intermediary should have examined (1) the hospital's ability to collect amounts due it from related entities, (2) the cash payments to related entities, and (3) the combined financial capability of the related entities.[3]

On November 30, 1980, the hospital had about $346,000 in receivables from related parties. This amount included over $200,000 in demand notes from the owners and the Belvue Medical Clinic for loans made in July and October 1980. The intermediary could have reasonably required the hospital to collect on its demand notes to repay Medicare.

While the provider maintained that it could not repay Medicare, in 5 months it paid substantial amounts to related parties for rent, ancillary services, and management fees. These payments are summarized as follows:

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[3]If a provider requests a repayment schedule longer than 12 months, Medicare's Intermediary Manual requires the intermediary to do an analysis similar to the one listed here.

Rent expense for hospital building to officers and directors		$225,000
Rent expense for the medical records area to Woodruff Medical Center, Ltd.		50,500
Rent expense for equipment to Belvue Enterprises, Inc., the parent company		21,515
Laboratory, physical therapy, and electrocardiogram fees to Belvue Enterprises, Inc., and Belvue Medical Clinic		493,929
Management fees to Long Beach Medical Management		165,000
Directors' fees		1,500
Total expenses incurred in transactions with related parties		$957,444
Less: Increase in accrued expenses payable to parent company and related entities.		
Amount payable 11-30-80	$144,811	
Less: amount payable 6-30-80	66,522	78,289
Net cash payments to related organizations for the 5 months ended 11-30-80		$879,155

This information was disclosed in the notes to the financial statements submitted by the hospital in support of its request for an extended repayment schedule. Although not all of these amounts would have been available for repaying the overpayment, these data should have provided information about the hospital's ability to make timely repayments.

In determining whether to permit a repayment schedule to the hospital, the intermediary should have analyzed the financial condition of both the hospital and the related organizations as one economic unit. Such a determination should include an analysis of intercompany loans and transactions in order to insure that a need exists for an extended, interest-free, repayment schedule.

SUMMARY

The intermediary is adjusting Woodruff's cost reports to reflect our findings and recover or avoid excessive payments.

The recent change in law requiring payment of interest by providers on overpayments to them should help prevent the adverse impacts on the Government from situations like the "interest-free loan" resulting from the miscalculation of interim rates discussed above.

CHAPTER 4

SALE AND LEASEBACK BY A RELATED ORGANIZATION OF NONEXISTENT EQUIPMENT INFLATED MAD RIVER COMMUNITY HOSPITAL'S COSTS

A sale and leaseback of hospital equipment among organizations related to Mad River Community Hospital could be inflating the hospital's operating costs by more than $500,000 over an 8-year period. The sale and leaseback arrangement is a sham which creates income for a related organization at a cost to the hospital and its parent corporation. For the hospital's 1979 cost reporting year, the Government paid almost $29,000 in unallowable costs because the intermediary failed to disallow unsupported costs.

BACKGROUND

Mad River Community Hospital, a 78-bed acute care hospital, is fully owned and operated by the publicly owned American Hospital Management Corporation (AHMC). AHMC owns or controls several related organizations that are engaged in transactions affecting the hospital's operating costs. A chart showing AHMC's corporate structure, ownership interests, business activities, and transactions between related organizations is shown in appendix IV. In 1980, about 52 percent of Mad River Hospital's charges were for services to Medicare and Medicaid beneficiaries.

We selected this hospital because the intermediary had difficulties obtaining evidence to support an equipment lease transaction between the hospital, its parent corporation, and Medical Properties and Equipment Company (MPEC). MPEC, a partnership, is owned by another partnership, which is controlled by the president of AHMC. We did not review intercompany transactions between AHMC and Esperanza Intercommunity Hospital, another hospital owned by AHMC. In 1980, the intermediary reported to HCFA that Esperanza Hospital was not complying with Medicare regulations that require providers to provide only necessary, quality services and to properly document them. The intermediary recommended that HCFA terminate the hospital's Medicare certification. The Esperanza Hospital was subsequently closed and sold in April 1981.

WRITE-UP OF HOSPITAL EQUIPMENT-- A SHAM TO CREATE INCOME FOR RELATED ORGANIZATIONS

The sale and leaseback transactions between Mad River Community Hospital, its parent corporation, and MPEC created income for MPEC by increasing the hospital's overall operating costs. In 1979, the Government paid part of these additional costs.

In December 1975, upon closing its Fullerton Community Hospital, AHMC, the parent corporation, revalued equipment that had been leased to its Fullerton Hospital from $84,812 to $560,000. The write-up was accomplished by selling the equipment to MPEC and leasing it back, at a monthly rental of $9,100, for 8 years. Appendix V shows the original cost and book value of the equipment and a sample of the items included in the transaction.

In September 1976, AHMC and MPEC adjusted the sale and leaseback agreement to return equipment valued at $260,000 to AHMC. At that time, the monthly lease payment was reduced from $9,100 to $4,875. Simultaneously, AHMC obtained an option from MPEC to repurchase the remaining equipment valued at $300,000 with an original book value of $45,461 for the greater of fair market value or $150,000 at the end of the lease period.

However, no one--not the hospital, its independent auditors, or its parent company--has been able to document for us the equipment's existence. In 1977, the hospital capitalized this lease at the discounted value of $9,100 per month for 10 months and $4,875 per month for 86 months, or a total capitalized value on the hospital's books of $361,646. If the hospital abides by the lease arrangement, over the 8 years it would pay a total of $510,250[1] in rent for the equipment with an original book value of $45,461. The hospital could be incurring this substantial additional cost despite the fact that the intermediary has not been able to verify that the hospital acutally has and uses this equipment.

INTERMEDIARY FAILURE TO DISALLOW UNDOCUMENTED COSTS RESULTS IN INCREASED GOVERNMENT SPENDING

Medicare regulations authorize an intermediary to disallow payments for costs that are not supported by factual and verifiable records. This authority allows the intermediary to require providers to document costs. We believe the intermediary should have disallowed the undocumented costs claimed by the hospital.

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[1]Sum of 10 x $9,100 + 86 x $4,875 = $510,250.

Although no documentation was provided in support of the equipment transaction, or even in support of the equipment's existence, the intermediary did not disallow all unsubstantiated costs. For fiscal year 1978, it disallowed 80 percent of the unsupported claimed asset value and applicable return on equity. But for Mad River's 1979 cost report, the intermediary auditor did not disallow any costs or return on equity claimed for unsupported equipment costs. The auditor's explanation was that he left the equipment as allowable assuming that the provider would forward documents supporting its existence. The documentation never arrived, and the hospital's claim remained unadjusted.

Before the audit of the 1980 cost report, we pointed out to the intermediary that there was no evidence that the equipment was located and used at the hospital. As a result, the intermediary disallowed all costs and returns on equity applicable to the equipment for the 1980 cost report, about a $22,000 savings to the Medicare and Medicaid programs. In addition, the intermediary has reopened the 1979 cost report and again asked the provider for documentation to support the equipment's existence.

Another factor contributing to the overpayment was the intermediary's failure to recognize that equipment costs were treated inconsistently in fiscal years 1976 through 1978. Had the intermediary maintained a permanent audit file, this oversight might not have occurred.

The equipment sale and leaseback occurred during cost reporting year 1976 but was not recorded on the hospital books until cost reporting year 1977. The equipment costs and equity included in the hospital's books for fiscal year 1977 were properly adjusted by the provider.

However, the 1978 cost report was prepared by a different accountant, who incorrectly filed for Medicare reimbursement for the equipment, claiming full written-up asset cost less accumulated depreciation. The intermediary auditor, suspecting that at least part of the written-up value was not allowable, arbitrarily chose to reduce by about 80 percent the $361,646 in asset costs on which depreciation and return on equity were claimed. The auditor rationalized that if the cost was legitimate, the provider would appeal the 80-percent reduction and supply supporting documentation. However, the provider never appealed the reduction on the 1978 cost report.

On the 1979 cost report, the provider again included the full written-up asset cost, less accumulated depreciation. In

addition, the provider claimed depreciation expense and leases payable for the equipment. The intermediary allowed all of these items. If the intermediary had reviewed the previous year's audit adjustments and had realized that these costs were substantially disallowed previously and never appealed, a $29,000 overpayment might have been avoided.

Another factor contributing to the overreimbursement in 1979 was that, although required by regulations, the intermediary did not have a permanent audit file. The previously discussed overpayment could have been avoided if the intermediary had maintained and reviewed an adequate file.

INTERMEDIARY COMMENTS

The intermediary agreed with our finding that no one was able to verify the equipment's existence. On this basis, it agreed that all costs and return on equity on the leased equipment should be disallowed. The intermediary, however, believed the decision to allow the equipment in 1979 was reasonable at the time in light of the provider's promises to document the equipment's existence.

Although the intermediary was aware of the lack of documentation and had requested data in support of the equipment transaction for 2 years, it nevertheless closed the cost reports for those years without receiving documentation.

CHAPTER 5

BROOKWOOD HOSPITAL'S FAILURE TO DISCLOSE DEALINGS WITH RELATED ORGANIZATIONS

INFLATED MEDICARE COSTS

Brookwood Hospital claimed reimbursement for excessive management fees paid to an affiliated management company and for equipment rent expense which exceeded the cost of a related equipment leasing entity. The fact that the hospital did not disclose its related organizations' transactions may have contributed to the intermediary's failure to evaluate and adjust Brookwood's non-arm's-length transactions. We estimate that Medicare overreimbursed Brookwood more than $150,000 for cost reporting years 1978-80. If we had not brought the related organizations to the intermediary's attention, the intermediary would probably not have evaluated the management agreement and consequently might have overpaid the hospital another $93,000 for fiscal year 1981.

