

Skiff Medical Center
Newton, Iowa

**Basic Financial Statements and
Supplementary Information
June 30, 2014 and 2013**

Together with Independent Auditor's Report

Skiff Medical Center

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Skiff Medical Center

Officials
June 30, 2014

<u>Board of Trustees</u>	<u>Title</u>	<u>Term Expires</u>
Jeff King, Ph.D	Chair	December 2015
Debby Pence	Vice Chair	December 2015
Lois Vogel	Secretary	December 2016
Rick Hartz	Treasurer	December 2015
Larry DeCook, OD	Member	December 2016

<u>Medical Center Officials</u>	<u>Title</u>
Brett Altman	President and CEO
Jeanne Goche	Interim Chief Administrative Officer
Sheryl Tilus	Chief Nursing Officer

Independent Auditor's Report

To the Board of Trustees of
Skiff Medical Center
Newton, Iowa:

Report on the Financial Statements

We have audited the accompanying financial statements of Skiff Medical Center (Medical Center) as of and for the years ended June 30, 2014 and 2013, and the related notes to the financial statements, which collectively comprise the Medical Center's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

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

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

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Medical Center as of June 30, 2014 and 2013, and the respective changes in its financial position and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis on pages 4 through 10, schedule of funding progress for the retiree health plan on page 30, and the budgetary comparison information on page 31 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the financial statements that collectively comprise the Medical Center's basic financial statements. The supplementary information included in Exhibits 1 – 6 is presented for the purposes of additional analysis and is not a required part of the basic financial statements.

The supplementary information in Exhibits 1 – 6 is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the supplementary information in Exhibits 1 – 6 is fairly stated, in all material respects, in relation to the financial statements as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated October 2, 2014 on our consideration of the Medical Center's internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Medical Center's internal control over financial reporting and compliance.

SEEM JOHNSON, LLP

Omaha, Nebraska,
October 2, 2014.

Skiff Medical Center

Management's Discussion and Analysis June 30, 2014 and 2013

As management of Skiff Medical Center (Medical Center), we offer readers of the Medical Center's financial statements this narrative overview and analysis of the Medical Center's financial performance during the fiscal years ending June 30, 2014, 2013 and 2012. Please read it in conjunction with the Medical Center's financial statements, which follow this section.

OVERVIEW OF THE FINANCIAL STATEMENTS

This annual report includes this management's discussion and analysis report, the independent auditor's report and the basic financial statements of the Medical Center. The financial statements also include notes that explain in more detail some of the information in the financial statements.

REQUIRED FINANCIAL STATEMENTS

The financial statements of the Medical Center report information using accounting methods similar to those used by private sector companies. These statements offer short-and long-term financial information about its activities. The statement of net position includes all of the Medical Center's assets and liabilities and provides information about the nature and amounts of investments in resources (assets) and the obligations to Medical Center creditors (liabilities). It also provides the basis for evaluating the capital structure of the Medical Center and assessing the liquidity and financial flexibility of the Medical Center.

All of the current year's revenues and expenses are accounted for in the statement of revenues, expenses and changes in net position. This statement measures the success of the Medical Center's operations over the past year and can be used to determine whether the Medical Center has successfully recovered all its costs through its patient service revenue and other revenue sources, profitability and credit worthiness.

The final required financial statement is the statement of cash flows. The statement reports cash receipts, cash payments, and net changes in cash resulting from operations, non-capital financing, capital and related financing and investing activities and provides answers to such questions as where did cash come from, what was cash used for and what was the change in the cash balance during the reporting period.

FINANCIAL ANALYSIS OF THE MEDICAL CENTER

The statement of net position and the statement of revenues, expenses, and changes in net position report the net position of the Medical Center and the changes in them. The Medical Center's net position, the difference between assets and liabilities, is a way to measure financial health or financial position. Over time, sustained increases or decreases in the Medical Center's net position are one indicator of whether its financial health is improving or deteriorating. However, other non-financial factors, such as changes in economic conditions, population growth and new or changed governmental legislation, should also be considered.

Skiff Medical Center

Management's Discussion and Analysis June 30, 2014 and 2013

NET POSITION

A summary of the Medical Center's statements of net position at June 30, 2014, 2013 and 2012 are presented in Table 1 below.

Table 1- Condensed Statements of net position (In Thousands)

	<u>June 30, 2014</u>	<u>June 30, 2013</u>	<u>June 30, 2012</u>
Current and other assets	\$ 10,185	11,598	13,105
Capital assets	<u>13,204</u>	<u>15,806</u>	<u>18,268</u>
Total assets	\$ <u>23,389</u>	<u>27,404</u>	<u>31,373</u>
Long-term debt outstanding	\$ 1,749	2,574	3,293
Other liabilities	<u>2,406</u>	<u>2,502</u>	<u>2,985</u>
Total liabilities	\$ <u>4,155</u>	<u>5,076</u>	<u>6,278</u>
Net investment in capital assets	\$ 11,454	13,232	14,975
Unrestricted	7,718	9,046	10,070
Restricted, nonexpendable	<u>62</u>	<u>50</u>	<u>50</u>
Total net position	\$ <u><u>19,234</u></u>	<u><u>22,328</u></u>	<u><u>25,095</u></u>

Skiff Medical Center

Management's Discussion and Analysis June 30, 2014 and 2013

REVENUES, EXPENSES, AND CHANGES IN NET POSITION

The following table presents a summary of the Medical Center's historical revenues and expenses for each of the fiscal years ended June 30, 2014, 2013 and 2012:

Table 2- Condensed Statements of Revenue, Expenses, and Changes in Net Position (In Thousands)

	<u>2014</u>	<u>2013</u>	<u>2012</u>
Net patient service revenue	\$ 31,740	33,742	35,145
Other operating revenue	<u>2,213</u>	<u>1,192</u>	<u>3,057</u>
Total revenue	<u>33,953</u>	<u>34,934</u>	<u>38,202</u>
Operating expenses:			
Salaries	16,667	17,441	17,624
Employee benefits	5,617	5,843	6,073
Purchased services and professional fees	4,051	3,611	2,885
Utilities	909	796	750
Supplies and other expense	7,099	7,368	7,203
Depreciation and amortization	2,391	2,750	2,583
Insurance	253	194	266
Interest	<u>39</u>	<u>55</u>	<u>39</u>
Total operating expenses	<u>37,026</u>	<u>38,058</u>	<u>37,423</u>
Operating income (loss)	(3,073)	(3,124)	779
Non-operating revenue (expense) - Investment income (loss), net	<u>(70)</u>	<u>223</u>	<u>(11)</u>
Excess of revenues over (under) expenses before grants and contributions	(3,143)	(2,901)	768
Grants and contributions	<u>49</u>	<u>134</u>	<u>179</u>
Increase (decrease) in net position	(3,094)	(2,767)	947
Total net position, beginning of year	<u>22,328</u>	<u>25,095</u>	<u>24,148</u>
Total net position, end of year	<u>\$ 19,234</u>	<u>22,328</u>	<u>25,095</u>

Operating and Financial Performance

The following summarizes the Medical Center's statements of revenue, expenses and changes in net position during the past fiscal year (FY14):

Volume:

Volume decreases were experienced in 2014. Total admissions followed national trends and dropped by roughly 15% compared to FY13, total patient days decreased by nearly 20%. This was in large part due to decreases in swing bed admissions. Outpatient visits decreased by more than 6% with the majority of this decrease happening in the rehabilitation therapy department. This decrease in overall volume led to a slight decrease in gross patient service revenue.

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Management's Discussion and Analysis June 30, 2014 and 2013

Significant volume increases were experienced in 2013. Though total admissions remained relatively flat compared to FY12, total patient days increased by more than 7%. This was primarily due to increases in swing bed admissions and lengths of stay. Outpatient visits increased by more than 8% with the majority of this growth happening in the emergency room and rehabilitation therapy departments. This increase in overall volume led to a nearly 7% increase in gross patient service revenue.

Gross Patient Service Revenue:

Gross patient service revenue decreased 0.4% over FY13. Most of this decrease can be attributed to declines in admissions and rehabilitation services, which we feel have been impacted by narrow networks and the Des Moines metro systems not providing reciprocal referrals.

In 2013, gross patient service revenue increased 6.7% over FY12. Approximately 50% of the increase can be attributed to targeted price increases in a number of service lines, with the remainder attributable to year-on-year volume growth.

As noted in the following chart, payer mix remained fairly stable, with a slight shift from Medicare to Commercial payers. This shift is associated with an increase in the number of patients choosing a "Medicare Advantage" plan. These plans are included in the "Commercial" payer bucket. We also experienced an uptick of Medicaid, and a decrease of Wellmark/Blue Cross.

Table 3- Payor Mix by Percentage

<u>Year Ended June 30,</u>	<u>2014</u>	<u>2013</u>	<u>2012</u>
Medicare	43.0%	44.7%	46.4%
Wellmark / Blue Cross	16.2%	19.6%	19.8%
Commercial	24.7%	21.4%	19.6%
Medicaid	12.8%	10.8%	10.7%
Self Pay	3.3%	3.5%	3.5%
Total	<u>100.0%</u>	<u>100.0%</u>	<u>100.0%</u>

Revenue Adjustments:

Revenue adjustments were significantly impacted by a number of issues for FY14.

- Shift to Medicare Advantage plans
- Shift to high deductible commercial plans
- Changes in commercial payer contracts and movement of local employers to payers with lower reimbursement rates
- 2% increase in Medicaid

In July 2011, Skiff Medical Center was admitted to the Medicare Rural Community Hospital (RCH) Demonstration Program, a five year program allowing cost-based reimbursement for inpatient services provided to Medicare beneficiaries. The RCH Demonstration Program provides exceptional value to the Medical Center, but it applies only to patients enrolled in traditional Medicare. Unfortunately over the past year we have experienced an increasing number of beneficiaries selecting Medicare Advantage plans. In addition to removing these patients from the demonstration program, Medicare Advantage plans tend to have extremely poor reimbursement rates, thus negatively impacting the reimbursement rate for our "commercial insurance" bucket.

Skiff Medical Center

Management's Discussion and Analysis June 30, 2014 and 2013

Contractual adjustments have also been negatively impacted by reductions in reimbursements by commercial payers, especially for outpatient services. For example, Wellmark BC/BS implementation of enhanced ambulatory patient grouping (EAPG) reimbursement methodology. In addition, we have seen the largest employer in our community switch from a BC/BS plan to a United Health Care plan which provides lower reimbursement.

Additionally, with rising health care costs, we have experienced an increase in the number of commercially insured patients choosing high-deductible health plans. Our own health plan was significantly revised for the last half of FY 13 with deductibles more than doubling. We brought self pay collections back in-house April 2014 and placed a concentrated effort in this area. As a result discounts for prompt pay increased \$326,713 over prior year, "Skiff Cares" adjustments decreased \$57,553 and bad debt adjustments decreased \$236,039. Medicaid presumptive eligibility was implemented also which impacted the decreased bad debt adjustments.

Finally, the federal "sequester" reduced Medicare reimbursement and the implementation of the value-based-purchasing concept placed a portion of Medicare reimbursement at risk.

Net Patient Service Revenue:

In addition to the Medical Center experiencing volume declines during FY 14, more than a 2% increase in revenue adjustments negatively impacted net revenue. Fortunately, the RCH Demonstration Program continued to provide additional funding to the Medical Center and serves to partially offset significant revenue declines from other sources. Even with RCH revenues, the Medical Center experienced a decline in net patient revenue of nearly 1%.

