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January 13, 2009

Board of Directors
Woodlawn Hospital
1400 East Ninth Street
Rochester, Indiana 46975

We have reviewed the audit report prepared by Blue & Co., LLC, Independent Public Accountants, for the period January 1, 2007 to December 31, 2007. In our opinion, the audit report was prepared in accordance with the guidelines established by the State Board of Accounts. Per the Independent Public Accountants' opinion, the financial statements included in the report present fairly the financial condition of Woodlawn Hospital, as of December 31, 2007 and the results of its operations for the period then ended, on the basis of accounting described in the report.

The Independent Public Accountants' report is filed with this letter in our office as a matter of public record.

We call your attention to the corrected misstatements identified on page three of the Board of Trustees Letter and to the auditor recommendations, beginning on page four of that same document.

STATE BOARD OF ACCOUNTS

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WOODLAWN HOSPITAL

FINANCIAL STATEMENTS

AND

SUPPLEMENTARY INFORMATION

DECEMBER 31, 2007 AND 2006

WOODLAWN HOSPITAL

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REPORT OF INDEPENDENT AUDITORS

Board of Trustees
Woodlawn Hospital
Rochester, Indiana

We have audited the accompanying balance sheet of Woodlawn Hospital (the Hospital), as of December 31, 2007 and the related statements of revenues, expenses, and changes in net assets and cash flows for the year then ended. These financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these financial statements based on our audit. The financial statements of the Hospital as of December 31, 2006 were audited by other auditors whose report dated April 24, 2007, expressed an unqualified opinion on those statements.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Hospital as of December 31, 2007, and the results of its revenues, expenses, and changes in net assets and cash flows for the year then ended, in conformity with accounting principles generally accepted in the United States of America.

Management's Discussion and Analysis, as listed in the table of contents is not a required part of the basic financial statements but is supplementary information required by accounting principles generally accepted in the United States of America. We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the required supplementary information. However, we did not audit the information and express no opinion on it.

Blue & Co., LLC

June 12, 2008

REQUIRED SUPPLEMENTARY INFORMATION

WOODLAWN HOSPITAL

MANAGEMENT'S DISCUSSION & ANALYSIS (UNAUDITED)
DECEMBER 31, 2007 AND 2006

This section of Woodlawn Hospital's (Hospital) annual financial statements presents background information and management's discussion and analysis (MD&A) of the Hospital's financial performance during the year ended December 31, 2007. Please read it in conjunction with the Hospital's financial statements that follow this MD&A.

Financial Highlights

- The Hospital's net assets increased approximately $465,136 or 4% in 2007.
- The Hospital reported operating income of approximately $176,239 for 2007, representing a decrease of approximately $389,207 in comparison to the year 2006 results.

Using This Annual Report

The Hospital's financial statements consist of three statements – a Balance Sheet; a Statement of Revenues, Expenses, and Changes in Net Assets; and a Statement of Cash Flows. These financial statements and related notes provide information about the activities and the financial position of the Hospital.

The Balance Sheet includes all of the Hospital's assets and liabilities and provides information about the nature and amounts of investments in resources (assets) and the obligations to Hospital creditors (liabilities).

All of the current year's revenue earned and expenses incurred are accounted for in the Statement of Revenues, Expenses, and Changes in Net Assets.

Finally, the Statement of Cash Flows' purpose is to provide information about the Hospital's cash flows from operating activities, financing activities including capital additions, and investing activities. This statement provides information on the sources and uses of cash and the change in cash balance during the year.

The Hospital's Net Assets

The Hospital's net assets are the difference between its assets and liabilities reported in the balance sheet. The Hospital's net assets increased by $465,136 in 2007 compared to 2006.