BACKGROUND

Brookwood Hospital in Santa Rosa, California, is a 61-bed facility emphasizing rehabilitation services. The hospital is operated by the Brookwood Hospital Management Corporation, a California for-profit corporation owned by a small group of shareholders who invested a total of $125,000--$31,250 in equity capital plus $93,750 in promissory notes--in 1976. The promissory notes were paid off with interest in less than 4 years. Brookwood Hospital Management Corporation was organized to take over the operation of Brookwood Hospital. The corporation agreed to pay A. E. Brim and Associates, at that time a commonly owned and controlled hospital management firm, and the owners of the hospital building 5 percent of gross revenue as a management fee and as rent, respectively. Hospital officials maintain that the rate and resulting amounts were comparable to the amounts paid by the hospital's previous operator.[1] In fiscal year 1977 the hospital paid A. E. Brim and Associates close to $100,000; by 1981 the annual management fee rose to over $181,000.

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[1]Brookwood Hospital claimed $69,000 for management and accounting fees in its cost report for the fiscal year ended June 30, 1976, the last fiscal year it was operated by its previous owner, Pacific Medical Center, Inc. Until 1976, Pacific held the operating license and actually owned the hospital operation. With the formation of Brookwood Hospital Management Corporation, Pacific's role was divided between the corporation and A. E. Brim and Associates.

Brookwood Hospital also has a number of equipment leases with Plaza Leasing, another commonly owned and controlled organization. Appendix VI shows the hospital's relationships and transactions with several other entities.

We selected Brookwood Hospital for review because (1) it had a low investment in long-term assets, indicating that it leased its facilities, (2) its owners also had ownership interest in other hospitals, (3) a substantial portion of its business was with the Medicare and Medicaid programs, and (4) it was a small hospital that would not require extensive audit effort.

BROOKWOOD HOSPITAL FAILED TO DISCLOSE ITS RELATED ORGANIZATIONS AND ADJUST ITS REIMBURSEMENT CLAIMS

Medicare regulations require providers to disclose transactions with related organizations and, where appropriate, reduce costs claimed for reimbursement to the costs of the related firms. Contrary to program regulations, Brookwood Hospital did not disclose its management agreement with A. E. Brim and Associates in its 1978 and later cost reports. Brookwood also failed to disclose its lease transactions with Plaza Leasing.

MEDICARE REIMBURSED BROOKWOOD HOSPITAL FOR EXCESSIVE MANAGEMENT FEES PAID TO A RELATED ENTITY

On July 1, 1976, the newly organized Brookwood Hospital Management Corporation signed a management agreement with Brim. The Medicare intermediary considered the relationship between the hospital and the management company during its review of the hospital's fiscal year 1977 cost report. While the intermediary found that the hospital was related to Brim through common ownership and control, Brim presented documentation which satisfied the intermediary that Brim met the exception to the related organizations principle outlined on page 3 of this report. Based on this determination, the intermediary concluded that the hospital's $99,812 management fee paid to Brim was allowable. Medicaid also allowed the management fee for cost reporting year 1977.

In filing later cost reports, the hospital did not disclose its relationship with the management company or adjust its costs. In fact, in these cost reports, Brookwood indicated that it had not incurred any costs with related organizations. For example, in 1978 the hospital checked "no" in response to the question in its cost report to the intermediary of whether it

had incurred any costs with related firms. We believe Medicare regulations required Brookwood to disclose Brim as a related organization annually. To qualify as unrelated under the exception to the related organization principle, the provider is required to demonstrate by convincing evidence to the intermediary's satisfaction that it meets the four conditions. For 1978 and later cost reporting years, Brookwood did not demonstrate that it met the conditions. The fact that the hospital did not disclose the transactions with Brim may have been one reason why the Medicare intermediary did not reevaluate the management fee. Unlike Medicare, Medicaid again evaluated the management fee for cost reporting year 1978 and decreased it by about $40,000.

Brookwood paid higher management fees than other similar hospitals

After deeming Brim as exempt from the related organization principle for cost reporting year 1977, the Medicare intermediary did not reevaluate Brookwood's management agreement and relationship with Brim for later years. If the intermediary had evaluated the arrangement correctly in the first place, it would have found that Brookwood and Brim are related organizations because the management company failed to satisfy the exception to the related organization principle. Brim does not satisfy the exception because the fees it charged to Brookwood exceeded fees it charged to similar, unrelated hospitals. We believe Brookwood's fees were excessive because (1) the agreement is not comparable to Brim's other management agreements, (2) Brim realized large profits on the contract, and (3) the resulting hourly consulting rate paid by Brookwood is excessive.

Brim provides health care management and consulting services to more than 35 health care facilities, but its agreement with Brookwood is not comparable to its other management contracts. Brim charges Brookwood a higher fee--that is, a higher percentage of gross revenue--than it charges other facilities. Further, Brim does not pay the salary and fringe benefit costs for Brookwood's administrator as it does for other managed hospitals. The higher fees, combined with Brim's lower costs because the hospital pays for its own administrator, result in Brim's realizing an extremely high gross profit margin on the Brookwood contract. In calendar years 1978-81, Brim realized an average of more than 86 percent gross profit (revenue less direct identified and allocated costs) from Brookwood, while its average gross profit margin on all its businesses was 45 percent.

For the 4 cost reporting years 1978-81, Brookwood Hospital paid Brim about $584,000. During the same period, Brim recorded that it provided 4,845 hours of service to the hospital. In effect, Brim charged the hospital over $120 per hour ($584,000/ 4,845) for all hours recorded, including secretarial services. In 1982, during the time of our audit, Brim's fee schedule indicated it was charging clients $50 to $60 per hour for the services of experienced consultants and substantially less for inexperienced and secretarial personnel. While we recognize that Brim's responsibilities under management contracts may be greater than under consulting agreements, we question whether that difference warrants a variance of such magnitude in hourly fee rates.

Non-arm's-length management arrangement cost Medicare almost $250,000

Brookwood's management fee to Brim, which amounts to 5 percent of gross revenue, is substantial. The following table shows the management fees paid by Brookwood and the amounts allowed by Medicare and Medicaid for cost reports that had been submitted at the time of our audit.

Cost reporting year	Management fee paid to Brim	Fee allowed by Medicare	Fee allowed by Medicaid
1977	$ 99,812	$ 99,812	$99,812
1978	118,097	118,097	78,563
1979	126,425	126,425	Open
1980	157,858	157,858	Open
1981	181,539	Open	Open

Because the hospital and its management company are related organizations and because, in our opinion, Brim does not meet the criteria for an exception cited on page 3, we believe the hospital's management fee should be limited to Brim's cost. We estimate that Brookwood claimed over $400,000 excess costs in 1978 through 1981 as follows:

Calendar year (note a)	Fee paid and claimed	Estimated cost of Brim	Excess cost claimed
1978	$120,230	$ 39,036	$ 81,194
1979	134,368	46,774	87,594
1980	169,134	57,788	111,346
1981	181,698	37,735	143,963
Total	$605,430	$181,333	$424,097

a/Based on calendar year rather than the hospital's September 1-August 31 cost reporting year because Brim's records are kept on calendar year. The amount of fees paid and claimed by the hospital for cost reporting years 1978-81 is $583,919.

Since the intermediary reimbursed Brookwood an average of about 55 percent of its costs for the 3 cost reporting years 1978-80, we estimate that Medicare overpaid the hospital $154,000 ($280,134 X 55 percent) for 3 years. The intermediary probably would not have evaluated the management fee and might have overpaid Brookwood another $93,000 ($143,963 X 65 percent) if we had not audited the hospital and presented our findings to the intermediary before the 1981 cost report was settled.

BROOKWOOD HOSPITAL FAILED TO DISCLOSE AND ADJUST ITS COSTS FOR LEASE PAYMENTS TO A RELATED ENTITY

Brookwood Hospital's equipment lease transactions with Plaza Leasing, a related firm, resulted in an over $33,000 cost overstatement for 1976-81. Because the hospital failed to disclose and adjust costs incurred in transactions with Plaza Leasing, the intermediary did not evaluate the hospital's lease payments to Plaza. As a result, the Government programs reimbursed Brookwood based on its total lease expenses rather than Plaza's lower costs of ownership.

Plaza Leasing is related to Brookwood Hospital through common ownership and control. The leasing entity's four equal partners own over 50 percent of Brookwood's stock and are officers of the hospital. Furthermore, through 1980, three partners also owned about 85 percent of Brim, the management company that manages Brookwood (see app. VIII). These individuals continue, in our opinion, to have control over the management company because they are the senior officers of it.

Plaza Leasing was organized to provide equipment financing for Brim-managed hospitals.[2] Between 1976 and 1981 Brookwood Hospital paid Plaza about $108,000 for equipment rent. Since the bulk of Plaza's leases are with Brookwood and other commonly owned and controlled firms, Plaza does not qualify for the exception to the related organization principle outlined on page 3.

Because Plaza Leasing was not disclosed as a related organization on Brookwood's annual Medicare cost reports, neither the Medicare intermediary nor Medicaid evaluated Brookwood's payments to Plaza.

We determined the costs of ownership from Plaza Leasing records and estimate that Brookwood Hospital claimed about $33,000 in excess equipment rental costs between 1976 and 1981. While a portion of the Government overpayments would have been offset by a return on equity due the provider, the Government nevertheless reimbursed Brookwood based on excessive costs claimed on the cost reports. Since Brookwood serves a high proportion of Medicare and Medicaid patients, these excessive costs were borne mostly by the Government.

INTERMEDIARY CORRECTIVE ACTION

The Medicare intermediary agreed with our conclusion that A. E. Brim and Associates is related to Brookwood Hospital and does not satisfy the exceptions to the related organization principle. The intermediary has referred the hospital for investigation to the regional office of HCFA's Division of Quality Control for nondisclosure of related organizations. Meanwhile, the intermediary has reopened the hospital's cost reports for fiscal years 1977-80 and plans to make adjustments for management fees paid to Brim and lease payments to Plaza Leasing but is awaiting the results of the Division of Quality Control investigation.