Though the Medical Center experienced strong volume growth during FY 13 that, coupled with increased prices, led to record gross revenue of more than \$77.5M (nearly 7% higher than the previous year), the more than 12% increase in revenue adjustments wiped away the positive impact of this growth in volume. Fortunately, the RCH demonstration program continued to provide additional funding to the Medical Center and serves to partially offset significant revenue declines from other sources. Even with RCH revenues, the Medical Center experienced a decline in net patient revenue of 4%, even though gross revenue increased more than 6%

Other Operating Revenue:

Other operating revenue increased significantly due primarily to receipt of funds associated with the federal electronic health records (EHR) incentive program.

Total Operating Expense:

Salaries: Salaries declined by roughly 4% in FY14 due to an attrition program driven by labor productivity benchmarking. A number of positions in which the incumbents retired were not replaced and the duties of those positions were absorbed into other positions or multiple positions were combined prior to new personnel being hired. There was no merit increase issued in January 2014.

Salaries declined in FY13 due to an attrition program driven by labor productivity benchmarking. A number of positions in which the incumbents retired were not replaced and the duties of those positions were absorbed into other positions or multiple positions were combined prior to new personnel being hired. The decline in salary expense was realized despite a 3.1% merit increase in January 2013.

Employee Benefits: Total benefits declined commensurate with attrition of staff and great labor productivity.

The decrease in employee benefits in 2013 was associated with a decline in health insurance expenses due to the move from self-funded to a fully-funded plan and the implementation of a high deductible health plan. Total benefits declined despite an increase in the required employer contribution to the IPERS pension plan

Purchased Services and Professional Fees: An increase in these expenses in 2014 and 2013 is primarily associated with radiology equipment (MRI, CT, Rad room) coming off warranty and into a service contract period. Additional increases were experienced in the area of physician recruitment expenses and lab and pharmacy service contracts.

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Management's Discussion and Analysis June 30, 2014 and 2013

Supplies and Other Expenses: Supplies expenses declined in 2014 relation to volume decreases. In 2013, Supplies expenses rose in relation to volume increases with the largest increases experienced in the areas of pharmaceuticals, infusions, and blood. These last items are associated with exceptional growth in the cancer clinic and outpatient infusion center.

Depreciation Expense: Depreciation expense decreased due to aging of the plant and lack of investment.

Non-Operating Gain/(Loss):

Overall, Skiff Medical Center realized a non-operating loss in FY14 due to negative investment returns. The Medical Center partnered with Health Enterprises of Iowa to develop a regional medical laboratory in Newton. This lab, which opened in 2014, provides the Medical Center with state of the art anatomic and clinical pathology services while setting the stage for significant lab expense reductions in the future. Investment return, though, for 2014 was negative.

CAPITAL ASSETS

Minimal investments in capital assets were made in FY14 and FY13 with the majority being infrastructure improvements and renovation projects funded by gifts.

DEBT ADMINISTRATION

Capital Leases

The outstanding long term debt decreased in FY14 and FY13 due to the reduction in outstanding balances of capital leases.

ECONOMIC FACTORS

The economy of Newton, Iowa continues to mend slowly. The unemployment rate in the county currently stands at 5.0 percent. In addition, the demographics of the county continue to shift toward an older, poorer population.

Though Newton and Jasper County are now essentially operating as a far-flung eastern suburb of Des Moines, there is continued growth in local industry. TPI, a manufacturer of blades for large wind turbines, continues to employ nearly 1,000 people. Trinity, a manufacturer of wind towers, employs another 250 workers. Other firms that entered the market in the last few years are in a stable to growing condition. Nine companies and more than 1,800 manufacturing jobs have come to Newton since the closure of Maytag in 2007. Though the return of manufacturing to the area has been a blessing, it is important to note that the new jobs are much lower-paying and less robust in terms of benefits than the jobs they replaced at Maytag.

The Newton area is hard at work in developing and implementing a vision for vigorous growth over the next several years. These efforts are being spear-headed by the city, the economic development organization, and the chamber of commerce. Efforts are being guided by the comprehensive plan developed by the city in 2012. This plan includes the following elements:

- Grow Newton's population, specifically targeting young families
- Increase employment opportunities
- Improve the city's curb appeal
- Fill vacant buildings and increase local shopping options

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Management's Discussion and Analysis June 30, 2014 and 2013

Significant progress is being made in each of these areas and includes the development of a significant plan to invest in housing infrastructure, participation in a consulting engagement aimed at identifying retail niches, acceptance in the "Main Street" program by the Chamber of Commerce focused on downtown revitalization, and development of a branding campaign to change the image of the community.

The commitment of the community to the Medical Center is evident in the following excerpt from the "guiding principle on healthcare" contained in the comprehensive plan: "Newton will support the local hospital Medical Center and health care providers and recognizes that maintaining Skiff Medical Center is of utmost importance for the community."

The Medical Center strategic plan includes elements related to quality, patient satisfaction, caregiver engagement, and growth (financial performance):

1. Put people first by fostering a culture of ownership focused on our fundamental values with a shared hopefulness on the part of each caregiver (employee, volunteer, or medical staff member), having a desire to make Skiff the best possible place to work and provide patient care.
2. Identify opportunities to partner with other organizations to provide existing or new service lines in a manner which enhances the level of service provided to patients, and broadens our economic impact on the communities we serve.
3. Continuously evaluate our services based on environmental trends, community needs, and financial performance to ensure we are providing core hospital services to the best of our ability and filling a niche in areas where we have, or can develop, specific expertise.
4. Build confidence in our abilities by:
 - a. Improving our ability to handle higher acuity patients in the in-patient environment as we seek to grow the in-patient practice and keep patient care local.
 - b. Developing advanced diagnostic and therapeutic capabilities to ensure local access to the highest level of care in both the inpatient and outpatient environments.
 - c. Ensuring the appropriate number and type of medical providers are available in our service area by partnering with medical practices to recruit them.
5. Implement benchmarking processes and increase performance in all areas compared to those benchmarks by:
 - a. Increasing the quality of, and satisfaction with, the patient care we provide through the implementation of national best practices and benchmarking tools and by creating a sense of urgency throughout Skiff in regards to the importance of keeping our promise to achieve positive care outcomes and exceed the expectations of our patients.
 - b. Better manage our resources and reduce our operating costs through the use of operational improvement strategies such as "lean" and labor productivity management and by actively benchmarking our operations against peer institutions.
6. Be intentional in telling the Skiff story to the community and focus our efforts on increasing physician referrals, building good will, and increasing awareness about our service offerings.

With this plan in mind, the Medical Center continued to partner with the existing medical group in hiring two new providers in FY14 and became involved with a joint venture of a second physician group in Newton by partnering with the Newton Clinic. This group will add an additional provider in October 2014.

Skiff Medical Center

Management's Discussion and Analysis June 30, 2014 and 2013

FY14 provided a preview of the future of health care with volume decreases and significant reductions in reimbursements. This calls for even greater attention to expense reduction initiatives in the future. The current focus on decreasing labor costs using productivity benchmarking and attrition are beginning to be realized. Continued reduction in health insurance expenses are expected and supply costs will decline with the implement of the Ascend program via Health Enterprises. Growth in the number of physicians should positively impact volumes in the coming year.

Uncertainties in the future will be associated with the implementation of health care reform and the impact this will have on reimbursement rates. The move from a volume-based reimbursement system to a value-based system is well underway. The future of population-health-based reimbursement is still unclear, but additional reductions in reimbursement to hospitals are the likely outcome.

The key to a successful future is a focus on the foundational elements of quality/patient safety, patient experience, and caregiver engagement. We have made tremendous progress in each of these areas over the past few years. We will continue our focus on these key elements while giving even more attention to the expense reduction initiatives currently underway, all while developing a plan to weather a fundamental transformation of the health care industry over the next several years. Finally, Skiff will seek to partner with a health system in 2015 to help provide economies of scale, expertise, a safety net, and financial stability for our local medical community.

CONTACTING THE MEDICAL CENTER'S ADMINISTRATION

The Medical Center's financial statements are designed to present users with a general overview of the Medical Center's finances and to demonstrate the Medical Center's accountability. If you have questions about the report or need additional information, please contact the hospital's CEO, Brett Altman, at 641-791-4344 or via mail at 204 N. 4th Ave. East, Newton, Iowa 50208.

Skiff Medical Center

Statements of Net Position June 30, 2014 and 2013

	<u>2014</u>	<u>2013</u>
ASSETS		
Current assets:		
Cash and cash equivalents	\$ 1,171,958	773,534
Patient receivables, net of allowance for doubtful accounts of \$1,389,432 in 2014 and \$1,388,704 in 2013	5,336,464	5,134,435
Inventories	518,610	423,264
Prepaid expenses	210,959	187,539
Estimated third-party payor settlements	<u>--</u>	<u>448,443</u>
Total current assets	7,237,991	6,967,215
Investments, including assets limited as to use or restricted	2,947,632	4,631,011
Capital assets, net	<u>13,203,626</u>	<u>15,805,917</u>
Total assets	<u>23,389,249</u>	<u>27,404,143</u>
LIABILITIES		
Current liabilities:		
Current maturities of long-term debt	757,472	821,783
Accounts payable	641,808	658,962
Accrued expenses -		
Accrued payroll and payroll taxes	520,801	512,567
Accrued employee benefits	1,047,666	1,330,909
Estimated third-party payor settlements	<u>195,085</u>	<u>--</u>
Total current liabilities	3,162,832	3,324,221
Long-term debt, net of current maturities	<u>992,280</u>	<u>1,751,975</u>
Total liabilities	<u>4,155,112</u>	<u>5,076,196</u>
NET POSITION		
Net investment in capital assets	11,453,874	13,232,159
Restricted, nonexpendable permanent endowment	61,500	50,500
Unrestricted	<u>7,718,763</u>	<u>9,045,288</u>
Total net position	<u>\$ 19,234,137</u>	<u>22,327,947</u>

See notes to the financial statements

Skiff Medical Center

Statements of Revenue, Expenses and Changes in Net Position For the Years Ended June 30, 2014 and 2013

	<u>2014</u>	<u>2013</u>
OPERATING REVENUE:		
Net patient service revenue, net of provision for bad debts of \$2,915,733 in 2014 and \$3,151,770 in 2013	\$ 31,739,651	33,741,592
Other operating revenue	<u>2,212,664</u>	<u>1,191,585</u>
Total operating revenue	<u>33,952,315</u>	<u>34,933,177</u>
OPERATING EXPENSES:		
Salaries	16,667,153	17,440,789
Employee benefits	5,616,603	5,837,533
Purchased services and professional fees	4,050,929	3,615,975
Utilities	909,414	796,143
Supplies and other expenses	7,099,237	7,368,080
Depreciation and amortization	2,390,765	2,750,237
Insurance	253,121	193,962
Interest	<u>38,617</u>	<u>54,992</u>
Total operating expenses	<u>37,025,839</u>	<u>38,057,711</u>
OPERATING LOSS	(3,073,524)	(3,124,534)
NONOPERATING REVENUE (EXPENSES), NET:		
Investment income (loss), net	<u>(70,059)</u>	<u>223,118</u>
EXCESS OF EXPENSES OVER REVENUE BEFORE CAPITAL GRANTS AND CONTRIBUTIONS AND ADDITIONS TO PERMANENT ENDOWMENTS	(3,143,583)	(2,901,416)
CAPITAL GRANTS AND CONTRIBUTIONS	38,773	133,944
ADDITIONS TO PERMANENT ENDOWMENTS	<u>11,000</u>	<u>--</u>
DECREASE IN NET POSITION	(3,093,810)	(2,767,472)
NET POSITION, Beginning of year	<u>22,327,947</u>	<u>25,095,419</u>
NET POSITION, End of year	<u>\$ 19,234,137</u>	<u>22,327,947</u>