Assets, Liabilities, and Net Assets

	2007	2006
ASSETS		
Current assets	$ 8,693,291	$ 7,941,896
Assets whose use is limited	3,176,028	2,896,890
Capital assets, net	5,892,579	6,499,770
Other assets	44,426	89,349
Total assets	$ 17,806,324	$ 17,427,905
LIABILITIES		
Current liabilities	$ 3,958,512	$ 3,279,555
Long-term debt	2,277,716	3,043,390
Total liabilities	6,236,228	6,322,945
NET ASSETS		
Invested in capital assets, net of related debt	2,578,300	2,604,438
Restricted		
For debt service	136,551	6,582
Expendable - other specific purposes	231,501	195,808
Total restricted net assets	368,052	202,390
Unrestricted	8,623,744	8,298,132
Total net assets	11,570,096	11,104,960
Total liabilities and net assets	$ 17,806,324	$ 17,427,905

The significant changes in the Hospital's assets were Capital Assets decreasing $607,000 and Current Assets increasing $751,000. Patient accounts receivable, a portion of current assets decreased $944,392.

Operating Results and Changes in the Hospital's Net Assets

In 2007, the Hospital's net assets increased $465,136, as shown below. This increase is made up of different components, which will be discussed in the following paragraphs.

Operating Results and Changes in Net Assets

	2007	2006
Revenues		
Net patient service revenue	$ 29,654,170	$ 28,207,098
Other operating revenue	1,539,399	1,304,131
Total operating revenues	31,193,569	29,511,229
Expenses		
Salaries and benefits	17,931,165	16,840,362
Supplies	4,375,754	4,188,810
Depreciation and amortization	1,249,512	1,369,635
Other operating expenses	7,460,899	6,546,976
Total expenses	31,017,330	28,945,783
Operating income	176,239	565,446
Non-operating expenses, net	28,897	(26,071)
Transfers from County	260,000	264,000
Change in net assets	465,136	803,375
Net assets beginning of year	11,104,960	10,301,585
Net assets end of year	$ 11,570,096	$ 11,104,960

Sources of Revenue

During 2007, the Hospital derived substantially all of its revenue from patient service and other related activities. A significant portion of the patient service revenue is from patients that are insured by government health programs, principally Medicare and Medicaid, which are highly regulated and subject to frequent and substantial changes. Revenues from the Medicare and Medicaid programs represented approximately 47% of the Hospital's gross revenues in 2007.

Following is a table of the patient accounts receivable mix as of December 31, 2007 and 2006, respectively:

	2007	2006
Medicare	20.5%	24.3%
Medicaid	9.6%	9.2%
Blue Cross	11.0%	9.6%
Other	29.4%	30.3%
Self Pay	29.5%	26.6%
	100.0%	100.0%

The Hospital's outpatient and physician services represented 82% of the Hospital's gross patient revenue in 2007.

Operating and Financial Performance

The Hospital had a return on equity of 4%, down from last year's 7.2%. The hospital's debt service coverage ratio was at approximately 1.8 times.

This following section highlights the major financial factors for 2007:

- The Hospital's patient days decreased to 3,003 in 2007 compared to 3,559 in 2006. The majority of the decrease was in medical/surgical days of 471.

- During 2007 the Hospital's net patient services revenue was enhanced by Indiana Medicaid Municipal Hospital Payments of approximately $2,000,000 compared to the payments of approximately $1,200,000 received in 2006.

- Operating expenses increased $2,071,547 or 7%. This growth is attributable to the increasing costs of resources utilized to provide services to the Hospital's patients.

- Salaries and Benefits represented the largest increase over 2006. Salaries and Benefits expense for 2007 was $1,090,803 greater than 2006. The increase represented a 6.5% change from 2006.

Capital Assets

During 2007, the Hospital invested $642,398 in capital assets gross of asset disposals. The change in capital assets is outlined in the following table:

	2007	2006
Land and improvements	$ 750,452	$ 650,423
Buildings and improvements	10,182,474	10,248,572
Equipment	9,162,150	10,803,481
Construction in progress	45,000	-0-
Total property and equipment	20,140,076	21,702,476
Less accumulated depreciation	14,247,497	15,202,706
Capital assets, net	$ 5,892,579	$ 6,499,770

Debt

Total long-term debt decreased from $3,895,332 to $3,314,279 due to current year principal payments.