The California Department of Health Services, Audits Section, also used our findings to decrease Brookwood's claimed costs for fiscal years 1979 and 1980.

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[2]The company leases only to for-profit hospitals so that its partners can take advantage of the investment tax credit.

CHAPTER 6

ESKATON CORPORATION'S CASH MANAGEMENT POLICIES COULD INCREASE MEDICARE AND MEDICAID COSTS AND SUBSIDIZE NONPATIENT CARE ACTIVITIES

Eskaton Corporation, a nonprofit corporation, pools the excess cash of its related entities and uses this money to help cover cash deficiencies in other related entities, including ones not involved in patient care. This practice could increase Medicare and Medicaid costs, especially to the extent that excess cash from the entities serving Medicare and Medicaid beneficiaries is used to subsidize entities not involved in the programs. Also, Eskaton had large amounts outstanding from a for-profit related organization at an effective interest rate of about 4 percent while it was borrowing funds at about 20 percent.

BACKGROUND

Eskaton was organized as a nonprofit corporation in 1967 to own and operate the American River Hospital, now a 250-bed acute care hospital in Carmichael, California. Since that time the corporation has grown, and it now owns and operates four acute care hospitals, a skilled nursing facility, a visiting nurses association operating in seven counties, and two extended care housing facilities for the elderly. In addition, Eskaton owns a separate for-profit corporation, Western Hospital Equipment and Supply Company (Western), which provides various medical or medically related supplies and services primarily to Eskaton facilities but also to other providers and the public. Eskaton also provides management and consulting services to other unrelated facilities. Eskaton Administrative Center, the home office, manages and performs accounting and data processing services for all the businesses. The financial results of these activities, including Western, are consolidated into one set of financial statements. Operating funds received by the facilities, except for Western operations, are deposited in a common bank account, which all the businesses draw on.

In addition to the above medical services and housing activities, Eskaton sponsors several other separate but commonly controlled nonprofit corporations that own and operate housing facilities for the elderly. Appendix VII is a diagram of Eskaton and its activities.

In total, Eskaton has 1,900 employees in various locations in northern California. It provides health care services to Medicare and Medicaid beneficiaries as follows:

Medicare/Medicaid Revenue in 1980

Provider	Amount	Percent of total revenue
Eskaton American River Hospital	$16,669,572	52
Eskaton Colusa Hospital	2,741,010	63
Eskaton Monterey Hospital (note a)	3,867,666	58
Mount Shasta Community Hospital	1,760,466	48
Eskaton Manzanita Manor	815,919	50
Visiting Nurses Association, Sacramento	(b)	
Visiting Nurses Association, Mt. Shasta	(b)	

a/Eskaton was selling its Monterey Hospital effective October 1, 1982, and also planned to sell Colusa Hospital because, according to Eskaton, they required a constant infusion of operating cash. The corporation is in the process of purchasing Lassen Memorial Hospital in rural northern California.

b/Became part of Eskaton in 1981.

We selected the Eskaton American River Hospital for review because (1) we wanted to include a nonprofit hospital, (2) the hospital has substantial Medicare and Medicaid participation, and (3) none of the Eskaton hospitals had been subject recently to extensive audits.

CLOSELY AFFILIATED HOSPITALS SUBSIDIZE EACH OTHER AND FINANCE EXPANSION INTO NONPATIENT CARE ACTIVITIES

Eskaton Corporation uses funds generated by some of its hospitals, especially Eskaton American River Hospital, to subsidize its other facilities and finance expansion into nonpatient care businesses. The Government's health program costs increase when excess operating funds from one hospital are diverted to other hospitals or to finance nonpatient care activities rather than allowing each hospital to earn interest income that would be offset against interest expense on the facility cost report.

Medicare regulations provide that necessary interest expense related to providing patient care is an allowable, reimbursable cost. However, regulations require that interest expense be reduced by investment income, including interest earned on excess operating funds.

Eskaton pools operating cash generated by all its facilities into one bank account, and all facilities draw on the common account. The corporation has a line-of-credit arrangement with its bank, whereby it borrows additional operating funds as needed to cover disbursements using facility accounts receivable as collateral. Interest costs on the line of credit are distributed to the various facilities based on their cash deficit balance.

While this cash management system works to Eskaton's advantage because it limits borrowing to the minimum total amount required to fund the operations of all the facilities, it provides the greatest benefit to facilities that need to borrow and works to the disadvantage of facilities generating more cash than they need for their own operations. Eskaton American River Hospital, for example, usually has a positive cash balance which is used to fund overall operations, thereby decreasing the interest paid by Eskaton facilities that use the funds. This practice precludes American River from earning interest on its cash balance, which would serve to decrease its interest expense claimed on its cost report. In 1980, the hospital reported over $1 million in interest costs in its cost report. Since over half of American River's services are to Medicare and Medicaid patients, the Government paid more than half of the interest costs. If American River had earned interest income on its excess operating funds, the Government reimbursement would have been decreased accordingly.

We recognize that, if Eskaton did not use American River's funds to subsidize its other hospitals, the other hospitals would incur additional interest costs that are also partly paid by the Government. However, American River's excess cash can be and has been used under Eskaton's system to subsidize nonpatient care activities. In our opinion, Eskaton's cash concentration practice results in commingling facility operations and in losing accountability for each facility. Thus, it is difficult to ensure that an appropriate amount of interest expense is considered allowable for an individual hospital or all of Eskaton's patient care activities in total.

Besides using cash generated by some hospitals to subsidize others, Eskaton uses hospital-generated cash to invest and expand into nonpatient care businesses through its wholly owned for-profit subsidiary, Western Hospital Equipment and Supply Company.

Eskaton Corporation's officers formed Western Hospital Equipment and Supply Company in 1974. The parent corporation invested $10,000, purchasing all of Western's outstanding stock. Eskaton officials said that Western was formed to be

able to do business with unrelated parties without jeopardizing Eskaton's tax-exempt status. In 1981 Eskaton invested an additional $500,000 in equity capital in Western to provide Western with capital to construct a medical office building adjacent to Eskaton American River Hospital.

Western's early function was to act as purchasing agent for Eskaton facilities, but its functions have expanded as the corporation has grown. In 1980, Western had almost $1.9 million in total sales, including about $1.6 million to Eskaton facilities for equipment, supplies, printing, and pulmonary services sales. The remainder, about $300,000, was revenue for pulmonary services to unrelated hospitals and rental income on office buildings and medical equipment. (App. IX shows the components of Western's net profit.)

Western Hospital Equipment and Supply Company receives substantial financing from the parent corporation. This financing has allowed Western to acquire properties and expand its operations. In addition to equity funding, the parent corporation provides substantial continuous debt financing. At the end of 1980, with less than $50,000 in equity and retained earnings, Western had a $600,000 investment in fixed assets, including two medical office buildings. At the end of 1981, with $585,000 equity, Western had close to $2 million invested in property, plant, and equipment. Western is able to invest in properties and expand partially because of the continuous financing from the parent corporation. The following table shows the amounts Western owed the parent corporation for the past 3 years.

Year ended	Due Eskaton Corporation
12-31-79	$350,581
12-31-80	458,360
12-31-81	388,219

During 1980 Western reimbursed Eskaton $16,821 in interest, an effective rate of about 4 percent, while Eskaton paid about 20 percent to the bank on the amounts it borrowed on its credit line for working capital. Appendix VIII shows that Western, along with several other facilities, has consistently operated with deficit working capital balances, which are covered primarily by Eskaton American River and Mount Shasta Hospitals. As noted, Eskaton is expanding and realizing gains that are partly generated by program funds, but the Government does not share in these gains.

RELATED ORGANIZATIONS MAKE DETERMINING THE GOVERNMENT'S REIMBURSABLE COSTS DIFFICULT

Commingling various business activities requires Eskaton to use various discretionary methods in reporting the non-arm's-length transactions and costs on the cost reports and in allocating patient care costs from cost pools. We believe such an arrangement gives providers excessive discretion in reporting their costs and reduces the intermediaries' ability to determine allowable costs.

Before our audit, Eskaton and the intermediary had adopted a method of reporting Western's transactions with the Eskaton hospitals that did not provide adequate disclosure on the cost reports. Eskaton had adopted a method whereby it reduced the home office costs by Western's net profit when Western realized a profit.[1] No adjustments were made when Western had a loss. The intermediary accepted this method.

Upon examining Western's activities closely, we found that the above method, although relatively easy to implement, did not result in a correct statement of each facility's costs. Offsetting Western's net profit against home office costs does not result in the appropriate costs being assigned to each facility. Western's net profit results from several business activities, some patient ancillary services, and some nonpatient business with both related and unrelated entities. Accordingly, the net result of each business activity and the respective adjustments on the various cost reports depend on how Western's general administrative and marketing costs are distributed. (See app. IX.)

Western sells goods and services to Eskaton facilities and the home office; consequently, its operations affect several facilities. The intermediary used Western's operating results as summarized by us in appendix IX to adjust Eskaton's 1981 cost reports. To reduce each hospital's cost to Western's costs, it was necessary to estimate each hospital's purchases from Western and to make assumptions in apportioning Western's costs. While the non-arm's-length transactions and inadequate reporting to date had not resulted in overall Government overpayments to

---

[1]Eskaton first adopted this method on its 1977 home office cost report. It neglected to adjust the 1978 cost report, but the intermediary made the adjustment. No adjustment was made in 1979 as Western incurred a loss. Eskaton again neglected to adjust the 1980 cost report, but the intermediary adjusted the various cost reports based on our findings.

Eskaton, the provider and the intermediary had adopted an inadequate reporting practice which resulted in a misstatement of individual facility costs. The established practice would have resulted in some facilities being overreimbursed and others being underreimbursed. We are concerned that under such circumstances the Government's correct reimbursable costs are concealed and overpayments could result.