See notes to financial statements

Skiff Medical Center

Statements of Cash Flows For the Years Ended June 30, 2014 and 2013

	<u>2014</u>	<u>2013</u>
CASH FLOWS FROM OPERATING ACTIVITIES:		
Cash received from patients and third-party payors	\$ 32,181,150	34,034,321
Cash paid for employee salaries and benefits	(22,558,765)	(23,559,438)
Cash paid to suppliers and contractors	(12,448,621)	(12,100,591)
Other operating receipts	<u>2,433,706</u>	<u>1,309,620</u>
Net cash used in operating activities	<u>(392,530)</u>	<u>(316,088)</u>
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES,		
Endowment gifts received	<u>11,000</u>	<u>--</u>
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Proceeds from sale of capital assets	209,524	182,604
Purchase of capital assets	(219,040)	(508,206)
Capital grants and contributions	38,773	133,944
Payments on long-term debt	(824,006)	(799,921)
Interest paid on debt	<u>(38,617)</u>	<u>(54,992)</u>
Net cash used in capital and related financing activities	<u>(833,366)</u>	<u>(1,046,571)</u>
CASH FLOWS FROM INVESTING ACTIVITIES:		
Withdrawals from investments limited as to use, net	1,683,379	350,989
Investment in Affiliates	(381,085)	--
Investment income, net	<u>311,026</u>	<u>223,118</u>
Net cash provided by investing activities	<u>1,613,320</u>	<u>574,107</u>
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	398,424	(788,552)
CASH AND CASH EQUIVALENTS, Beginning of year	<u>773,534</u>	<u>1,562,086</u>
CASH AND CASH EQUIVALENTS, End of year	<u>\$ 1,171,958</u>	<u>773,534</u>
SUPPLEMENTAL DISCLOSURE OF CASH FLOWS INFORMATION:		
Equipment acquired under capital lease obligations	<u>\$ --</u>	<u>80,723</u>

See notes to financial statements

Skiff Medical Center

Statements of Cash Flows (Continued) For the Years Ended June 30, 2014 and 2013

	<u>2014</u>	<u>2013</u>
RECONCILIATION OF OPERATING LOSS TO NET CASH USED IN OPERATING ACTIVITIES:		
Operating loss	\$ (3,073,524)	(3,124,534)
Adjustments to reconcile operating loss to net cash used in operating activities:		
Depreciation and amortization	2,390,765	2,750,237
Loss on disposal of capital assets	221,042	118,035
Interest expense included in operating expenses	38,617	54,992
(Increase) decrease in current assets -		
Patient receivables	(202,029)	(68,178)
Inventories	(95,346)	89,615
Prepaid expenses	(23,420)	(14,481)
Estimated third-party payor settlements	448,443	360,907
Increase (decrease) in current liabilities -		
Accounts payable	(17,154)	(201,565)
Accrued payroll and payroll taxes	8,234	51,836
Accrued employee benefits	(283,243)	(332,952)
Estimated third-party payor settlements	195,085	--
Net cash used in operating activities	<u>\$ (392,530)</u>	<u>(316,088)</u>

See notes to financial statements

Skiff Medical Center

Notes to the Financial Statements June 30, 2014 and 2013

(1) Reporting Entity and Summary of Significant Accounting Policies

Skiff Medical Center (Medical Center) is a municipal hospital and is an enterprise fund of the City of Newton, Iowa, organized under Chapter 392 of the Code of Iowa and as such, is not subject to taxes on income or property. The Medical Center grants credit to patients, substantially all of whom are residents of Jasper County, Iowa.

The following is a summary of significant accounting policies of Skiff Medical Center (Medical Center). These policies are in accordance with accounting principles generally accepted in the United States of America.

A. Reporting Entity

For financial reporting purposes, the Medical Center has included all the funds, organizations, account groups, agencies, boards, commissions and authorities that are not legally separate. The Medical Center has also considered all potential component units for which it is financially accountable, and other organizations for which the nature and significance of their relationship with the Medical Center are such that exclusion would cause the Medical Center's financial statements to be misleading or incomplete. The Governmental Accounting Standards Board has set forth criteria to be considered in determining financial accountability. These criteria include appointing a voting majority of an organization's governing body and (1) the ability of the Medical Center to impose its will on that organization or (2) the potential for the organization to provide specific benefits to or impose specific financial burdens on the Medical Center. The Medical Center has no component units required to be reported in accordance with the Governmental Accounting Standards Board criteria.

B. Industry Environment

The health care industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursements for patient services, and Medicare and Medicaid fraud and abuse. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

Management believes that the Medical Center is in compliance with applicable government laws and regulations as they apply to the areas of fraud and abuse. While no regulatory inquiries have been made which are expected to have a material effect on the Medical Center's financial statements, compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

As a result of recently enacted federal healthcare reform legislation, substantial changes are anticipated in the United States healthcare system. Such legislation includes numerous provisions affecting the delivery of healthcare services, the financing of healthcare costs, reimbursement of healthcare providers and the legal obligations of health insurers, providers and employers. These provisions are currently slated to take effect at specified times over approximately the next decade.

C. Basis of Presentation

The statements of net position display the Medical Center's assets and liabilities, with the differences reported as net position. Net position is reported in three categories:

Net investment in capital assets consists of capital assets, net of accumulated depreciation and amortization and reduced by outstanding balances for bonds, notes and other debt attributable to the acquisition, construction or improvement of those assets.

Skiff Medical Center

Notes to the Financial Statements June 30, 2014 and 2013

Restricted net position:

Nonexpendable – Nonexpendable net position is subject to externally imposed stipulations which require them to be maintained permanently by the Medical Center.

Expendable – Expendable net position results when constraints are placed on net position use and are either externally imposed or imposed by law through constitutional provisions or enabling legislation. The Medical Center had no expendable restricted net position at June 30, 2014 and 2013.

Unrestricted net position – Consist of net position not meeting the definition of the preceding categories. Unrestricted net position often has constraints on resources imposed by management which can be removed or modified.

When both restricted and unrestricted resources are available for use, generally it is the Medical Center's policy to use restricted resources first.

D. Measurement Focus and Basis of Accounting

Measurement focus refers to when revenue and expenses are recognized in the accounts and reported in the financial statements. Basis of accounting relates to the timing of the measurements made, regardless of the measurement focus applied.

The accompanying basic financial statements have been prepared on the accrual basis of accounting in conformity with accounting principles generally accepted in the United States of America. Revenues are recognized when earned and expenses are recorded when the liability is incurred.

E. Use of Estimates

The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting periods. Actual results could differ from those estimates.

F. Cash and Cash Equivalents

Cash and cash equivalents include highly liquid investments with an original maturity of three months or less, excluding amounts limited as to use by the Board of Trustees or donors.

G. Patient Receivables, Net

Patient receivables are uncollateralized customer and third-party payor obligations. Unpaid patient receivables are not assessed interest.

Payments of patient receivables are allocated to the specific claim identified on the remittance advice or, if unspecified, are applied to the earliest unpaid claim.

The carrying amount of patient receivables is reduced by a valuation allowance that reflects management's best estimate of amounts that will not be collected from patients and third-party payors. Management reviews patient receivables by payor class and applies percentages to determine estimated amounts that will not be collected from third parties under contractual agreements and amounts that will not be collected from patients due to bad debts. Management considers historical write off and recovery information in determining the estimated bad debt provision.

Skiff Medical Center

Notes to the Financial Statements June 30, 2014 and 2013

H. *Inventories*

Inventories are stated at cost (principally on the first-in, first-out basis) not in excess of market value. Market value is determined by comparison with recent purchases or realizable value.

I. *Investments, Including Assets Limited as to Use or Restricted*

Investments, including assets limited as to use or restricted consist of the following:

Investment in Affiliates – The Medical Center is accounting for its investments in affiliates by the equity method of accounting, under which, the Medical Center's share of the net income (loss) is recognized as income (loss) in the Medical Center's statements of revenue, expenses and changes in net position and added to (subtracted from) the investment account. Contributions to the affiliates are treated as additions to, and dividends received are treated as reductions of, the investment account.

By Board of Trustees – Periodically, the Medical Center's Board of Trustees has set aside assets for future capital improvements and expansion. The Board retains control over these funds and may, at its discretion, subsequently use them for other purposes.

By Donor – These funds have been restricted by donors for specific capital improvements and operating expenses of the Medical Center.

J. *Capital Assets, Net*

Capital assets acquisitions in excess of \$5,000 are capitalized and recorded at cost. Donated capital assets are recorded at fair value at the date of receipt. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed on the straight-line method. Equipment under capital leases is amortized on the straight-line method over the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the financial statements. Capital assets are depreciated or amortized using the following asset lives:

Land improvements	5 to 56 years
Buildings	5 to 40 years
Fixed equipment	5 to 30 years
Major movable equipment	3 to 20 years

The Medical Center's long-lived assets are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. If the sum of the expected cash flows is less than the carrying amount of the asset, a loss is recognized.

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

K. *Compensated Absences*

Paid time off is accrued as an expense and a liability as earned and may be carried forward by employees up to a specified maximum based upon years of service. The cost of paid time off is recorded as a current liability on the statements of net position. The paid time off liability has been computed based on rates of pay in effect at June 30, 2014 and 2013.

Skiff Medical Center

Notes to the Financial Statements June 30, 2014 and 2013

L. Statements of Revenue, Expenses, and Changes in Net Position

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

M. Net Patient Service Revenue

The Medical Center has agreements with third-party payors that provide for payments to the Medical Center at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments.

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

N. Charity Care

To fulfill its mission of community service, the Medical Center provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Medical Center does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. Charges excluded from patient service revenue under the Medical Center's charity care policy amounted to \$287,541 and \$345,094 for the years ended June 30, 2014 and 2013, respectively.

O. Grants and Contributions

From time to time, the Medical Center receives contributions from Skiff Medical Center Foundation, as well as grants and contributions from individuals, governmental and private organizations. Revenue from grants and contributions (including contributions of capital assets) are recognized when all eligibility requirements, including time requirements are met.

Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are unrestricted or that are restricted to a specific operating purpose are reported as nonoperating revenue. Amounts restricted to capital acquisitions are reported after nonoperating revenue and expenses.

P. Risk Management

The Medical Center is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; and medical malpractice. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Q. Insurance

The Medical Center is commercially insured for property and casualty, general and professional liability and worker's compensation risks. The Medical Center was self-insured under its employee group health program through December 31, 2012, in which claims are charged to expense in the period in which they are incurred. Effective January 1, 2013, the employee group health program is also covered under a commercial insurance carrier.

Skiff Medical Center

Notes to the Financial Statements June 30, 2014 and 2013

R. *Subsequent Events*

The Medical Center considered events occurring through October 2, 2014 for recognition or disclosure in the financial statements as subsequent events. That date is the date the financial statements were available to be issued.

(2) **Deposits and Investments, Including Assets Limited as to Use**

The Medical Center's deposits in banks at June 30, 2014 and 2013 were entirely covered by federal depository insurance or the State Sinking Fund in accordance with Chapter 12C of the Code of Iowa. This chapter provides for additional assessments against the depositories to insure there will be no loss of public funds.

The Medical Center is authorized by statute to invest public funds in obligations of the United States government, its agencies and instrumentalities; certificates of deposit or other evidences of deposit at federally insured depository institutions approved by the Board of Trustees; prime eligible bankers acceptances; certain high rated commercial paper; perfected repurchase agreements; certain registered open-end management investment companies; certain joint investment trusts, and warrants or improvement certificates of a drainage district.