Economic Outlook

Management believes that the health care industry's and the Hospital's operating margins will continue to be under pressure because of changes in payer mix and growth in operating expenses that are in excess of the increases in contractually arranged and legally established payments received for services rendered. Another factor that poses a challenge to management is the increasing competitive market for the delivery of health care services. The ongoing challenge facing the Hospital is to continue to provide quality patient care in this competitive environment, and to attain reasonable rates for the services that are provided while managing costs. The most significant cost factor affecting the Hospital is the increases in labor costs due to the increasing competition for quality health care workers.

Contacting the Hospital's Financial Management

This financial report is designed to provide our patients, suppliers, taxpayers, and creditors with a general overview of the Hospital's finances and to show the Hospital's accountability for the money it receives. If you have questions about this report or need additional financial information, contact the Hospital Administrative offices at 1400 East Ninth Street, Rochester, IN 46975.

WOODLAWN HOSPITAL

BALANCE SHEETS
DECEMBER 31, 2007 AND 2006

ASSETS

	2007	2006
Current assets		
Cash and cash equivalents	$ 725,480	$ 5,387
Patient accounts receivable, net of estimated uncollectibles of $2,900,156 and $2,468,440 in 2007 and 2006, respectively	5,136,374	6,053,329
Inventories	906,922	743,174
Estimated third party settlements	1,242,463	276,931
Other current assets	682,052	863,075
Total current assets	8,693,291	7,941,896
Assets whose use is limited		
Board designated	2,807,976	2,694,500
Trustee held funds, less current portion	136,551	6,582
Donor restricted	231,501	195,808
Total assets whose use is limited	3,176,028	2,896,890
Capital assets		
Land	345,223	220,127
Depreciable capital assets, net	5,502,356	6,279,643
Construction in progress	45,000	-0-
Total capital assets	5,892,579	6,499,770
Other assets	44,426	89,349
Total assets	$ 17,806,324	$ 17,427,905

See accompanying notes to financial statements.

WOODLAWN HOSPITAL

BALANCE SHEETS
DECEMBER 31, 2007 AND 2006

LIABILITIES AND NET ASSETS

	2007	2006
Current liabilities		
Book overdraft	$ -0-	$ 175,883
Line of credit	525,000	-0-
Accounts payable and accrued expenses	1,226,097	1,223,196
Accrued salaries and related liabilities	1,170,852	1,028,534
Current portion of long-term debt		
Capital leases	364,974	295,353
Revenue bonds payable	671,589	556,589
Total current liabilities	3,958,512	3,279,555
Long-term debt and capital leases		
Capital leases	729,893	823,978
Long-term debt	1,547,823	2,219,412
Total long-term debt	2,277,716	3,043,390
Total liabilities	6,236,228	6,322,945
Net assets		
Invested in capital assets, net of related debt	2,578,300	2,604,438
Restricted		
For debt service	136,551	6,582
Expendable - other specific purposes	231,501	195,808
Total restricted net assets	368,052	202,390
Unrestricted	8,623,744	8,298,132
Total net assets	11,570,096	11,104,960
Total liabilities and net assets	$ 17,806,324	$ 17,427,905

See accompanying notes to financial statements.

WOODLAWN HOSPITAL

STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET ASSETS
YEARS ENDED DECEMBER 31, 2007 AND 2006

	2007	2006
Revenues		
Net patient service revenue	$ 29,654,170	$ 28,207,098
Other operating revenue	1,539,399	1,304,131
Total operating revenue	31,193,569	29,511,229
Expenses		
Salaries and wages	14,623,169	13,720,051
Employee benefits	3,307,996	3,120,311
Professional fees	4,130,050	3,395,735
Supplies	4,375,754	4,188,810
Rent	415,312	167,499
Utilities	549,188	557,236
Repairs and maintenance	792,273	981,090
Insurance	463,496	426,213
Depreciation and amortization	1,249,512	1,369,635
Other	1,110,580	1,019,203
Total operating expenses	31,017,330	28,945,783
Operating income	176,239	565,446
Nonoperating revenue (expense)		
Investment income	157,071	129,932
Interest expense	(118,943)	(172,077)
Loss on disposition of assets	(15,879)	(12,938)
Other nonoperating income (expense)	6,648	29,012
Total nonoperating revenue (expense)	28,897	(26,071)
Transfers from the county	260,000	264,000
Change in net assets	465,136	803,375
Net assets		
Beginning of year	11,104,960	10,301,585
End of year	$ 11,570,096	$ 11,104,960

See accompanying notes to financial statements.