PROVIDER AND INTERMEDIARY COMMENTS

Eskaton Corporation officials agreed that some hospitals, primarily American River, contribute to operating cash requirements of other facilities and Western Hospital Equipment and Supply Company. In principle, they agreed that interest income should be calculated and credited to hospitals that provide operating cash. However, because they view Eskaton Corporation as one financial entity, rather than each hospital, each residential facility, Western, and the other entities separately, they believe their cash management procedures are acceptable. They believe that any disadvantage to specific facilities are balanced by the advantages to others.

The Medicare intermediary also finds Eskaton's cash concentration practice acceptable because regulations do not prohibit such methods and because separating each facility is not practical. However, they agreed to evaluate the impact on each hospital in future audits.

Both Eskaton and the intermediary agreed with our conclusion that commingling direct patient care activities with nonpatient care business reduces the intermediary's ability to determine allowable patient care costs. Based on our findings, the provider and the intermediary agreed on a reporting method that they said will provide full, detailed disclosure of non-arm's-length transactions with Western.

CHAPTER 7

CONCLUSIONS

The Government pays some hospitals excessive amounts for the health care of Medicare and Medicaid beneficiaries. The cost reimbursement system is designed to limit Government payments to hospitals to the reasonable cost of serving program beneficiaries. However, hospitals that are closely affiliated with related organizations can attempt, through various means, to circumvent reimbursement limitations.

In the hospitals reviewed, we found examples of:

--Hospitals that used related organizations to inflate costs.

--Hospitals that failed to disclose their related organizations and properly report transactions with them.

--Intermediaries that failed to adequately analyze transactions between related organizations and compute the correct amount payable by the Government.

--Hospitals whose costs were so intermingled with other entities that the Government reimbursement had to be based on relatively arbitrary allocation of costs among the various entities.

We believe that non-arm's-length transactions between hospitals and closely related organizations increase Government costs for Medicare and Medicaid and make it difficult to identify allowable costs that should be paid by the Government. Non-arm's-length transactions also hamper the intermediaries' audits because they make it necessary for intermediaries to audit entities other than the hospital in order to segregate allowable patient care costs. Moreover, the widely varying nature of these organizations' interrelationships obliges auditors sometimes to make arbitrary decisions in auditing them.

Intermediaries frequently fail to scrutinize non-arm's-length transactions because they are not aware of them when hospitals do not report them properly. Additionally, since intermediaries generally direct their efforts toward hospital costs that appear aberrantly high, they do not necessarily analyze costs incurred in non-arm's-length transactions. Consequently, there is no assurance that the Government makes appropriate payments to hospitals involved in such transactions.

Each hospital in our review had a unique organizational structure. To uncover and analyze the related transactions, we invested considerable time and enlisted much assistance and cooperation from the intermediaries, the providers, and several Government agencies. Without similar emphasis on related organizations and non-arm's-length transactions, intermediaries are unlikely to identify the impact of such transactions on the Medicare and Medicaid programs and may overpay hospitals that are part of complex, multiple organizations.

The intermediaries responsible for the hospitals reviewed agreed with our findings and are acting to recover the overpayments.

This report addresses only related organization transactions in hospitals; however, other types of providers--nursing homes, home health agencies, renal dialysis facilities, cost-basis paid health maintenance organizations, and others--can be involved in such transactions. Because of the complexity of the issues surrounding the related organization reimbursement principle and its application, we are studying the principle as it relates to all types of providers. We intend to make recommendations in a report on that study addressing the overall related organization issue.

APPENDIX I

NORTH LAS VEGAS HOSPITAL

HUNTINGTON HEALTH SERVICES, INC., AFFILIATES AND ACTIVITIES

DIVISIONS AND ORGANIZATIONS	BUSINESS FUNCTIONS (note a)
PARENT COMPANY	
1. Huntington Health Services, Inc. 10100 Santa Monica Boulevard Los Angeles, California	Publicly owned company listed on the American Stock Exchange. Owns and manages all the subsidiaries. Advances to subsidiaries - $4,938,811. Advances from subsidiaries - $1,659,884.
ACUTE CARE	
2. Community Hospital of Huntington Park, Inc. Huntington Park, California	99-bed hospital, 37 percent occupied in 1980. Leases the real estate from a corporation and a partnership each partly owned by three hospital directors who also own a small interest in the parent company. Advances to Huntington - $217,593.
3. Mission Hospital of Huntington Park, Inc. Huntington Park, California	128-bed hospital, 28 percent occupied in 1980. Sub-leases real estate from a partnership partly owned by six hospital directors who also own a small interest in the parent company. Parent company owns option to purchase real estate. Advances from Huntington - $5,871.
4. North Las Vegas Hospital, Inc. North Las Vegas, Nevada	99-bed hospital, 77 percent occupied in 1980. Leases real estate from Nevada Medical Properties, Inc. Advances to Huntington - $137,448.
5. Inter Se Corporation, dba Pasadena General Hospital Pasadena, Texas	158-bed hospital, 65 percent occupied in 1980. Leases the real estate. Advances from Huntington - $1,306,723.
LONG-TERM CARE Skilled nursing facilities	
6. Grevillea Convalescent Center Corporation, dba Hawthorne Convalescent Center Hawthorne, California	88-bed facility, 98 percent occupied in 1980. Leases real estate from a partnership partly owned by the parent company president. Advances to Huntington - $327,269.

APPENDIX I

DIVISIONS AND ORGANIZATIONS	BUSINESS FUNCTIONS (note a)
7. Huntington Park Convalescent Center Corporation, dba Huntington Park Convalescent Center Huntington Park, California	99-bed facility, 98 percent occupied in 1980. Owns own real estate. Advances from Huntington - $207,680.
8. Park Imperial Lodge Corporation, dba Park Imperial Lodge Hawthorne, California	59-bed facility, 98 percent occupied in 1980. Leases real estate from a partnership partly owned by the parent company president. Advances from Huntington - $52,218.
9. Southwest Health Center Corporation, dba Southwest Convalescent Center Hawthorne, California	99-bed facility, 92 percent occupied in 1980. Owns own real estate. Advances from Huntington - $305,394.
Intermediate care for the developmentally disabled	
10. Seaside Extended Care Center, dba Seaside Child Care Center Long Beach, California	99-bed facility, 98 percent occupied in 1980. Leases the real estate. Advances to Huntington - $243,003.
11. West Coast Pharmaceuticals, dba South Bay Child Care Center Hawthorne, California	90-bed facility, 96 percent occupied in 1980. Owns own real estate. Advances to Huntington - $729,571.
12. Gruter Foundation, Inc. Wooster, Ohio	190-bed facility, 100 percent occupied in 1980. Owns own real estate. Advances from Huntington - $27,022.
Retirement hotels	
13. Hawthorne Manor Corporation, dba Hawthorne Manor Hawthorne, California	65 rooms, 83 percent occupied in 1980. Owns own real estate.
AND	
Inglewood Manor Inglewood, California	87 rooms, 84 percent occupied in 1980. Leases the real estate. Advances from Huntington - $346,643.
14. San Fernando Care, Inc., dba Vista Retirement Hotel Vista, California	91 rooms, new facility. Owns own real estate.
AND	
Torrance Manor Torrance, California (Under construction as of December 1980)	98 rooms, new facility. Leases the real estate. Advances from Huntington - $720,764.