The Medical Center manages the following risks in accordance with their formal investment policy:

Concentration of Credit Risk: The Medical Center's investment policy limits the amounts the Medical Center may investment in any one sector of the market up to 50% of total investments.

Interest Rate Risk: The Medical Center's investment policy limits the investment of operating funds (funds expected to be expended in the current budget year or within 15 months of receipt) to instruments that mature within 397 days. Funds not identified as operating funds may be invested in investments with maturities longer than 397 days, but the maturities shall be consistent with the needs and use of the Medical Center.

Custodial Credit Risk: Custodial credit risk for deposits is the risk that, in the event of the failure of a depository financial institution, a government will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The custodial credit risk for investments is the risk that, in the event of the failure of the counterparty (e.g. broker dealer) to a transaction, a government will not be able to recover the value of its investment or collateral securities that are in the possession of another party. The Medical Center's investment policy requires funds to be deposited into the banking institutions that have the ability to collateralize any deposits made in excess of the Federal Deposit Insurance Corporation's insurance limits.

Skiff Medical Center

Notes to the Financial Statements June 30, 2014 and 2013

The composition of investments, including assets limited as to use or restricted as of June 30, 2014 and 2013 is as follows:

	<u>2014</u>	<u>2013</u>
Investments:		
Investments in Affiliates -		
Jasper County Health Ventures and Health Enterprises	\$ <u>148,718</u>	<u>24,100</u>
Assets limited as to use or restricted:		
By Board of Trustees for capital improvements -		
Cash and cash equivalents	2,733,918	131,373
Certificates of deposit	--	600,000
Mutual funds -		
Fixed Income	--	2,204,190
Equities	--	1,618,659
Accrued interest	3,496	2,189
	<u>2,737,414</u>	<u>4,556,411</u>
By Donor:		
Certificates of deposit	<u>61,500</u>	<u>50,500</u>
Total investments limited as to use or restricted	\$ <u><u>2,947,632</u></u>	<u><u>4,631,011</u></u>

Investment income (loss), net is composed of the following:

	<u>2014</u>	<u>2013</u>
Interest and dividend income	\$ 3,623	105,112
Realized and unrealized gains and losses, net	155,405	118,006
Loss on investments in Affiliates, net	<u>(229,087)</u>	<u>--</u>
	\$ <u><u>(70,059)</u></u>	<u><u>223,118</u></u>

(3) Patient Receivables

Patient receivables reported as current assets consisted of these amounts:

	<u>2014</u>	<u>2013</u>
Total patient receivables	\$ 13,383,757	11,232,971
Less allowance for doubtful accounts	(1,389,432)	(1,388,704)
Less allowance for contractual adjustments	<u>(6,657,861)</u>	<u>(4,709,832)</u>
Net patient receivables	\$ <u><u>5,336,464</u></u>	<u><u>5,134,435</u></u>

The Medical Center grants credits without collateral to its patients and residents, most of whom are insured under third-party payor agreements. The mix of receivable from patients and third-party payors was as follows:

	<u>2014</u>	<u>2013</u>
Medicare	38%	32%
Medicaid	12	8
Commercial insurance	29	38
Patients	<u>21</u>	<u>22</u>
	<u><u>100%</u></u>	<u><u>100%</u></u>

Skiff Medical Center

Notes to the Financial Statements June 30, 2014 and 2013

(4) Net Patient Service Revenue

The Medical Center has agreements with third-party payors that provide for payments to the Medical center at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare. Inpatient acute care and swing-bed services rendered to Medicare program beneficiaries are paid based on Medicare defined costs of providing the services pursuant to the terms of the Rural Community Hospital Demonstration Program. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Outpatient, physician clinic and home health and hospice services rendered to Medicare program beneficiaries are paid at prospectively determined rates per service. The Medical Center is reimbursed for some items at a tentative rate with final settlement determined after submission of annual cost reports and audits thereof by the Medicare Administrative Contractor.

The Medical Center's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization under contract with the Medical Center. The Medical Center's Medicare cost reports have been audited by the Medicare Administrative Contractor through June 30, 2011.

The "Budget Control Act of 2011" requires, among other things, mandatory across-the-board reductions in Federal spending, also known as sequestration. As required by law, a sequestration order was issued on March 1, 2013. In general, Medicare claims with dates of service or dates of discharge on or after April 1, 2013, will incur a two percent reduction in Medicare payment.

Medicaid - Inpatient services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge. Outpatient services are paid at prospectively determined rates per outpatient ambulatory patient group.

Blue Cross - Inpatient services are paid at prospectively determined rates per discharge. Payments for outpatient services are based upon the lesser of the Medical Center's billed charges, a maximum allowable fee or a percentage of charges.

The Medical Center has also entered into payment agreements with certain health maintenance organizations and managed care programs. The basis for payment to the Medical Center under these agreements includes prospectively determined daily rates, prospectively determined rates for ambulatory surgery services and home health services, and discounts from established rates.

Revenue from the Medicare and Medicaid programs accounted for approximately 50% of the Medical Center's net patient service revenue for the years ended June 30, 2014 and 2013, respectively. Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The 2014 net patient service revenue decreased approximately \$193,000 and the 2013 net patient service revenue decreased approximately \$70,000 due to removal of allowances previously estimated that are no longer necessary as a result of final settlements and years no longer subject to audits, reviews and investigations.

Skiff Medical Center

Notes to the Financial Statements June 30, 2014 and 2013

The following illustrates the Medical Center's patient service revenue at its established rates and revenue deductions by major third party payors:

	<u>2014</u>	<u>2013</u>
Gross patient service revenue -		
Inpatient	\$ 22,192,938	25,456,794
Outpatient	52,514,780	48,612,649
Home health and hospice	2,511,948	3,458,350
	<u>77,219,666</u>	<u>77,527,793</u>
Deductions from gross patient service revenue -		
Medicare	(20,725,646)	(21,455,736)
Medicaid	(6,580,509)	(5,301,926)
Blue Cross	(5,362,382)	(6,475,624)
Commercial insurance and other	(9,608,204)	(7,056,051)
Charity care	(287,541)	(345,094)
	<u>(42,564,282)</u>	<u>(40,634,431)</u>
Provision for bad debts	<u>(2,915,733)</u>	<u>(3,151,770)</u>
Net patient service revenue	<u>\$ 31,739,651</u>	<u>33,741,592</u>

(5) Capital Assets

Capital assets and the related accumulated depreciation and amortization are summarized as follows:

	<u>June 30, 2013</u>	<u>Additions</u>	<u>Transfers and Disposals</u>	<u>June 30, 2014</u>
Capital assets not being depreciated/amortized:				
Land	\$ 2,091,558	--	(18,140)	2,073,418
Construction in progress	119,319	115,460	(128,585)	106,194
Total capital assets not being depreciated/amortized	<u>2,210,877</u>	<u>115,460</u>	<u>(146,725)</u>	<u>2,179,612</u>
Capital assets being depreciated/amortized:				
Land improvements	2,261,976	--	--	2,261,976
Buildings	21,539,932	16,648	(374,660)	21,181,920
Fixed equipment	7,188,051	11,917	(37,265)	7,162,703
Major moveable equipment, including equipment under capital lease	18,957,894	108,613	(475,661)	18,590,846
Total capital assets being depreciated/amortized	<u>49,947,853</u>	<u>137,178</u>	<u>(887,586)</u>	<u>49,197,445</u>
Less accumulated depreciation/amortization:				
Land improvements	2,108,082	59,749	--	2,167,831
Buildings	13,797,278	729,919	(74,827)	14,452,370
Fixed equipment	6,085,463	235,724	(11,024)	6,310,163
Major moveable equipment including equipment under capital lease	14,361,990	1,365,373	(484,296)	15,243,067
Total accumulated depreciation/amortization	<u>36,352,813</u>	<u>2,390,765</u>	<u>(570,147)</u>	<u>38,173,431</u>
Total capital assets being depreciated/amortized, net	<u>13,595,040</u>	<u>(2,253,587)</u>	<u>(317,439)</u>	<u>11,024,014</u>
Total capital assets, net	<u>\$ 15,805,917</u>	<u>(2,138,127)</u>	<u>(464,164)</u>	<u>13,203,626</u>

Skiff Medical Center

Notes to the Financial Statements June 30, 2014 and 2013

	<u>June 30, 2012</u>	<u>Additions</u>	<u>Transfers and Disposals</u>	<u>June 30, 2013</u>
Capital assets not being depreciated/amortized:				
Land	\$ 2,144,173	--	(52,615)	2,091,558
Construction in progress	91,973	194,773	(167,427)	119,319
Total capital assets not being depreciated/amortized	<u>2,236,146</u>	<u>194,773</u>	<u>(220,042)</u>	<u>2,210,877</u>
Capital assets being depreciated/amortized:				
Land improvements	2,247,002	9,560	5,414	2,261,976
Buildings	21,770,518	73,482	(304,068)	21,539,932
Fixed equipment	7,108,397	36,697	42,957	7,188,051
Major moveable equipment, including equipment under capital lease	<u>20,144,568</u>	<u>365,214</u>	<u>(1,551,888)</u>	<u>18,957,894</u>
Total capital assets being depreciated/amortized	<u>51,270,485</u>	<u>484,953</u>	<u>(1,807,585)</u>	<u>49,947,853</u>
Less accumulated depreciation and amortization:				
Land improvements	2,008,580	99,502	--	2,108,082
Buildings	13,078,155	796,800	(77,677)	13,797,278
Fixed equipment	5,775,381	330,108	(20,026)	6,085,463
Major moveable equipment including equipment under capital lease	<u>14,376,651</u>	<u>1,523,827</u>	<u>(1,538,488)</u>	<u>14,361,990</u>
Total accumulated depreciation/amortization	<u>35,238,767</u>	<u>2,750,237</u>	<u>(1,636,191)</u>	<u>36,352,813</u>
Total capital assets being depreciated/amortized, net	<u>16,031,718</u>	<u>(2,265,284)</u>	<u>(171,394)</u>	<u>13,595,040</u>
Total capital assets, net	<u>\$ 18,267,864</u>	<u>(2,070,511)</u>	<u>(391,436)</u>	<u>15,805,917</u>

(6) Long-Term Debt

Long-term debt activity of the Medical Center as of June 30, 2014 and 2013 is summarized as follows:

	<u>July 1, 2013</u>	<u>Additions</u>	<u>Principal Payments</u>	<u>June 30, 2014</u>	<u>Due Within One Year</u>
Obligations under capital leases	\$ <u>2,573,758</u>	<u>--</u>	<u>824,006</u>	<u>1,749,752</u>	<u>757,472</u>
	<u>July 1, 2012</u>	<u>Additions</u>	<u>Principal Payments</u>	<u>June 30, 2013</u>	<u>Due Within One Year</u>
Obligations under capital leases	\$ <u>3,292,956</u>	<u>80,723</u>	<u>799,921</u>	<u>2,573,758</u>	<u>821,783</u>

Skiff Medical Center

Notes to the Financial Statements June 30, 2014 and 2013

Obligations Under Capital Leases

The Medical Center leases various medical equipment and information system hardware and software under capital lease agreements. The property cost and the related liability under each capital lease was recorded at the present value of the future minimum payments due under the lease, as determined with imputed interest rates ranging from 0.3% to 5.0%. The cost of equipment financed under capital lease obligations is as follows:

Cost	\$	4,420,216
Accumulated amortization		<u>2,632,857</u>
Net book value	\$	<u><u>1,787,359</u></u>