WOODLAWN HOSPITAL

STATEMENTS OF CASH FLOWS
YEARS ENDED DECEMBER 31, 2007 AND 2006

	2007	2006
Operating activities		
Cash received from patients and third party payors	$ 29,605,593	$ 28,580,935
Cash paid to employees for wages and benefits	(17,788,847)	(15,387,405)
Cash paid to vendors for goods and services	(12,301,249)	(12,459,043)
Other operating receipts, net	1,539,399	1,304,131
Net cash from operating activities	1,054,896	2,038,618
Noncapital financing activities		
Other nonoperating	6,648	29,012
Capital and related financing activities		
Transfers from the county	260,000	264,000
Acquisition and construction of capital assets	(333,509)	(345,024)
Loss on disposal of assets	15,879	12,938
Interest expense on long-term debt	(118,943)	(172,077)
Proceeds on line of credit, net	525,000	-0-
Principal payments on long-term debt and capital leases, net	(893,353)	(931,265)
Net cash from capital and related financing activities	(544,926)	(1,171,428)
Investing activities		
Other assets	29,121	-0-
Investment income	157,071	129,932
Other change in assets whose use is limited, net	2,746,421	(1,136,037)
Net cash from investing activities	2,932,613	(1,006,105)
Net change in cash and cash equivalents	3,449,231	(109,903)
Cash and cash equivalents		
Beginning of year	207,777	317,680
End of year	$ 3,657,008	$ 207,777

See accompanying notes to financial statements.

WOODLAWN HOSPITAL

STATEMENTS OF CASH FLOWS
YEARS ENDED DECEMBER 31, 2007 AND 2006

	2007	2006
Reconciliation of operating income to net cash from operating activities		
Operating income	$ 176,239	$ 565,446
Adjustments to reconcile operating income to net cash from operating activities:		
Depreciation and amortization	1,249,512	1,369,635
Provision for bad debt	3,155,010	2,477,037
Changes in assets and liabilities		
Patient accounts receivable	(2,238,055)	(2,558,149)
Inventories	(163,748)	579,339
Estimated third-party settlements	(965,532)	(319,650)
Other current assets	181,023	(863,075)
Book overdraft	-0-	175,883
Accounts payable and accrued expenses	(481,871)	258,195
Accrued salaries and related liabilities	142,318	353,957
Net cash flows from operating activities	$ 1,054,896	$ 2,038,618
Reconciliation of cash and cash equivalents to the balance sheets		
Cash and cash equivalents		
In current assets	$ 725,480	$ 5,387
In assets whose use is limited	2,931,528	202,390
Total cash and cash equivalents	$ 3,657,008	$ 207,777

See accompanying notes to financial statements.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization and Reporting Entity

Woodlawn Hospital (the Hospital) is a county-owned facility and operates under the Indiana County Hospital Law, Indiana Code 16-22. The Hospital provides short-term inpatient and outpatient health care.

The Board of County Commissioners of Fulton County appoints the Governing Board of the Hospital (Board) and a financial benefit/burden relationship exists between the County and the Hospital. For these reasons, the Hospital is considered a component unit of Fulton County.

On January 6, 1975, the Board of County Commissioners of Fulton County, upon written request of the Hospital Board of Trustees, created the Fulton County Hospital Association. The Association was created pursuant to the provisions of Indiana Code 16-22-6 for the exclusive purpose of financing and constructing hospital facilities of the Hospital.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles 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 period. Actual results could differ from those estimates.