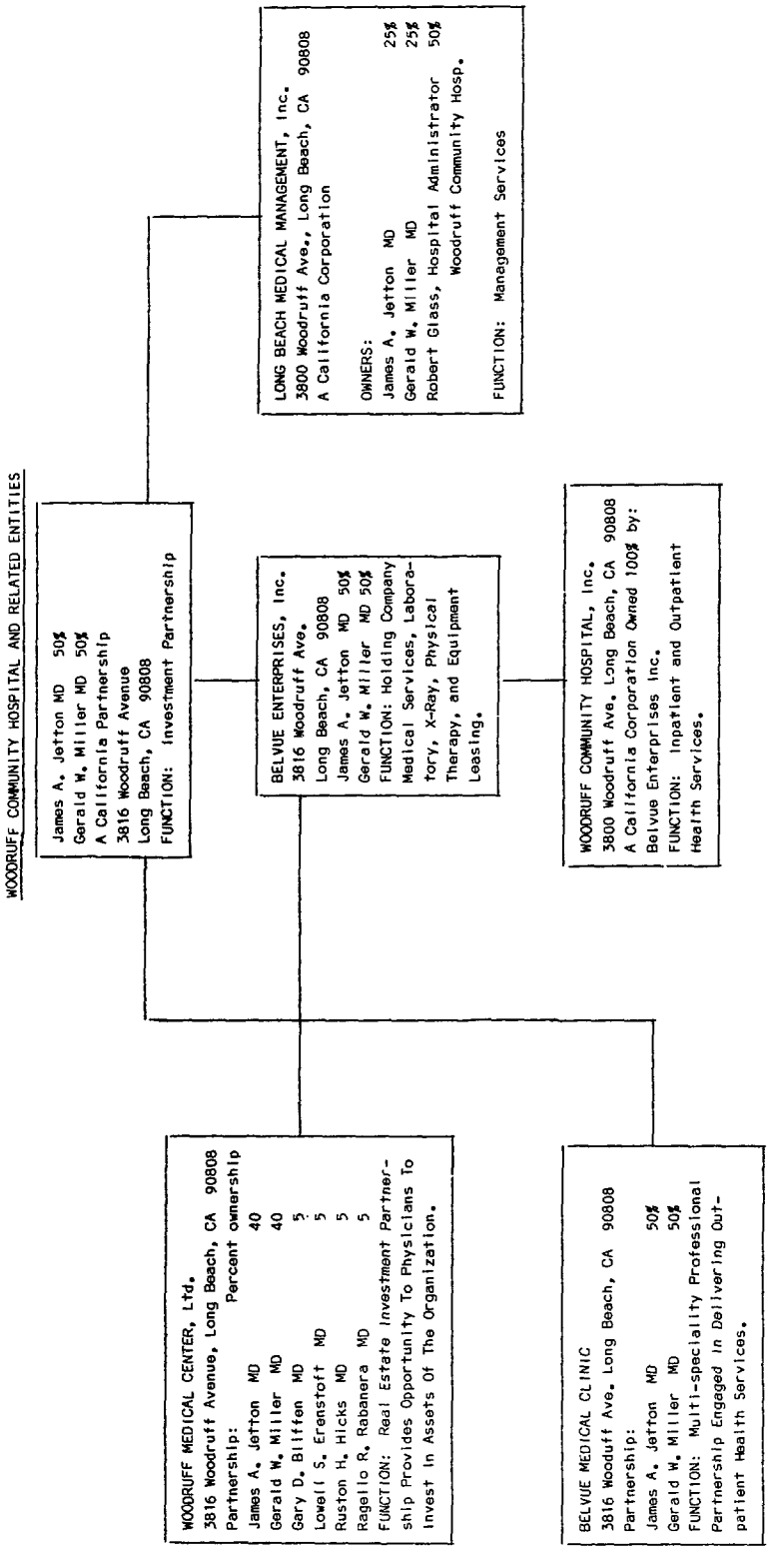
APPENDIX I

DIVISIONS AND ORGANIZATIONS	BUSINESS FUNCTIONS (note a)
OTHER BUSINESSES	
15. North Las Vegas Hospital Pharmacy, Inc., dba North Las Vegas Hospital Pharmacy Corporation North Las Vegas, Nevada	Pharmacy and supplies sales primarily to North Las Vegas Hospital. Leases real estate from Nevada Medical Properties, Inc. (note b)
16. Huntington Medical Systems, Inc. Los Angeles, California	Treatment programs for the developmentally disabled facilities. Physical therapy contracting and counseling, and temporary nursing services. Advances from Huntington - $14,916.
17. Medical Rehabilitation Services, Inc. Los Angeles, California	Respiratory, speech, physical, and occupational therapy under contract to affiliates and unrelated providers. Advances from Huntington - $114,601.
18. Nevada Medical Properties, Inc. North Las Vegas, Nevada	Owns the North Las Vegas Hospital building and medical office building. Leases to affiliates and others. Advances from Huntington - $868,141.
19. Med-Center Developments, Inc. Los Angeles, California	Owns a medical office building. Advances from Huntington - $356,358.
20. Pacific West Coast Labs, Inc., dba Pacific West Coast Construction Los Angeles, California	Originally intended to acquire and operate laboratories. Used as a construction company to build Torrance Manor. Advance from Huntington - $612,480.
21. South Bay Health Center, Inc. Los Angeles, California	Advances to Huntington - $5,000.

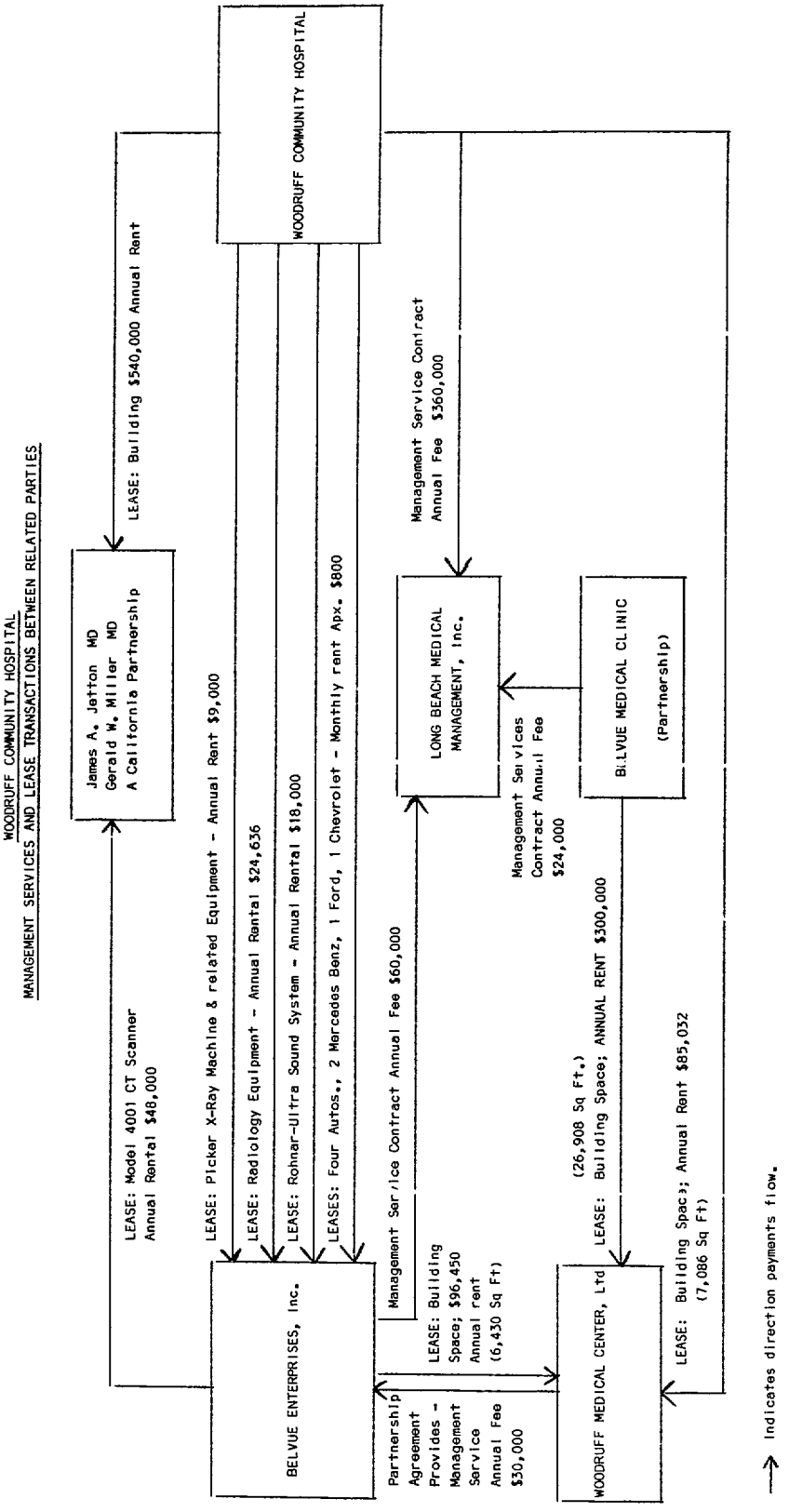
a/Advances to and from subsidiaries are as of August 31, 1979.

b/Not included on schedule provided by Huntington Health Services, Inc.; however, North Las Vegas Hospital Pharmacy Corporation balance sheet as of August 31, 1979, shows $5,000 capital stock plus $691,650 retained earnings. In addition, the pharmacy has loan receivables outstanding of $181,954 from Huntington Health Services, Inc., and $379,700 from North Las Vegas Hospital, Inc.