Principal and interest maturities of the capital lease obligations at June 30, 2014 are summarized as follows:

<u>Year</u>	<u>Principal</u>	<u>Interest</u>	<u>Total</u>
2015	\$ 757,472	22,979	780,451
2016	700,704	11,437	712,141
2017	286,184	2,629	288,813
2018	<u>5,392</u>	<u>--</u>	<u>5,392</u>
	<u>\$ 1,749,752</u>	<u>37,045</u>	<u>1,786,797</u>

(7) Other Operating Revenue

Other operating revenue for the years ended June 30, 2014 and 2013 consist of the following:

	<u>2014</u>	<u>2013</u>
Electronic health record incentive payment	\$ 1,203,500	--
Grant revenue for home health services	251,842	310,992
Vendor rebates and discounts	223,285	73,751
Facilities management	222,609	327,351
Cafeteria and dietary revenue	195,775	208,929
Lifeline rental	95,989	106,382
Other grant revenue	51,630	76,552
Grants and contributions for hospice services	44,406	62,481
Clinic rental	3,885	46,938
Loss on disposal of capital assets	(221,042)	(118,035)
Other	<u>140,785</u>	<u>96,244</u>
	<u>\$ 2,212,664</u>	<u>1,191,585</u>

The Health Information Technology for Economic and Clinical Health Act contains specific financial incentive payments beginning in 2011 to certain hospitals and professionals that implement and achieve meaningful use of certified electronic health record (EHR) technology in ways that demonstrate improved quality and effectiveness of care. Specific criteria is set by the Center for Medicare and Medicaid Services (CMS). Eligibility for annual Medicare incentive payments is dependent on providers demonstrating meaningful use of EHR technology in each period over a four-year period. An initial Medicaid incentive payment is available to providers that adopt, implement, or upgrade certified EHR technology. However, in order to receive additional Medicaid incentive payments in subsequent years, providers must demonstrate continued meaningful use of EHR technology.

Skiff Medical Center

Notes to the Financial Statements June 30, 2014 and 2013

The Medical Center accounts for meaningful use incentive payments under the grant accounting model, cliff recognition. Medicare EHR incentive payments are recognized as revenue when eligible providers demonstrate meaningful use of certified EHR technology and data is available to estimate the incentive payments for each period (a 365 day period after the initial 90 day attestation period). Medicaid EHR incentive payments are recognized as revenue when an eligible provider demonstrates meaningful use of certified EHR technology for each period. For the years ending June 30, 2014 and 2013 the Medical Center recognized \$1,090,293 and \$-0-, respectively, of Medicare meaningful use grant revenue. For the years ending June 30, 2014 and 2013, the Medical Center recognized \$113,207 and \$-0-, respectively, of Medicaid meaningful use grant revenue in other operating revenue in its statements of revenue, expenses and changes in net position.

(8) Operating Leases

The Medical Center leases a portion of its building to a corporation which provides dialysis services. This lease agreement requires annual rents of \$44,179 through January 2018. Either party may cancel this lease on February 1 of each year by giving sixty days notice.

The Medical Center has also entered into an arrangement to lease the land upon which the Medical Arts Building was erected to the developer for a term of ninety-nine years beginning January 1, 1993. The lease calls for annual rentals with the rental rate being adjusted every 10 years to reflect any changes in the Consumer Price Index. The current annual rental rate is \$6,264, of which the Medical Center is responsible for 59.72% of the annual lease payment. There was no lease payment charged to the Medical Center in 2014. The Developer also requires a monthly assessment payment for utilities, maintenance, and management of the Medical Arts Building. The current monthly assessment payment amounts to \$9,755 per month.

(9) Other Postemployment Benefits (OPEB)

Plan Description

The Medical Center operates a single-employer retiree benefit plan which provides medical benefits/prescription drug benefits for retirees and their spouses. There are 218 active and 5 retired members in the plan. Participants must be age 55 or older and have seven years of service at retirement.

The medical/prescription drug coverage was provided through a self-insured plan through December 31, 2012. Effective January 1, 2013, benefits are provided through a fully insured plan. Retirees under age 65 pay the same contribution for the medical/prescription drug benefit as active employees, which results in an implicit rate subsidy and an OPEB liability.

Funding Policy

The contribution requirements of plan members are established and may be amended by the Medical Center. The Medical Center currently finances the retiree benefit plan on a pay-as-you-go basis.

Annual OPEB Cost and Net OPEB Obligation

The Medical Center's annual OPEB cost is calculated based on the annual required contribution (ARC) of the Medical Center, an amount actuarially determined in accordance with GASB Statement No. 45. The ARC represents a level of funding that, if paid on an ongoing basis, is projected to cover normal cost each year and amortize any unfunded actuarial liabilities over a period not to exceed 30 years.

Skiff Medical Center

Notes to the Financial Statements June 30, 2014 and 2013

The following table shows the components of the Medical Center's annual OPEB cost for the years ended June 30, 2014 and 2013, the amount actually contributed to the plan and changes in the Medical Center's net OPEB obligations:

	<u>2014</u>	<u>2013</u>
Annual required contribution	\$ 28,475	28,475
Interest on net OPEB obligation	304	175
Adjustment to annual required contribution	<u>(838)</u>	<u>(481)</u>
Annual OPEB cost	27,941	28,169
Contributions made	<u>17,288</u>	<u>19,532</u>
Increase in net OPEB obligation	10,653	8,637
Net OPEB obligation, beginning of year	<u>20,278</u>	<u>11,641</u>
Net OPEB obligation, end of year	<u>\$ 30,931</u>	<u>20,278</u>

For calculation of the net OPEB obligation, the actuary has set the transition day as July 1, 2012. The end of year net OPEB benefit was calculated by the actuary as the cumulative difference between the actuarially determined funding requirements and the actual contributions for the year ended June 30, 2014.

The Medical Center's annual OPEB cost, the percentage of annual OPEB cost contributed to the plan and the net OPEB benefit as of June 30, 2014 and 2013 are summarized as follows:

<u>Fiscal Year Ended</u>		<u>Annual OPEB Cost</u>	<u>Percentage of annual OPEB Cost Contributed</u>	<u>Net OPEB Obligation</u>
June 30, 2012	\$	44,630	74%	\$ 11,641
June 30, 2013		28,475	69%	20,278
June 30, 2014		28,475	61%	30,931

Funded Status and Funding Progress

As of July 1, 2012, the most recent actuarial valuation date for the period July 1, 2012 through June 30, 2014, the actuarial accrued liability was \$296,400 with no actuarial value of assets, resulting in an unfunded actuarial accrued liability (UAAL) of \$296,400. The covered payroll (annual payroll of active employees covered by the plan) was approximately \$16,667,000 and the ratio of the UAAL to the covered payroll was 1.8%. As of June 30, 2014, there were no trust fund assets.

Actuarial Methods and Assumptions

Actuarial valuations of an ongoing plan involve estimates of the value of reported amounts and assumptions about the probability of occurrence of events far into the future. Examples include assumptions about future employment, mortality and the health care cost trend. Actuarially determined amounts are subject to continual revision as actual results are compared with past expectations and new estimates are made about the future. The schedule of funding progress, presented as required supplementary information in the section following the notes to financial statements, will present multiyear trend information about whether the actuarial value of the plan assets is increasing or decreasing over time relative to the actuarial accrued liabilities for benefits.

Projections of benefits for financial reporting purposes are based on the plan as understood by the employer and the plan members and include the types of benefits provided at the time of each valuation and the historical pattern of sharing of benefit costs between the employer and plan members to that point. The actuarial methods and assumptions used include techniques that are designed to reduce the effects of short-term volatility in actuarial accrued liabilities and the actuarial value of assets, consistent with the long-term perspective of the calculations.

Skiff Medical Center

Notes to the Financial Statements June 30, 2014 and 2013

As of the July 1, 2012 actuarial valuation date, the projected unit credit actuarial cost method was used. The actuarial assumptions include a 1.5% discount rate based on the Medical Center's funding policy. The projected annual medical trend rate is 8%. The ultimate medical trend rate is 3%. The medical trend rate is reduced 1% each year until reaching the 3% ultimate trend rate. An inflation rate of 0% is assumed for the purpose of this computation.

Mortality rates are from the RP2000 Group Annuity Generational Mortality Rates for Male and Female. Termination rates were based upon national termination studies performed by the Society of Actuaries, adjusted to reflect the recent lower termination rates experienced by the Medical Center. Retirement rates were developed based upon recent Medical Center experience.

Projected claim costs of the medical plan are \$873 per month for retirees less than age 65. The UAAL is being amortized as a level percentage of projected payroll expense on an open basis over 30 years.

(10) **Defined Benefit Pension Plan**

The Medical Center contributes to the Iowa Public Employees Retirement System (IPERS) which is a cost-sharing multiple-employer defined benefit pension plan administered by the State of Iowa. IPERS provides retirement and death benefits which are established by State statute to plan members and beneficiaries. IPERS issues a publicly available financial report that includes financial statements and required supplementary information. The report may be obtained by writing to IPERS, PO Box 9117, Des Moines, Iowa 50306-9117.

Plan members are required to contribute 5.95% and 5.78% of their annual salary and the Medical Center is required to contribute 8.93% and 8.67% of annual covered payroll for the years ended June 30, 2014 and 2013, respectively. Contribution requirements are established by State statute. The Medical Center's contributions to IPERS for the years ended June 30, 2014, 2013 and 2012 were \$1,370,134; \$1,394,790; and \$1,317,473; respectively, equal to the required contributions for each year.

(11) **Malpractice Claims**

The Medical Center carries a professional liability policy (including malpractice) providing coverage of \$1,000,000 for injuries per occurrence and \$3,000,000 aggregate coverage. In addition, the Medical Center carries an umbrella policy which provides \$5,000,000 coverage. These policies provide coverage on a claims-made basis covering only those claims which have occurred and are reported to the insurance company while the coverage is in force. In the event the Medical Center should elect not to purchase insurance from the present carrier or the carrier should elect not to renew the policy, any unreported claims which occurred during the policy year may not be recoverable from the carrier.

Accounting principles generally accepted in the United States of America require a healthcare provider to accrue the expense of its share of malpractice claim costs, if any, for any reported and unreported incidents of potential improper professional service occurring during the year by estimating the probable ultimate costs of the incidents. Based upon the Medical Center's claims experience, no such accrual has been made.

(12) **Related Party Transactions**

Because of the existence of common trustees and other factors, the Medical Center and Skiff Medical Center Foundation (Foundation) are related parties. The Foundation was formed to promote the recruitment of medical personnel to practice in Jasper County and the Medical Center for the purpose of maintaining and improving the medical-health care services available to all residents of Jasper County, Iowa.

Skiff Medical Center

Notes to the Financial Statements June 30, 2014 and 2013

A summary of the Foundation's assets, liabilities and net assets as of June 30, 2014 and 2013 follows:

	<u>2014</u>	<u>2013</u>
Assets	\$ 422,150	362,519
Net assets	\$ 422,150	362,519

The Foundation contributed \$58,749 and \$101,128 to the Medical Center during the years ended June 30, 2014 and 2013, respectively, for capital improvements and the purchase of medical and other equipment.

(13) Nonexpendable Permanent Endowment

Nonexpendable permanent endowment consists of contributions from the Geisler Penquite Charitable Corporation. The funds are currently invested in a certificate of deposit. The interest from the funds is to be used for hospice programs as the Board of Trustees shall direct. The value of the endowment at June 30, 2014 and 2013 is \$61,500 and \$50,500, respectively.