Enterprise Fund Accounting

The Hospital utilizes the enterprise fund method of accounting whereby revenue and expenses are recognized on the accrual basis of accounting. Substantially all revenues and expenses are subject to accrual.

Accounting Standards

Pursuant to Governmental Accounting Standards Board (GASB) Statement Number 20, *Accounting and Financial Reporting For Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting*, the Hospital has elected to apply the provisions of all relevant pronouncements of the Financial Accounting Standards Board (FASB), including those issued after November 30, 1989, that do not conflict with or contradict GASB pronouncements.

Cash and Cash Equivalents

Cash and cash equivalents include all cash held in checking, savings and money market accounts available for operating purposes with original maturity dates of 90 days or less. The Hospital maintains its cash in accounts, which at times may exceed federally insured limits. The Hospital has not experienced any losses in such accounts. The Hospital believes that it is not exposed to any significant credit risk on cash and cash equivalents.

Patient Accounts Receivable and Net Patient Service Revenue

Patient revenues and the related accounts receivable are recorded at the time services to patients are performed. Management estimates an allowance for doubtful accounts receivable based on an evaluation of historical losses, current economic conditions, and other factors unique to the Hospital's customer base.

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

Medicare – The Hospital has been granted Critical Access Status under which the Hospital is paid based upon a cost reimbursement methodology. The Hospital is reimbursed for cost reimbursable items at a tentative rate, with final settlement determined after submission of annual cost reports. Final determination of amounts earned is subject to review by the fiscal intermediary. Medicare reports have been settled through 2005. Management believes adequate provision has been made in the financial statements for any adjustments.

Medicaid – Inpatient and outpatient services rendered to the Medicaid program are paid based upon prospectively determined rates.

Revenue from the Medicare and Medicaid programs accounted for approximately 32 percent and 8 percent, respectively, of the Hospital's net patient revenue for the year ended 2007, and 34 percent and 8 percent, respectively, of the Hospital's net patient revenue, for the year ended 2006. 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 Hospital participates in the Disproportionate Share Hospital Program. Subject to certain qualification criteria, the Hospital is entitled to participate in the program annually. The Hospital recognized revenue related to the Medicaid Disproportionate Share Hospital and the Upper Payment Limitation programs of approximately $1,800,000 and $1,200,000 for the years ended December 31, 2007 and 2006, respectively. These amounts are reimbursements for providing care to the uninsured during periods prior to 2007 and 2006. This program is a Federal program administered by the state. In 2008, the current program is under review by the State and Federal governments and may not continue under its current format. The ultimate outcome and impact of potential changes is unknown.

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

Compassionate Care

The Hospital 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 Hospital does not collect amounts deemed to be charity care, they are not reported as revenue.

Inventories

Inventories are valued at the lower of cost or market with cost being determined on an average cost method.

Assets Whose Use is Limited

Assets whose use is limited are stated at fair value in the financial statements. These assets include investments designated by the Hospital Board for internal purposes and investments held by trustees for capital improvements. These investments consist primarily of cash and cash equivalents and certificates of deposit. Investment income, to the extent not capitalized, is reported as nonoperating income in the statements of revenues, expenses and changes in net assets.

Capital Assets and Depreciation

Capital assets such as property and equipment are stated at cost and include expenditures for new additions and other costs added to existing facilities which exceed $5,000 and which substantially increase the useful lives of existing facilities. Maintenance, repairs and minor renewals are expensed as incurred.

The Hospital provides for depreciation of property and equipment using annual rates, which are sufficient to depreciate the cost of depreciable assets over their estimated useful lives using the straight-line method.

The range of useful lives in computing depreciation is as follows:

Description	Range of Useful Lives
Land improvements	2-25 years
Buildings and fixed equipment	5-40 years
Major movable and minor equipment	2-20 years

For depreciated assets, the cost of normal maintenance and repairs that do not add to the value of the asset or materially extend assets lives are not capitalized.