APPENDIX II

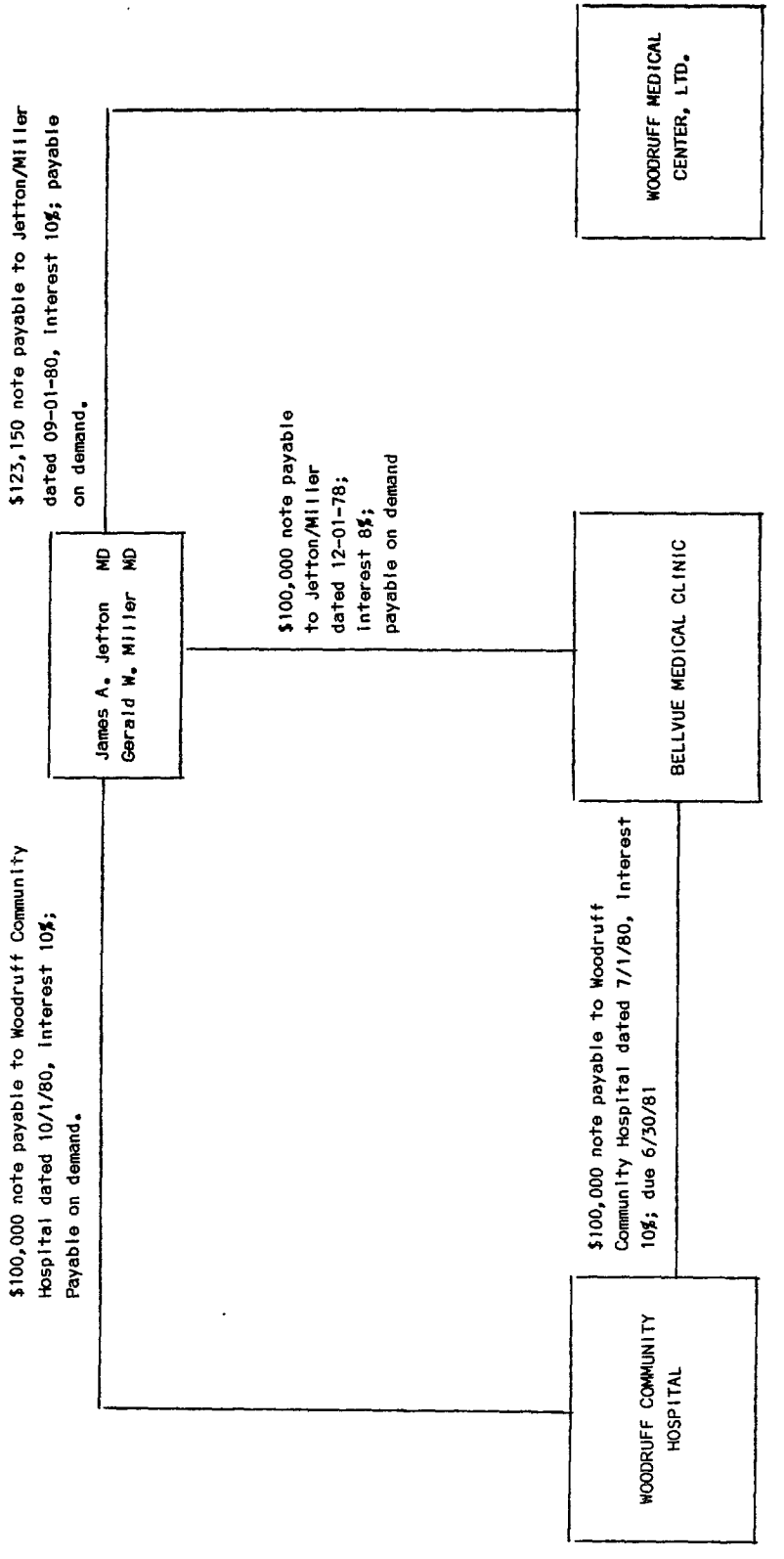

WOODRUFF COMMUNITY HOSPITAL AND RELATED ENTITIES
James A. Jetton MD 50%
Gerald W. Miller MD 50%
A California Partnership
3816 Woodruff Avenue
Long Beach, CA 90808
FUNCTION: Investment Partnership
LONG BEACH MEDICAL MANAGEMENT, Inc.
3800 Woodruff Ave., Long Beach, CA 90808
A California Corporation
OWNERS:
James A. Jetton MD 25%
Gerald W. Miller MD 25%
Robert Glass, Hospital Administrator 50%
Woodruff Community Hosp.
FUNCTION: Management Services
BELVUE ENTERPRISES, Inc.
3816 Woodruff Ave.
Long Beach, CA 90808
James A. Jetton MD 50%
Gerald W. Miller MD 50%
FUNCTION: Holding Company
Medical Services, Laboratory, X-Ray, Physical Therapy, and Equipment Leasing.
WOODRUFF COMMUNITY HOSPITAL, Inc.
3800 Woodruff Ave. Long Beach, CA 90808
A California Corporation Owned 100% by:
Belvue Enterprises Inc.
FUNCTION: Inpatient and Outpatient Health Services.
WOODRUFF MEDICAL CENTER, Ltd.
3816 Woodruff Avenue, Long Beach, CA 90808
Partnership: Percent ownership
James A. Jetton MD 40
Gerald W. Miller MD 40
Gary D. Bliffen MD 5
Lowell S. Erenstoft MD 5
Ruston H. Hicks MD 5
Ragello R. Rabanera MD 5
FUNCTION: Real Estate Investment Partnership Provides Opportunity To Physicians To Invest In Assets Of The Organization.
BELVUE MEDICAL CLINIC
3816 Woodruff Ave. Long Beach, CA 90808
Partnership:
James A. Jetton MD 50%
Gerald W. Miller MD 50%
FUNCTION: Multi-specialty Professional Partnership Engaged in Delivering Outpatient Health Services.

APPENDIX II

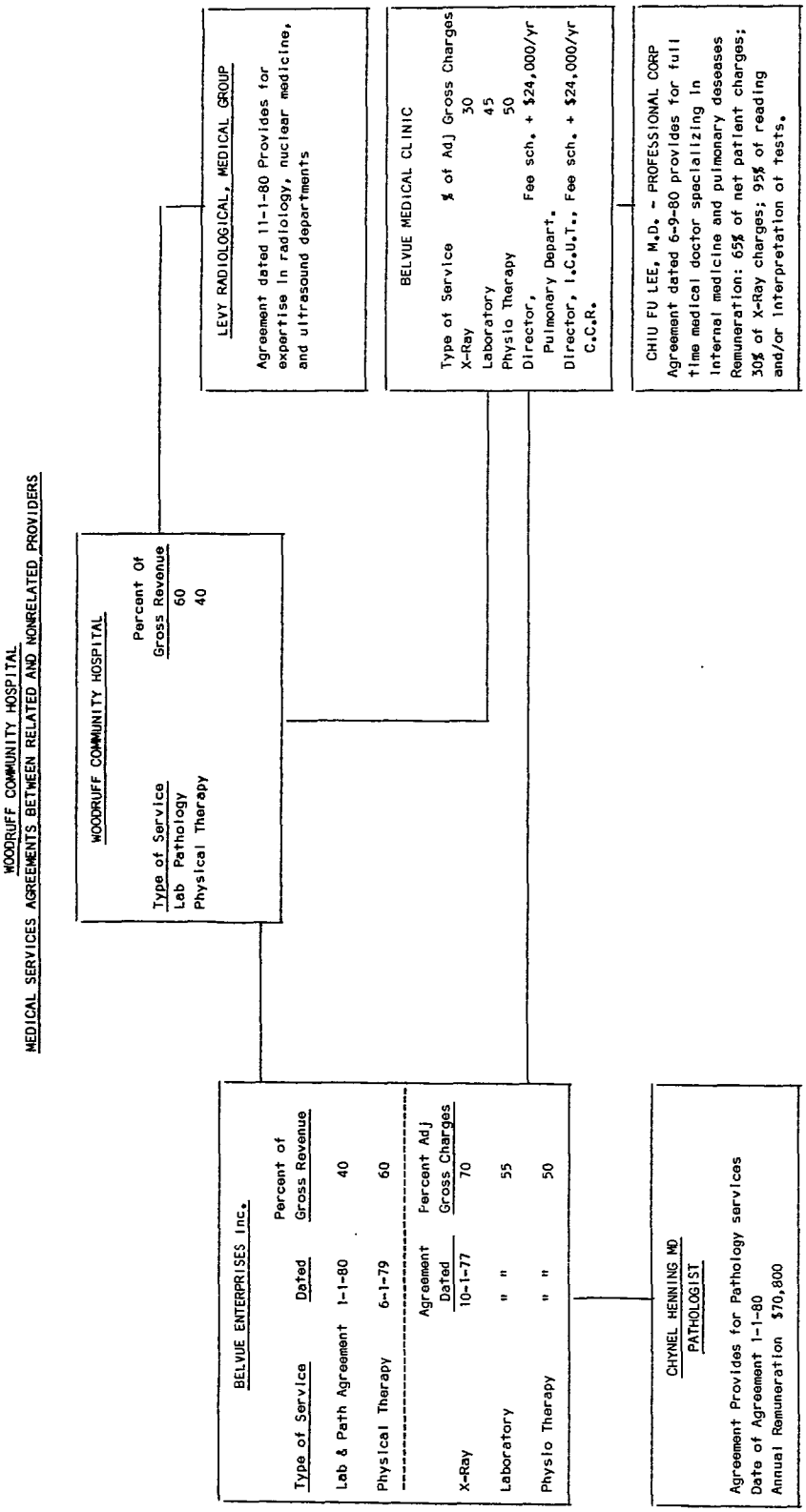

WOODRUFF COMMUNITY HOSPITAL
MANAGEMENT SERVICES AND LEASE TRANSACTIONS BETWEEN RELATED PARTIES
WOODRUFF COMMUNITY HOSPITAL
James A. Jetton MD
Gerald W. Miller MD
A California Partnership
LEASE: Building $540,000 Annual Rent
LEASE: Model 4001 CT Scanner
Annual Rental $48,000
LEASE: Picker X-Ray Machine & related Equipment - Annual Rent $9,000
LEASE: Radiology Equipment - Annual Rental $24,636
LEASE: Rohnar-Ultra Sound System - Annual Rental $18,000
LEASES: Four Autos., 2 Mercedes Benz, 1 Ford, 1 Chevrolet - Monthly rent Apx. $800
Management Service Contract
Annual Fee $360,000
LONG BEACH MEDICAL
MANAGEMENT, Inc.
Management Services
Contract Annual Fee
$24,000
BELVUE MEDICAL CLINIC
(Partnership)
BELVUE ENTERPRISES, Inc.
Management Service Contract Annual Fee $60,000
LEASE: Building
Space; $96,450
Annual rent
(6,430 Sq Ft)
Partnership
Agreement
Provides -
Management
Service
Annual Fee
$30,000
(26,908 Sq Ft.)
LEASE: Building Space; ANNUAL RENT $300,000
WOODRUFF MEDICAL CENTER, Ltd
LEASE: Building Space; Annual Rent $85,032
(7,086 Sq Ft)
→ Indicates direction payments flow.