(14) Operating Results

The Medical Center has experienced net operating losses of \$3,073,524 and \$3,124,534 in 2014 and 2013, respectively. These losses are primarily related to declining patient volumes due to increased competition from surrounding metropolitan areas, changes in payor mix and limited payment increases from third party payers, increases in higher deductible commercial insurance health plans, and increases in the cost to provide health care services, as well as a struggling local economy in recent years.

The Medical Center's Board of Trustees and management have implemented several measures in an attempt to improve operating results; including, among other things, entering into the Rural Community Hospital Demonstration Program (effective July 1, 2011) which reimburses Medicare inpatient acute care and swing bed services based upon Medicare defined costs of providing the services, partnering with local medical groups to recruit new providers to the area, entering into a joint venture partnership with the Newton clinic, and putting a greater attention toward expense reduction initiatives. The Medical Center is also actively seeking to partner with a health system to help provide financial stability for its local medical community.

(15) Risks and Uncertainties

Current Economic Conditions

The current economic environment presents organizations with unprecedented circumstances and challenges, which in some cases have resulted in large declines in the fair value of investments and other assets, large declines in contributions, constraints on liquidity and difficulty obtaining financing. The financial statements have been prepared using values and information currently available to the Medical Center.

Current economic conditions, including the rising unemployment rate, have made it difficult for certain of the Medical Center's patients to pay for services rendered. As employers make adjustments to health insurance plans or more patients become unemployed, services provided to self-pay and other payers may significantly impact net patient service revenue, which could have an adverse impact on the Medical Center's future operating results. Further, the effect of economic conditions on the state may have an adverse effect on cash flows related to the Medical program.

Given the volatility of current economic conditions the values of assets and liabilities recorded in the financial statements could change rapidly, resulting in material future adjustments in investment values and allowances for patient receivables that could negatively impact the Medical Center's ability to maintain sufficient liquidity.

Skiff Medical Center

Notes to the Financial Statements June 30, 2014 and 2013

(16) Prospective Accounting Change

The Governmental Accounting Standards Board has issued Statement No. 68, *Accounting and Financial Reporting for Pensions – an Amendment of GASB No. 27*. This statement will be implemented for the fiscal year ending June 30, 2015. The revised requirements establish new financial reporting requirements for state and local governments which provide their employees with pension benefits, including additional note disclosures and required supplementary information. In addition, the statement of net position is expected to include a significant liability for the government's proportionate share of the employee pension plan.

Skiff Medical Center

Required Supplementary Information Schedule of Funding Progress for the Retiree Health Plan For the Years Ended June 30, 2014 and 2013

Year Ended June 30	Actuarial Valuation Date	Actuarial Value of Assets	Actuarial Accrued Liability (AAL)	Unfunded AAL (UAAL)	Funded Ratio	Covered Payroll	UAAL as a Percentage of Covered Payroll
2009	July 1, 2008	\$ --	\$ 416,532	\$ 416,532	0.0%	\$ 19,942,000	2.1%
2010	July 1, 2008	\$ --	\$ 416,532	\$ 416,532	0.0%	\$ 17,377,000	2.4%
2011	July 1, 2010	\$ --	\$ 428,494	\$ 428,494	0.0%	\$ 16,694,000	2.6%
2012	July 1, 2010	\$ --	\$ 428,494	\$ 428,494	0.0%	\$ 17,624,000	2.4%
2013	July 1, 2012	\$ --	\$ 296,400	\$ 296,400	0.0%	\$ 17,441,000	1.7%
2014	July 1, 2012	\$ --	\$ 296,400	\$ 296,400	0.0%	\$ 16,667,000	1.8%

See Note 9 in the accompanying notes to financial statements for the plan description, funding policy, annual OPEB cost and net OPEB obligation, funded status and funding progress.

Skiff Medical Center

Required Supplementary Information Budgetary Comparison Schedule of Revenue, Expenses and Changes in Net Position Budget and Actual (Cash Basis) June 30, 2014 and 2013

	<u>Actual Accrual Basis</u>	<u>Accrual Adjustments</u>	<u>Actual Cash Basis</u>	<u>Budgeted Amounts</u>	<u>Variance Favorable (Unfavorable)</u>
Estimated other revenues/ receipts	\$ 33,932,029	1,253,150	35,185,179	37,980,717	2,795,538
Expenses/Disbursements	<u>37,025,839</u>	<u>(555,705)</u>	<u>36,470,134</u>	<u>39,990,554</u>	<u>3,520,420</u>
Net	(3,093,810)	1,808,855	(1,284,955)	(2,009,837)	\$ <u><u>724,882</u></u>
Balance, beginning of year	<u>22,327,947</u>	<u>(16,923,402)</u>	<u>5,404,545</u>	<u>5,404,545</u>	
Balance, end of year	\$ <u><u>19,234,137</u></u>	<u><u>(15,114,547)</u></u>	<u><u>4,119,590</u></u>	<u><u>3,394,708</u></u>	

See accompanying independent auditor's report

This budgetary comparison is presented as Required Supplementary Information in accordance with Government Accounting Standards Board Statement No. 41 for governments with significant budgetary prospective differences resulting from the Medical Center preparing a budget on the cash basis of accounting.

The Board of Trustees annually prepares and adopts a budget designating the amount necessary for the improvement and maintenance of the Medical Center on the cash basis following required public notice and hearing in accordance with Chapters 24 and 347 of the Code of Iowa. The Board of Trustees certifies the approved budget to the city council. The budget may be amended during the year utilizing similar statutorily prescribed procedures. Formal and legal budgetary control is based on total expenditures.

For the year ended June 30, 2014, the Medical Center's expenditures did not exceed the amount budgeted.

Schedules of Patient Service Revenue
For the Years Ended June 30, 2014 and 2013

	2014				2013			
	Inpatient	Outpatient	Home Health and Hospice Services	Total	Inpatient	Outpatient	Home Health and Hospice Services	Total
DAILY PATIENT SERVICES:								
Medical and surgical	\$ 5,140,358	667,495	--	5,807,853	5,500,919	412,121	--	5,913,040
Swing bed - skilled care	571,856	--	--	571,856	865,732	--	--	865,732
Coronary care	474,778	--	--	474,778	621,957	--	--	621,957
Obstetric	460,171	--	--	460,171	547,033	--	--	547,033
Nursery	210,156	--	--	210,156	245,604	--	--	245,604
	<u>6,857,319</u>	<u>667,495</u>	<u>--</u>	<u>7,524,814</u>	<u>7,781,245</u>	<u>412,121</u>	<u>--</u>	<u>8,193,366</u>
OTHER NURSING SERVICES:								
Emergency services	973,201	8,978,959	--	9,952,160	869,081	6,832,572	--	7,701,653
Operating room	4,036,487	5,879,599	--	9,916,086	4,993,780	4,827,762	--	9,821,542
Home health services	--	--	1,476,450	1,476,450	--	--	1,402,641	1,402,641
Recovery room	231,218	820,124	--	1,051,342	292,148	734,866	--	1,027,014
Delivery and labor room	738,940	179,942	--	918,882	317,971	188,778	--	506,749
Hospice services	--	--	816,018	816,018	--	--	1,810,474	1,810,474
	<u>5,979,846</u>	<u>15,858,624</u>	<u>2,292,468</u>	<u>24,130,938</u>	<u>6,472,980</u>	<u>12,583,978</u>	<u>3,213,115</u>	<u>22,270,073</u>
OTHER PROFESSIONAL SERVICES:								
Pharmacy	2,110,697	4,365,703	--	6,476,400	2,464,619	4,894,429	--	7,359,048
Laboratory	1,467,631	4,242,455	--	5,710,086	1,715,124	4,032,603	--	5,747,727
CT scans	736,910	4,339,597	--	5,076,507	883,006	3,954,302	--	4,837,308
Radiology and mammography	338,609	3,570,728	--	3,909,337	395,740	3,579,034	--	3,974,774
Anesthesiology	967,966	2,906,721	--	3,874,687	1,173,560	3,098,170	--	4,271,730
Physical therapy	628,678	2,675,107	135,450	3,439,235	700,501	2,550,962	133,515	3,384,978
Nuclear scans and ultrasound	229,201	3,207,368	--	3,436,569	260,309	3,084,752	--	3,345,061
Magnetic resonance imaging	148,443	2,516,184	--	2,664,627	153,553	2,666,538	--	2,820,091
Clinics	--	2,349,356	--	2,349,356	--	3,152,916	--	3,152,916
Respiratory therapy	1,393,498	245,621	--	1,639,119	1,604,005	206,850	--	1,810,855
Electrocardiology and cardiovascular	267,938	1,244,453	--	1,512,391	343,809	1,164,029	--	1,507,838
Cancer center	50,337	1,287,637	--	1,337,974	2,304	276,124	--	278,428
Occupational therapy	354,130	413,562	81,450	849,142	729,123	342,036	104,625	1,175,784
Intravenous therapy	424,543	389,210	--	813,753	451,535	321,945	--	773,480
Speech therapy	67,333	503,257	2,580	573,170	148,864	535,214	7,095	691,173
Sports rehabilitation	--	545,137	--	545,137	--	606,105	--	606,105
Audiology	14,975	384,674	--	399,649	16,210	395,054	--	411,264
Sleep disorder	--	393,132	--	393,132	3,096	405,339	--	408,435
Blood transfusions	151,749	167,507	--	319,256	156,705	144,762	--	301,467
Cardiac rehabilitation	--	222,584	--	222,584	--	187,738	--	187,738
Alternative health services	604	11,075	--	11,679	--	10,561	--	10,561
Electroencephalography	2,531	7,593	--	10,124	506	7,087	--	7,593
	<u>9,355,773</u>	<u>35,988,661</u>	<u>219,480</u>	<u>45,563,914</u>	<u>11,202,569</u>	<u>35,616,550</u>	<u>245,235</u>	<u>47,064,354</u>
GROSS PATIENT SERVICE REVENUE	\$ <u>22,192,938</u>	<u>52,514,780</u>	<u>2,511,948</u>	<u>77,219,666</u>	<u>25,456,794</u>	<u>48,612,649</u>	<u>3,458,350</u>	<u>77,527,793</u>
LESS:								
Contractual adjustments and other deductions, primarily Medicare and Medicaid				(42,276,741)				(40,289,337)
Charity care services and other discounts, based on charges forgone				(287,541)				(345,094)
Provision for bad debts				(2,915,733)				(3,151,770)
NET PATIENT SERVICE REVENUE				\$ <u>31,739,651</u>				<u>33,741,592</u>

See accompanying independent auditor's report

Other Operating Revenue
For the Years Ended June 30, 2014 and 2013

	<u>2014</u>	<u>2013</u>
Grant revenue for home health services -		
Jasper County	\$ 164,822	202,201
Iowa Department of Health and other grants	87,020	108,791
Total grant revenue for home health services	<u>251,842</u>	<u>310,992</u>
Electronic health record incentive payment	1,203,500	--
Vendor rebates and discounts	223,285	73,751
Facilities management	222,609	327,351
Cafeteria and dietary revenue	195,775	208,929
Lifeline rental	95,989	106,382
Other grant revenue	51,630	76,552
Grants and contributions for hospice services	44,406	62,481
Clinic rental	3,885	46,938
Loss on disposal of capital assets	(221,042)	(118,035)
Other	140,785	96,244
	<u>\$ 2,212,664</u>	<u>1,191,585</u>