Net Assets

Net assets of the Hospital are classified in three components. Net assets invested in capital assets net of related debt consist of capital assets net of accumulated depreciation and reduced by the current balances of any outstanding borrowings used to finance the purchase or construction of those assets. Restricted expendable net assets are net assets that must be used for a particular purpose, as specified by creditors, grantors, or contributors external to the Hospital, including amounts deposited with trustees as required by revenue bond indentures. Unrestricted net assets are remaining net assets that do not meet the definition of invested in capital assets net of related debt or restricted.

Grants and Contributions

From time to time, the Hospital receives grants from Fulton County and the State of Indiana as well as contributions from individuals and private organizations. Revenues 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 revenues. Amounts restricted to capital acquisitions are reported after nonoperating revenues and expenses.

Restricted Resources

When the Hospital has both restricted and unrestricted resources available to finance a particular program, it is the Hospital's policy to use restricted resources before unrestricted resources.

Statements of Revenues, Expenses, and Changes in Net Assets

The Hospital's statement of revenues, expenses and changes in net assets distinguishes between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services – the Hospital's principal activity. Nonexchange revenues, including grants, and contributions received for purposes other than capital asset acquisition, are reported as nonoperating revenues. Operating expenses are all expenses incurred to provide health care services, other than financing costs.

Statements of Cash Flows

For purposes of the statements of cash flows, cash and cash equivalents include all cash held in checking, savings, and money market accounts with original maturity dates of 90 days or less in current assets, board designated funds and trustee held assets. Additional cash flow information is as follows:

	2007	2006
Supplemental cash flows information		
Cash paid for interest	$ 118,943	$ 172,077
Noncash capital and related financing activities		
Capital leases	$ 308,889	$ 226,503

Costs of Borrowing

Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Bond Issuance Costs

The Hospital provides for the amortization of costs incurred for the issuance of bonds over the life of the debt. Bond issuance costs are amortized over the life of the bond utilizing the straight-line method.

Fair Value of Financial Instruments

Financial instruments consist of cash and cash equivalents, patient accounts receivable, assets whose use is limited, accounts payable, accrued liabilities, estimated third-party settlements and long-term debt. The carrying amounts reported in the balance sheets for cash and cash equivalents, patient accounts receivable, accounts payable, accrued liabilities and estimated third-party settlements approximate fair value.

The fair values of assets whose use is limited are estimated based on quoted market prices for those or similar investments. The fair value of the Hospital's long-term debt is estimated based on market prices for similar issues on current rates offered to the Hospital. As of December 31, 2007 and 2006, the carrying value of the Hospital's long-term debt approximated its fair value.

Federal or State Income Taxes

The Hospital is a governmental instrumentality organized under Title 16, Article 12, of the Indiana statues. The Hospital is exempt from federal income tax under Section 115 of the Internal Revenue Code of 1986 as a not-for-profit organization under Section 501(c)(3).

Compensated Absences

The Hospital's employees earn time off at varying rates depending on years of service. The estimated amount of unused earned time off is reported as a liability in the financial statements.

Advertising and Community Relations

The Hospital records advertising and community relations expense in the period incurred. Total expense for advertising and community relations was $218,911 and $240,312 for 2007 and 2006, respectively.

Litigation

The Hospital is involved in litigation arising in the normal course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Hospital's future financial position or results from operations.

Risk Management

The Hospital 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 employee health, dental, and accident benefits. 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.

Medical Malpractice

Malpractice insurance coverage is provided under a claims-made policy. Should the claims-made policy be terminated, the Hospital has the option to purchase insurance for claims having occurred during its term but reported subsequently. Prior to July 1, 1999, the Indiana Medical Malpractice Act provided for a maximum recovery of $750,000 per occurrence ($3,000,000 annual aggregate) for professional liability, $100,000 of which would be paid through the Hospital's malpractice insurance coverage and the balance would be paid by the State of Indiana Patient Compensation Fund. For claims on or after July 1, 1999, the Indiana Medical Malpractice Act provides for a maximum recovery of $1,250,000 per occurrence ($7,500,000 annual aggregate) with the first $250,000 covered by the Hospital's insurance and the remainder by the Fund.