APPENDIX II

WOODRUFF COMMUNITY HOSPITAL LOANS BETWEEN RELATED PARTIES



APPENDIX II


WOODRUFF COMMUNITY HOSPITAL
MEDICAL SERVICES AGREEMENTS BETWEEN RELATED AND NONRELATED PROVIDERS
WOODRUFF COMMUNITY HOSPITAL
Type of Service
Lab Pathology
Physical Therapy
Percent Of Gross Revenue
60
40
LEVY RADIOLOGICAL, MEDICAL GROUP
Agreement dated 11-1-80 Provides for expertise in radiology, nuclear medicine, and ultrasound departments
BELVUE MEDICAL CLINIC
Type of Service
X-Ray
Laboratory
Physio Therapy
Director, Pulmonary Depart.
Director, I.C.U.T., C.C.R.
% of Adj Gross Charges
30
45
50
Fee sch. + $24,000/yr
Fee sch. + $24,000/yr
CHIU FU LEE, M.D. - PROFESSIONAL CORP
Agreement dated 6-9-80 provides for full time medical doctor specializing in internal medicine and pulmonary deseases
Remuneration: 65% of net patient charges; 30% of X-Ray charges; 95% of reading and/or interpretation of tests.
BELVUE ENTERPRISES Inc.
Type of Service
Dated
Percent of Gross Revenue
Lab & Path Agreement
1-1-80
40
Physical Therapy
6-1-79
60
Agreement Dated
Percent Adj Gross Charges
X-Ray
10-1-77
70
Laboratory
" "
55
Physio Therapy
" "
50
CHYNEL HENNING MD
PATHOLOGIST
Agreement Provides for Pathology services
Date of Agreement 1-1-80
Annual Remuneration $70,800

WOODRUFF COMMUNITY HOSPITAL, INC., MANAGEMENT COSTS
SALARIES AND BENEFITS PAID, CLAIMED, AND ALLOWED (note a)
FISCAL YEAR 1980

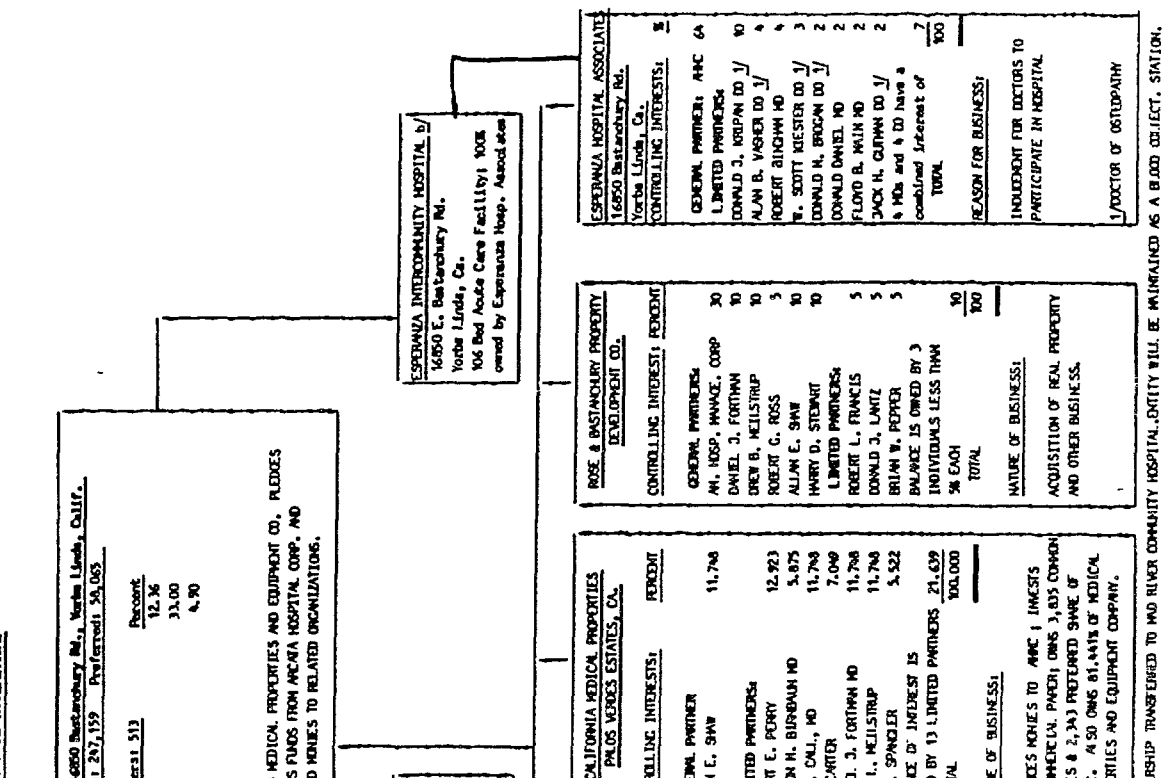
	Compensation cost incurred					Compensation allocated		Compensation allowed	
	Long Beach Medical Management, Inc.		Woodruff Community	Belvue Enterprises, Inc.	Total	Woodruff Community	Belvue Enterprises,	Woodruff Community	Belvue Enterprises,
	Salary	Pension	Hosp. Inc.	(home office)	paid	Hosp. Inc.	Inc.	Hosp. Inc.	Inc.
Salaries:									
Administrator	$ 65,153	$17,968	$	$	$ 83,118	$ 76,603	$	$30,523	$
Owner A	111,465	25,629		18,000	155,095	30,000	15,078	24,410	9,774
Owner B	98,666	42,718		22,500	163,884	30,000	18,823		
Associate Administrator	19,977	5,132			25,109	25,109		19,977	
Other benefits and costs:									
Payroll taxes	6,917				6,917	6,917		997	
Automobile rental	4,098				4,098	4,098			
Other, including legal, accounting, interest, insurance, etc.	3,063				3,063	3,063		3,063	
Life and health insurance				3,601	3,601	156	3,445		
Directors' fees			4,950		4,950	4,950			
Total compensation and benefits paid--all entities	$309,337	$91,447	$4,950	$44,101	$449,835	$180,896	$37,346	$78,970	$9,774
						$218,242			
Amount disallowed						b/ 129,498			
Allowable compensation						$ 88,744		$88,744	

a/Compiled from intermediary audit workpapers.

b/Based on documentation we provided to the intermediary, the intermediary was able to reduce compensation allocated for management services by about $129,000.

APPENDIX III

APPENDIX IV



a/PREVIOUSLY OWNED BY ARCATA HOSPITAL CORPORATION AND OPERATED AS A FULL FLEDGED LABORATORY, AS OF MARCH 2, 1981 OWNERSHIP TRANSFERRED TO MAD RIVER COMMUNITY HOSPITAL. ENTITY WILL BE MAINTAINED AS A BLOOD COLLECT. STATION.
b/ESPERANZA HOSPITAL WAS CLOSED IN APRIL 1981.

MAD RIVER COMMUNITY HOSPITAL

Original Cost and Book Value of Equipment

Type of equipment	Costs included in Fullerton Community Hospital books: Cost	Depreciation	Book value	Total selling price to California Medical Properties and Equipment Co., a related organization
Hospital	$205,937	$161,316	$44,621	
Patient	132,943	101,710	31,233	
Office	24,380	19,313	5,067	
Surgical	28,540	24,650	3,890	
Total	$391,800	$306,989	$84,811	$560,000

EXAMPLES OF EQUIPMENT UNDER LEASE

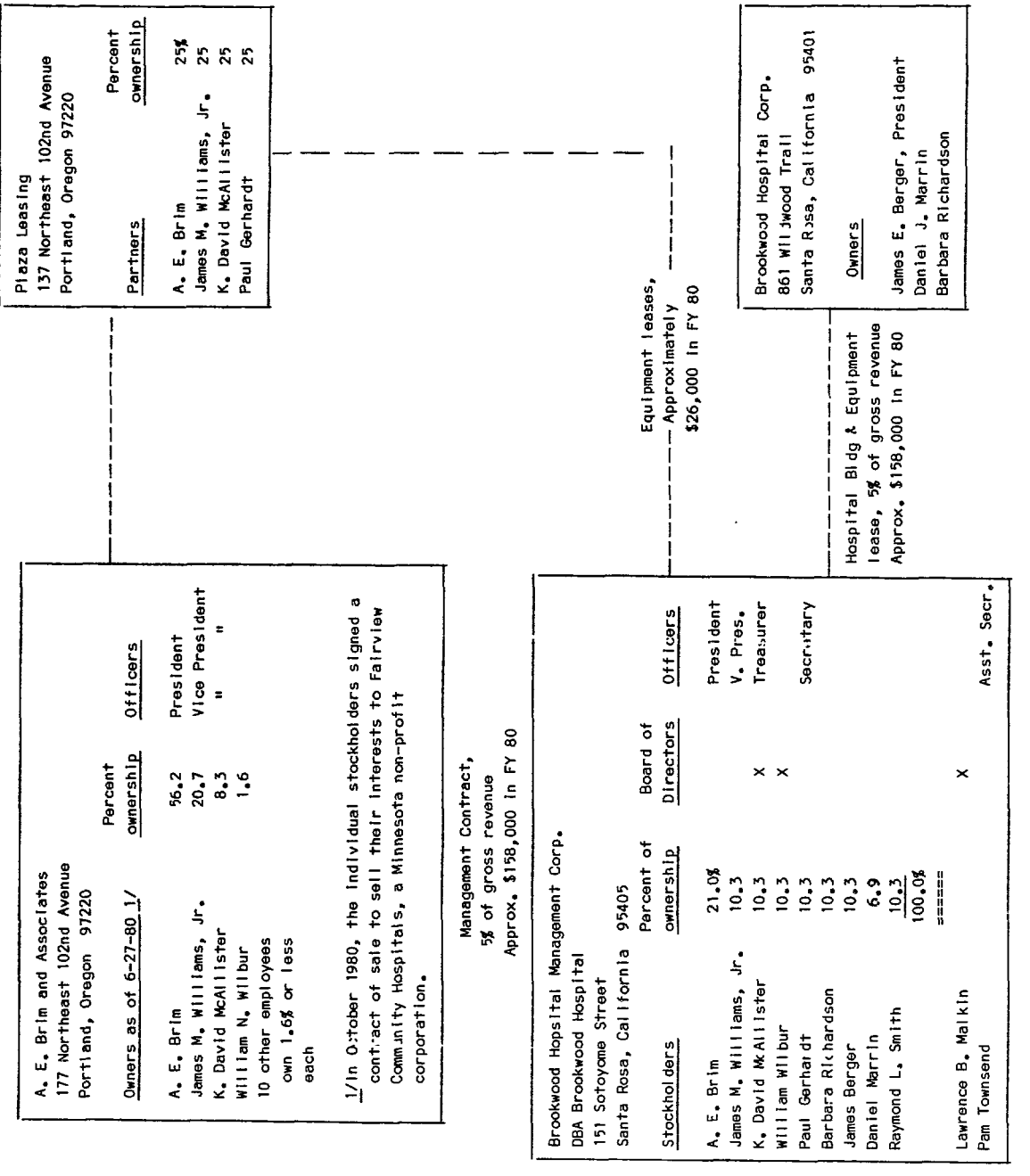
Included in the equipment valued at $560,000 are items ranging in value from $.90 for two medicine dispensing cups to $46,500 for a radiographic-tomographic fluoroscopic X-ray machine. The equipment list included such items as: [1]

7 garbage cans with a fair market value of $45.
1 wheel barrel with a fair market value of $25.
2 mop buckets with a fair market value of $30.
1 laundry basket with a fair market value of $30.
1 four-foot ladder with a fair market value of $5.
2 toasters with a fair market value of $175.
1 potted plant with a fair market value of $35.
2 sets of X-ray gloves with a fair market value of $25.
1 wastebasket with a fair market value of $2.
1 wastecan with a fair market value of $12.
1 wastecan with a fair market value of $2.
3 wastecans with foot-operated lids ("beauty cans") with a fair market value of $36.