See accompanying independent auditor's report

**Departmental Expenses
For the Years Ended June 30, 2014 and 2013**

	2014				2013			
	Salaries and Benefits	Professional Fees and Purchased Services	Supplies and Other	Total	Salaries and Benefits	Professional Fees and Purchased Services	Supplies and Other	Total
NURSING SERVICES:								
Adult and pediatric	\$ 2,288,505	75,260	139,026	2,502,791	2,379,891	323,095	147,195	2,850,181
Home health	915,041	60,027	70,716	1,045,784	890,294	62,887	156,394	1,109,575
Coronary care	483,668	37,418	16,770	537,856	304,777	81,866	9,030	395,673
Nursing administration	423,324	600	31,785	455,709	422,739	5,327	15,705	443,771
Hospice	228,043	9,327	134,792	372,162	317,423	6,712	186,531	510,666
	<u>4,338,581</u>	<u>182,632</u>	<u>393,089</u>	<u>4,914,302</u>	<u>4,315,124</u>	<u>479,887</u>	<u>514,855</u>	<u>5,309,866</u>
OTHER PROFESSIONAL SERVICES:								
Emergency room	2,280,252	461,005	194,398	2,935,655	2,426,426	316,529	154,385	2,897,340
Operating and recovery room	912,633	87,662	1,707,411	2,707,706	975,260	2,729	1,781,479	2,759,468
Laboratory	404,351	1,110,681	376,133	1,891,165	760,538	276,507	615,445	1,652,490
Radiology	1,068,803	373,753	318,694	1,761,250	1,070,923	252,356	484,733	1,808,012
Clinic	1,545,560	2,536	85,987	1,634,083	1,546,141	457,402	239,735	2,243,278
Pharmacy	414,108	129,204	838,218	1,381,530	438,283	121,610	1,602,219	2,162,112
Cancer center	70,867	--	1,088,872	1,159,739	57,770	--	9,406	67,176
Physical therapy	1,039,352	6,266	43,566	1,089,184	973,063	138,546	53,942	1,165,551
Anesthesiology	688,818	242,009	72,364	1,003,191	696,382	195,263	86,365	978,010
OB/delivery/nursery	580,258	153,771	57,451	791,480	638,467	61,593	56,958	757,018
Health information management	409,303	920	57,399	467,622	435,527	26,872	54,944	517,343
Respiratory therapy	375,881	905	47,501	424,287	381,540	7,038	48,236	436,814
Central services and supply	209,231	3,219	71,424	283,874	241,889	2,750	83,669	328,308
Social services	268,262	--	15,180	283,442	239,022	--	11,235	250,257
Occupational therapy	241,362	1,866	5,110	248,338	231,591	123,245	7,772	362,608
Audiology	76,061	--	160,207	236,268	78,198	--	152,494	230,692
Speech therapy	133,777	8,045	(2,416)	139,406	161,871	--	360	162,231
Cardiac rehab	103,375	--	1,960	105,335	106,540	--	1,697	108,237
Sleep lab	1,973	100,755	--	102,728	2,835	94,500	170	97,505
Electrocardiology	--	21,425	1,208	22,633	--	27,063	3,530	30,593
Alternative health	--	7,897	139	8,036	--	7,120	333	7,453
	<u>10,824,227</u>	<u>2,711,919</u>	<u>5,140,806</u>	<u>18,676,952</u>	<u>11,462,266</u>	<u>2,111,123</u>	<u>5,449,107</u>	<u>19,022,496</u>
GENERAL SERVICES:								
Plant operation and maintenance	385,847	98,201	896,098	1,380,146	360,264	60,990	846,940	1,268,194
Dietary	584,478	11,769	288,926	885,173	578,920	12,235	330,672	921,827
Housekeeping	334,138	980	44,211	379,329	302,919	1,013	51,645	355,577
Laundry and linen	77,798	67,316	12,838	157,952	123,605	--	22,656	146,261
	<u>1,382,261</u>	<u>178,266</u>	<u>1,242,073</u>	<u>2,802,600</u>	<u>1,365,708</u>	<u>74,238</u>	<u>1,251,913</u>	<u>2,691,859</u>
ADMINISTRATIVE SERVICES	<u>2,603,929</u>	<u>978,112</u>	<u>1,232,683</u>	<u>4,814,724</u>	<u>2,810,889</u>	<u>950,727</u>	<u>948,348</u>	<u>4,709,964</u>
NONDEPARTMENTAL:								
Employee benefits	3,134,758	--	--	3,134,758	3,324,335	--	--	3,324,335
Depreciation and amortization	--	--	2,390,765	2,390,765	--	--	2,750,237	2,750,237
Insurance	--	--	253,121	253,121	--	--	193,962	193,962
Interest	--	--	38,617	38,617	--	--	54,992	54,992
	<u>3,134,758</u>	<u>--</u>	<u>2,682,503</u>	<u>5,817,261</u>	<u>3,324,335</u>	<u>--</u>	<u>2,999,191</u>	<u>6,323,526</u>
\$	<u><u>22,283,756</u></u>	<u><u>4,050,929</u></u>	<u><u>10,691,154</u></u>	<u><u>37,025,839</u></u>	<u><u>23,278,322</u></u>	<u><u>3,615,975</u></u>	<u><u>11,163,414</u></u>	<u><u>38,057,711</u></u>

See accompanying independent auditor's report

**Patient Receivables and Allowance for Doubtful Accounts
For the Years Ended June 30, 2014 and 2013**

ANALYSIS OF AGING:

Days Since Discharge	2014		2013	
	Amount	Percent of Total	Amount	Percent of Total
0 - 30	\$ 4,290,977	32.06 %	5,631,236	50.13 %
31 - 60	2,129,533	15.91	1,410,299	12.55
61 - 90	1,346,732	10.06	1,014,224	9.03
91 - 120	1,072,579	8.01	606,307	5.40
120 - 150	775,364	5.80	548,331	4.88
> 150	3,768,572	28.16	2,022,574	18.01
	<u>13,383,757</u>	100.00 %	<u>11,232,971</u>	100.00 %
Less:				
Allowance for doubtful accounts	(1,389,432)		(1,388,704)	
Allowance for contractual adjustments	<u>(6,657,861)</u>		<u>(4,709,832)</u>	
	<u>\$ 5,336,464</u>		<u>5,134,435</u>	
			<u>2014</u>	<u>2013</u>
NET DAYS REVENUE IN PATIENT ACCOUNTS RECEIVABLE			36.63 days	55.54 days
ALLOWANCE FOR DOUBTFUL ACCOUNTS:				
Balance, beginning of year			\$ 1,388,704	1,291,004
Provision of uncollectible accounts			2,915,733	3,151,770
Recoveries of accounts previously written off			329,302	324,564
Accounts written off			<u>(3,244,307)</u>	<u>(3,378,634)</u>
Balance, end of year			<u>\$ 1,389,432</u>	<u>1,388,704</u>

See accompanying independent auditor's report

**Inventories / Prepaid Expenses
For the Years Ended June 30, 2014 and 2013**

	<u>2014</u>	<u>2013</u>
INVENTORIES:		
Operating room	\$ 302,619	233,598
Pharmacy	111,392	95,987
General stores	<u>104,599</u>	<u>93,679</u>
	<u>\$ 518,610</u>	<u>423,264</u>
PREPAID EXPENSES:		
Service contracts	\$ 163,169	123,032
Insurance	28,326	46,165
Dues	<u>19,464</u>	<u>18,342</u>
	<u>\$ 210,959</u>	<u>187,539</u>

See accompanying independent auditor's report

**Financial and Statistical Highlights
For the Years Ended June 30, 2014 and 2013**

	<u>2014</u>	<u>2013</u>
Patient Days:		
Hospital -		
Adult and pediatric -		
Medicare	3,467	3,952
All other	2,202	2,251
Swing bed - skilled	1,388	2,111
Nursery	331	391
Hospice	198	584
	<u>7,586</u>	<u>9,289</u>
Discharges:		
Hospital -		
Adult and pediatric -		
Medicare	741	826
All other	647	606
Swing bed	151	202
	<u>1,539</u>	<u>1,634</u>
Average length of stay:		
Hospital -		
Adult and pediatric -		
Medicare	4.68 days	4.78 days
All other	3.40 days	3.71 days
Swing bed	9.19 days	10.45 days
Observation equivalent days	632	401
Surgical procedures	3,285	3,340
Emergency room visits	10,539	10,513
Clinic visits	4,607	9,462
Home health visits	6,014	5,827
Total hospice days and visits	3,266	4,056
Full-time equivalents personnel	285.11	291.83

See accompanying independent auditor's report

**Independent Auditor's Report on Internal Control Over Financial Reporting and on
Compliance and Other Matters Based on an Audit of Financial Statements
Performed in Accordance with Government Auditing Standards**

To the Board of Trustees of
Skiff Medical Center
Newton, Iowa:

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of Skiff Medical Center (Medical Center) as of and for the years ended June 30, 2014 and the related notes to the financial statements, which collectively comprise the Medical Center's basic financial statements, and have issued our report thereon dated October 2, 2014.

Internal Control Over Financial Reporting

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

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A material weakness is a deficiency, or combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. We did identify a certain deficiency in internal control, described in the accompanying schedule of findings and responses as item II-A-14, that we consider to be a significant deficiency.

Compliance and Other Matters

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

Comments involving statutory and other legal matters about the Medical Center's operations for the year ended June 30, 2014 are based exclusively on knowledge obtained from procedures performed during our audit of the financial statements of the Medical Center. Since our audit was based on tests and samples, not all transactions that might have had an impact on the comments were necessarily audited. The comments involving statutory and other legal matters are not intended to constitute legal interpretations of those statutes.

The Medical Center's Response to the Findings

The Medical Center's response to the findings identified in our audit is described in the accompanying schedule of findings and responses. The Medical Center's response was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on it.

Purpose of this Report

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

SEEM JOHNSON, LLP

Omaha, Nebraska,
October 2, 2014.

Skiff Medical Center

Schedule of Findings and Responses June 30, 2014

Part I: Summary of the Independent Auditor's Results

- (a) An unmodified opinion was issued on the financial statements.
- (b) A significant deficiency in internal control over financial reporting was disclosed by the audit of the financial statements.
- (c) The audit did not disclose any non-compliance or other matters which are material to the financial statements.

Part II: Findings Related to the Financial Statements

Significant Deficiency

II-A-14

Criteria: The design or operation of the Medical Center's internal controls should allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements in the financial statements on a timely basis.

Condition: We identified misstatements in the financial statements during the audit that were not initially identified by the Medical Center's internal controls.

Effect: Audit entries were required to adjust the net realizable value of accounts receivable and the estimated amounts due to/from third party payors.

Cause: The process used by management to estimate third-party payor settlements and allowances for contractual adjustments in accounts receivable was not as extensive or detailed enough to properly compute the estimates.

Recommendation: Tremendous detail is needed to accurately estimate accounts receivable allowances and third-party settlements. The Medical Center should review and revise its estimation process of the stated accounts to ensure that financial statements are properly stated.

*Views of Responsible
Officials and Planned*

Corrective Action: The Medical Center concurs with the recommendation and will review and improve its estimation processes and procedures.

Instances of Non-Compliance

No matters were reported.

Skiff Medical Center

Schedule of Findings and Responses June 30, 2014

Part III: Other Findings Related to Required Statutory Reporting

- III-A-14 Official Depositories: A resolution naming official depositories has been adopted by the Board. The maximum deposit amounts stated in the resolution were not exceeded during the year ended June 30, 2014.
- III-B-14 Certified Budget: Medical Center disbursements during the year ended June 30, 2014 did not exceed budgeted amounts.
- III-C-14 Questionable Expenditures: We noted no expenditures that we believe would be in conflict with the requirements of public purpose as defined in an Attorney General's opinion dated April 25, 1979.
- III-D-14 Travel Expense: No expenditures of Medical Center money for travel expenses of spouses of Medical Center officials and/or employees were noted.
- III-E-14 Business Transactions: No business transactions were found between Medical Center and Medical Center officials and/or employees.
- III-F-14 Board Minutes: No transactions were found that we believe should have been approved in the Board minutes but were not.
- III-G-14 Deposits and Investments: No instances of non-compliance with the deposit and investment provisions of Chapter 12B and Chapter 12C of the Code of Iowa were noted.