Reclassifications

Certain amounts from the 2006 consolidated financial statements have been reclassified to conform to the current year presentation.

2. ACCOUNTS RECEIVABLE AND PAYABLE

Patient accounts receivable and accounts payable (including expenses) reported as current assets and liabilities as of December 31, 2007 and 2006 is as follows:

	2007	2006
Patient accounts receivable		
Receivable from patients and their insurance carriers	$ 5,657,600	$ 5,600,570
Receivable from Medicare	1,616,834	2,063,004
Receivable from Medicaid	762,096	858,195
Total patient accounts receivable	8,036,530	8,521,769
Less allowance for contractual agreements and uncollectible amounts	2,900,156	2,468,440
Patient accounts receivable, net	$ 5,136,374	$ 6,053,329
Accounts payable and accrued expenses		
Payable to employees (including payroll taxes and benefits)	$ 1,170,852	$ 1,028,534
Payable to suppliers	1,226,097	1,223,196
Total accounts payable and accrued expenses	$ 2,396,949	$ 2,251,730

3. ASSETS WHOSE USE IS LIMITED

Noncurrent cash and investments internally designated include the following:

Board Designated Funds

Assets set aside by the Hospital Board of Trustees for identified purposes and over which the Board retains control and may, at its discretion, subsequently use for other purposes.

Held by Trustee

Hospital Association funds deposited with a trustee and limited to use in accordance with the requirements of a trust indenture and funds from long-term debt borrowings to be expended.

Donor Restricted

Assets that are restricted by contributors or grantors are included in this category. The investments consist of a deposit at the Northern Indiana Community Foundation which is restricted for operating purposes of the Hospital, but are not readily available for use. The investments also consist of a cash account for the Woodlawn Development Council, which was set up to deposit contributions of cash which are restricted for the purchase of property and equipment.

4. DEPOSITS AND INVESTMENTS

Deposits with financial institutions in the State of Indiana at year end were entirely insured by the Federal Depository Insurance Corporation or by the Indiana Deposit Insurance Fund. This includes any deposit accounts issued or offered by a qualifying financial institution.

Investments are carried at fair market value. Investments consist primarily of cash and cash equivalents and certificates of deposit. Market value approximated cost as of December 31, 2007 and 2006.

The Hospital's investments generally are reported at fair value, as discussed in Note 1. As of December 31, 2007 and 2006, the Hospital had the following investments and maturities, all of which were held in the Hospital's name by custodial banks that are agents of the Hospital:

December 31, 2007

		Investment Maturities (in years)			
	Carrying Amount	Less than 1	1-5	6-10	More than 10
Cash and cash equivalents	$ 2,931,528	$ 2,931,528	$ -0-	$ -0-	$ -0-
Certificates of deposit	244,500	244,500	$ -0-	$ -0-	$ -0-
	$ 3,176,028	$ 3,176,028	$ -0-	$ -0-	$ -0-

December 31, 2006

		Investment Maturities (in years)			
	Carrying Amount	Less than 1	1-5	6-10	More than 10
Cash and cash equivalents	$ 202,390	$ 202,390	$ -0-	$ -0-	$ -0-
Certificates of deposit	2,694,500	2,694,500	-0-	-0-	-0-
	$ 2,896,890	$ 2,896,890	$ -0-	$ -0-	$ -0-

Interest rate risk – The Hospital does not have a formal investment policy that limits investment maturities as a means of managing its exposure to fair value losses arising from changing interest rates.

Credit risk - Statutes authorize the Hospital to invest in interest bearing deposit accounts, passbook savings accounts, certificates of deposit, money market accounts, mutual funds, pooled fund investments, securities backed by the full faith and credit of the United States Treasury and repurchase agreements. The statutes require that repurchase agreements be fully collateralized by U.S. Government or U.S. Government Agency obligations.