[1]Fair market value as indicated by a list of equipment provided by AHMC.

APPENDIX VI

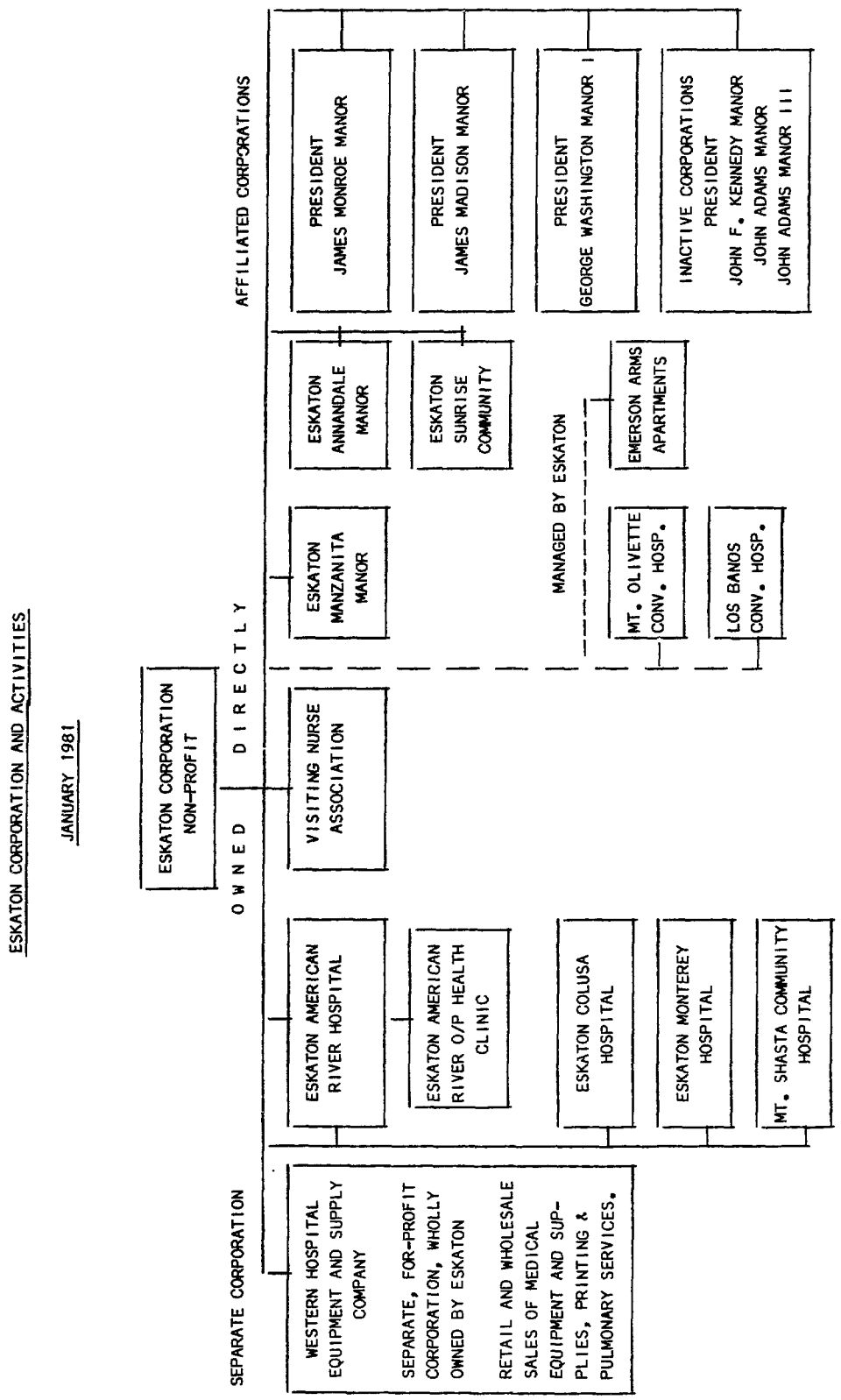
BROOKWOOD HOSPITAL MANAGEMENT CORPORATION DBA BROOKWOOD
HOSPITAL--ORGANIZATIONAL RELATIONSHIPS AND TRANSACTIONS



APPENDIX VII

ESKATON CORPORATION AND ACTIVITIES

JANUARY 1981



ESKATON CORPORATION

Equity, Working Capital Balance, Cash, and Cash Required by Facility

Corporate entity	Facility equity balance 12/31/80	Working capital (current assets minus current liabilities) 12/31/79	12/31/80	12/31/81	Cash 12/31/80	Cash funds required (Outstanding checks) 12/31/80 (note a)
Eskaton Administrative Center	$1,320,371	$ 255,043	$ 364,121	$ 216,495	$ 4,027	$131,199
Eskaton American River Hospital	2,429,950	1,230,699	900,666	522,469	1,365	165,088
Eskaton Colusa Hospital	120,116	(69,140)	(121,372)	(447,030)	10,447	135,969
Eskaton Monterey Hospital	1,314,115	(441,072)	(225,583)	(691,809)	4,723	140,369
Mount Shasta Community Hospital	2,260,514	226,560	395,585	365,127	18,334	52,367
Eskaton Manzanita Manor (skilled nursing facility)	182,595	(47,490)	112,578	(26,434)	125	6,079
Eskaton Annandale Manor	(70,583)	(36,555)	(33,485)	(53,985)	1,514	1,370
Eskaton Sunrise Community	(216,553)	(105,265)	(85,708)	(120,781)	501	2,045
Western Hospital Equipment and Supply Company	47,779	(198,644)	(247,074)	(91,624)	72,887	
Visiting Nursing Association				183,347		
California Healthcare Consultants, Inc. (note b)				2,385		
Consolidated	$7,388,304	$ 814,136	$1,059,728	$(141,840)	$113,923	$634,486

a/The company uses a cash management system which uses advances from the line of credit to fund net disbursements, as necessary. The cash management system funding requirement at December 31, 1980, represents outstanding checks that will be paid through cash receipts or advances from the line of credit, as required.

b/Established in July 1981.

APPENDIX VIII

ESKATON CORPORATION
WESTERN HOSPITAL AND EQUIPMENT SUPPLY COMPANY
INCOME STATEMENT FOR FY 80

	Western Hospital Equipment & Supply Co. (note a)	Medi-print	Arbuckle Medical Office Building	Mt. Shasta Medical Office Building	Pulmonary services: Related hospitals Monterey	Related hospitals Colusa	Related hospitals Mt. Shasta	Unrelated hospitals Corning	Unrelated hospitals Gridley	Total
GROSS REVENUE	$949,393	$131,434	$2,000	$35,228	$178,806	$203,086	$116,587	$75,573	$162,693	$1,854,800
Less:										
DIRECT EXPENSES										
Merchandise	868,340									868,340
Supplies		4,011			21,378	24,201	9,010	13,906	29,148	101,654
Oxygen					6,763	10,536	6,574	3,737		27,610
Paper/forms		42,968								42,968
Salaries	11,458	46,607			97,314	80,463	50,594	26,588	51,448	364,472
Employee benefits	2,106	6,327			7,713	6,558	4,239	2,458	5,038	34,439
Travel	1,228				493	434	560	258	1,590	4,563
Rent	6,000	6,000								12,000
Purchased services from Eskaton	24,500	4,200								28,700
Purchased services	1,799	1,384			2,820	2,547		1,104	834	10,488
Management fee				801						801
Physicians' fees					2,105	6,255	12,275			20,635
Depreciation	6,908			11,095	8,855	5,755	4,428	1,595	1,135	39,771
Interest	354			26,888	3,364	3,364	3,364	3,364	3,364	44,062
Repair and maintenance	102	542		522	7,180	3,892	1,099	752	3,127	17,216
Taxes				4,730						4,730
Other expenses	15,088	15,418	400		8,318	4,375	2,527	3,445	4,158	53,729
Total direct expenses	$937,883	$127,457	$ 400	$44,036	$166,303	$148,380	$94,670	$57,207	$99,842	$1,676,178
GROSS INCOME	$ 11,510	$ 3,977	$1,600	$(8,808)	$ 12,503	$ 54,706	$21,917	$18,366	$62,851	$ 178,622
Less:										
GENERAL ADMINISTRATIVE AND MARKETING										
Salaries										106,402
Fringe benefit										11,714
Travel										11,386
Rent										6,000
Purchased services										1,582
Other										10,012
Subtotal										$147,096
Net Income										$ 31,526

a/Mostly equipment and supplies sales to Eskaton hospitals; however, includes $13,679 home care equipment rental.

APPENDIX IX

AN EQUAL OPPORTUNITY EMPLOYER

UNITED STATES
GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE, $300

POSTAGE AND FEES PAID
U. S. GENERAL ACCOUNTING OFFICE

THIRD CLASS

24091