Skiff Medical Center

**Audit Staff
For the Year Ended June 30, 2014**

This audit was performed by:

Darren R. Osten, FHFMA, CPA, Partner

Amanda L. Patrick, CPA, In-Charge

Bradley D. Pieper, Associate

October 2, 2014

To the Board of Trustees of
Skiff Medical Center
Newton, Iowa:

In planning and performing our audit of the financial statements of Skiff Medical Center (Medical Center), as of and for the year ended June 30, 2014, in accordance with auditing standards generally accepted in the United States of America, we considered the Medical Center's internal control over financial reporting (internal control) as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Medical Center's internal control. Accordingly, we do not express an opinion on the effectiveness of the Medical Center's internal control.

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

Our consideration of internal control was for the limited purpose described in the first paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified.

Our audit was also not designed to identify deficiencies in internal control that might be significant deficiencies. A significant deficiency is a deficiency, or combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. We consider the following control deficiency to be a significant deficiency:

Management Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimations that affect the reported amounts of assets and liabilities as of the date of the financial statements. As part of the audit, we reviewed the following significant estimates made by management:

- Allowance for uncollectible accounts receivable
- Allowance for third-party payor adjustments
- Estimated third-party payor settlements

Tremendous detail is needed to accurately estimate the net realizable value of accounts receivable and third-party payor settlements. Management performed an analysis of the estimated collectability of accounts receivable based upon historical collection rates. As part of our audit procedures, additional tests of the estimated settlements and allowances were performed which resulted in audit adjustments.

We recommend management continue to monitor and improve its current estimation process to compute appropriate estimates for an allowance for uncollectible accounts receivable and third-party payor adjustments and settlements to ensure that they are accurate as possible and methodologies are consistent between years. We have provided management with some templates to assist them with the estimation process.

The following are offered as constructive suggestions to be considered part of the ongoing process of modifying and improving the Medical Center's policies and procedures:

Recovery Audit Contracts (RAC)

The Medicare Recovery Audit Contractor (RAC) program was established by the *Medicare Modernization Act of 2003*. The program was established as a three year demonstration project in three states as a means to identify Medicare overpayments and underpayments to providers. The *Tax Relief and Health Care Act of 2006* made the RAC program permanent and required the Centers for Medicare & Medicaid Services (CMS) to expand the program nationwide by 2010. RAC program audits began in August 2009 for the State of Iowa.

RAC audits are not performed directly by CMS, but rather by private contractors that are awarded contracts in one of the four CMS designated regions of the United States. Health Data Insights (HDI) is the contractor for the Midwest Region D, which includes Iowa. These private contracts are paid on a contingency fee basis by receiving a percentage of the improper overpayments and underpayments they collect from providers. RAC audits can be automated (claims selection solely based on data from CMS without human review of the medical record) or complex (human review of medical record required to identify discrepancies between the medical record and claim). RAC audits are focused on overpayments to the provider for the following: (1) incorrect payment amounts; (2) non-covered services; (3) incorrectly coded services; and (4) duplicate services. RAC audits are limited in the type of items they are contracted to review, RAC audits cannot review (1) services provided outside of Medicare fee-for-service; (2) cost report settlements; and (3) claims paid dates after October 1, 2007.

The Medical Center has been subject to recent RAC audit activity and has recognized a liability for potential future settlements resulting from RAC audits. We recommend management continue to stay aware of the ongoing RAC audit activity.

Rural Community Hospital Demonstration Program

Section 10313 of the Patient Protection and Affordable Care Act of 2010 mandates an extension of the Rural Community Hospital Demonstration Program for an additional 5 years. The law allows additional hospitals to participate in the demonstration program. The Medical Center was selected to participate in this program for a period of 5 years effective July 1, 2011.

Since 2004, CMS has been conducting a "Rural Community Hospital Demonstration Program" as mandated under Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. The original 5-year period of performance mandated by the MMA will ended in 2010.

Case study analyses of hospitals participating as of December 2009 found that:

- Although the hospitals that have participated in the demonstration shared certain characteristics by virtue of their eligibility, they also differed in important respects—including their ownership and governance, their market environments, the size and scope of their operations, and their patterns of inpatient utilization.
- All of the hospitals in the demonstration have relied on a relatively small number of physicians for both inpatient and outpatient care. Although some sites were more attractive to physicians than others, problems with physician recruitment and retention were ubiquitous. On-call rotations for hospital inpatient coverage imposed an added hardship when there were few colleagues available to share the burden.
- Expenses related to capital improvements and major equipment purchases pose a continuing challenge for all demonstration hospitals. They have deemed it essential to maintain state-of-the-art equipment and facilities comparable to those of larger hospitals.
- Most hospitals used initial additional reimbursements for a range of expenses, including losses they would have had under IPPS, improvement projects, medical equipment, expanded or additional services, and community outreach programs.

The Medical Center will receive payment for inpatient services, with the exclusion of services furnished in a psychiatric or rehabilitation unit that is a distinct part of the hospital, using the following rules:

1. Reasonable cost for covered inpatient services, for discharges occurring in the first cost reporting period on or after the implementation of the program;
2. For subsequent cost reporting periods, the lesser amount of reasonable cost or the previous year's amount updated by the inpatient prospective payment update factor for that particular cost reporting period.

The June 30, 2012 Medicare cost report was the base year used to establish the reasonable cost that will be reimbursed. The audit of the base year was completed by the Medicare Administrator Contractor during this past year. We recommend that management continue its process in reviewing overhead allocations in order to receive accurate and appropriate reimbursement.

Sequestration

Certain provisions of the *Federal Government's Budget Control Act of 2011* went into effect on January 1, 2013. Among these are mandatory payment reductions under the Medicare Fee-for-Service program, known as sequestration. The *American Taxpayer Relief Act of 2012* postponed sequestration for two months, but the order was issued by President Obama on March 1, 2013. Under these provisions, Medicare reimbursement was reduced by two percent on all claims with dates-of-service or dates-of-discharge on or after April 1, 2013. Under current law, sequestration is scheduled to last through 2021. The estimated impact of sequestration in 2014 for the Medical Center is approximately \$170,000. The continuation of these payment cuts for an extended period of time will have an adverse effect on operating results of the Medical Center.

Affordable Care Act

The effects of the *Affordable Care Act* (the Act) are far-reaching and complex and will have an impact on substantially all employers. The bulk of the provisions will phase in by January 2015, with the remaining major provisions phased in by 2018. Beginning in 2015, a large employer that does not offer qualifying health insurance coverage as required under the Act, will be required to pay a penalty if any full-time employee certifies to the employer as having purchased health insurance through a state exchange and a tax credit or cost-sharing reduction is allowed or paid to the employee. To make sure you are in compliance with the Act, we suggest you work to:

- Determine what your health insurance compliance requirements are under the Act
 - Review the regulations of the Act and compare the requirements to provide minimum essential coverage to your current health insurance plan
 - Consider new benchmarks for health insurance in your industry
 - Determine what the acceptable level of health insurance coverage is for your employees
 - Determine what the required employer contributions will be
- Determine what options are available under the Act and which is best for your business model
 - Analyze financial implications of the Act to your financial statements
 - Perform cost projections to evaluate costs and benefits of current insurance coverage, state sponsored plans or other alternatives
 - Develop a multiyear strategy for plan design and employer and employee contributions
 - Develop an implementation plan and monitoring procedures

While many of these provisions do not take effect until 2015, the evaluation should start now to determine the best options for the Medical Center and what the reporting requirements to comply with the Act will be.

Current Economic Conditions

The current protracted economic environment has created unprecedented circumstances and challenges for the health care industry. As a result, hospitals are facing declines in the fair values of investments and other assets, declines in contributions, constraints on liquidity and difficulty obtaining financing. The values of the assets and liabilities recorded in the financial statements could change rapidly, resulting in material future adjustments to asset values, the allowance for accounts and contributions receivable, etc. that could negatively impact the Medical Center's ability to maintain sufficient liquidity. Now, more than ever, we recommend that management and the Board of Trustees continue to monitor and aggressively manage all of these matters, including:

- Review and monitor allowances for uncollectible accounts and contractual adjustments
- Review service lines and/or cost centers for savings opportunities
- Evaluate financing needs and liquidity plans

GASB Statement No. 68

GASB Statement No. 68, *Accounting and Financial Reporting for Pensions*, issued June 2012, will be effective for the Medical Center beginning with its year ending June 30, 2015. This Statement replaces requirements of GASB Statement No. 27, *Accounting for Pensions by State and Local Governmental Employers*, and GASB Statement No. 50, *Pension Disclosures*, as they relate to governments that provide pensions through pension plans administered as trusts or similar arrangement that meet certain criteria. This Statement requires governments providing defined benefit pensions to recognize their long-term obligation for pension benefits as a liability for the first time, and enhances accountability and transparency through revised and new note disclosures and required supplementary information.

Accounting for Leases

The International Accounting Standards Board (IASB), the body responsible for setting International Financial Reporting Standards (IFRS), and the Financial Accounting Standards Board (FASB), the body responsible for setting accounting principles generally accepted in the United States of America, issued a Proposed Accounting Standards Update on May 16, 2013 to Topic 842, Leases in response to concerns raised by users of financial statements regarding the treatment of leases. Existing lease accounting treatment has been criticized for its complexity on the basis that it has proved difficult to define the dividing line between capital and operating leases, as the current standards require the application of subjective judgments.

Under the proposal, most leases of assets other than property, which include equipment, cars, trucks, etc., would be classified as Type A leases and the entity would:

- Recognize a right-of-use asset and a lease liability, measured at the present value of lease payments.
- Recognize the unwinding of the discount on the lease liability as interest separately from the amortization of the right-of-use asset, which would typically be amortized on the straight-line basis over the shorter of the estimated useful life of the asset or the lease term.

Leases of property such as land or buildings would be classified as Type B leases and would:

- Recognize a right-of-use asset and a lease liability, measured at the present value of lease payments.
- Recognize a single lease cost, combining the unwinding of the discount on the lease liability with the amortization of the right-of-use asset. The amortization of the right-of-use asset would be determined as the difference between the periodic lease cost determined on a straight line basis, and the unwinding of the discount of the lease liability.

Variable leases would be mostly excluded from the measurement of assets and liabilities, and payments in optional periods would be excluded unless the lessee had a significant economic incentive to exercise the option to extend the lease term. Leases with maximum possible terms (including options to extend) of 12 months or less could be accounted for with simplified requirements that are similar to existing accounting for operating leases.

The standards would be applied with either a modified or full retrospective approach for the earliest period presented in the financial statements. There currently is no indication of a proposed effective date. However, it would be prudent for businesses to plan ahead on the basis that the current accounting rules are expected to change, especially when they are negotiating long-term leases or loan facilities with financial covenants that could be impacted by these changes.

The recommendations that we have outlined above are for management's use only, and are not intended to be part of a formal report which would customarily be delivered to outside vendors, third-party payors, etc. We would be pleased to answer any questions you may have regarding the comments and suggestions contained in the preceding paragraphs.

Sincerely,

SEIM JOHNSON, LLP



Darren R. Osten