Deposits and investments consist of the following as of December 31, 2007 and 2006:

	2007	2006
Carrying amount		
Deposits	$ 725,480	$ 5,387
Investments	3,176,028	2,896,890
	$ 3,901,508	$ 2,902,277

	2007	2006
Included in the following balance sheet captions:		
Cash and cash equivalents	$ 725,480	$ 5,387
Board designated	2,807,976	2,694,500
Held by trustee	136,551	6,582
Donor restricted	231,501	195,808
	$ 3,901,508	$ 2,902,277

5. CAPITAL ASSETS

Capital asset activity for the years ended December 31, 2007 and 2006 is as follows:

	Balance December 31, 2006	Additions	Retirements	Transfers	Balance December 31, 2007
Land	$ 220,127	$ 125,096	$ -0-	$ -0-	$ 345,223
Land improvements	430,296	-0-	(39,399)	14,332	405,229
Buildings and fixtures	10,248,572	28,276	(94,374)	-0-	10,182,474
Moveable equipment	10,803,481	444,026	(2,071,025)	(14,332)	9,162,150
Construction in progress	-0-	45,000	-0-	-0-	45,000
Total	21,702,476	642,398	(2,204,798)	-0-	20,140,076
Less accumulated depreciation					
Land improvements	390,779	9,692	(39,399)	-0-	361,072
Buildings and fixtures	7,069,383	329,004	(94,374)	-0-	7,304,013
Moveable equipment	7,742,544	895,014	(2,055,146)	-0-	6,582,412
Total accumulated depreciation	15,202,706	1,233,710	(2,188,919)	-0-	14,247,497
Capital assets, net	$ 6,499,770	$ (591,312)	$ (15,879)	$ -0-	$ 5,892,579

	Balance December 31, 2005	Additions	Retirements	Transfers	Balance December 31, 2006
Land	$ 220,127	$ -0-	$ -0-	$ -0-	$ 220,127
Land improvements	430,296	-0-	-0-	-0-	430,296
Buildings and fixtures	10,197,489	72,298	(21,215)	-0-	10,248,572
Moveable equipment	11,004,866	495,896	(813,534)	116,253	10,803,481
Construction in progress	112,920	3,333	-0-	(116,253)	-0-
Total	21,965,698	571,527	(834,749)	-0-	21,702,476
Less accumulated depreciation					
Land improvements	381,520	9,259	-0-	-0-	390,779
Buildings and fixtures	6,749,295	341,303	(21,215)	-0-	7,069,383
Moveable equipment	7,524,701	1,003,271	(785,428)	-0-	7,742,544
Total accumulated depreciation	14,655,516	1,353,833	(806,643)	-0-	15,202,706
Capital assets, net	$ 7,310,182	$ (782,306)	$ (28,106)	$ -0-	$ 6,499,770

Assets acquired through capital leases still in effect are as follows:

	2007	2006
Equipment	$ 1,832,573	$ 1,523,684
Accumulated depreciation	744,926	702,913
	$ 1,087,647	$ 820,771

6. LONG-TERM DEBT

A summary of long-term debt as of December 31, 2007 is as follows:

- The Hospital's $2,510,000, 2003 First Mortgage Refunding Bonds are due in varying installments of $85,000 to $125,000 through July 2015 at interest rates ranging from 1.10% to 4.2%. Principal and interest is due semi-annually on July 1 and January 1. The bonds are secured by certain Hospital property.

- The Hospital's $2,445,000 Taxable Promissory Note, Series B is due in varying installments of $245,000 to $1,050,000 through October 2008 at interest rates ranging from 3.5% to 4.25%. Principal and interest is due semi-annually on October 1 and April 1. The note is secured by the Hospital's accounts receivable.

- The Hospital has entered into several capital obligations with interest rates of 3.55% to 6.02%, collateralized by the leased equipment. Monthly installments are due in varying amounts from $1,198 to $18,160, including interest. Principal and interest payments are due through May 2010 to April 2012.

General obligation bonds of Fulton County were issued October 2, 2003, in the total amount of $2,510,000, to fund the early extinguishment of the FMHA loan debt. The bonds and interest thereon are being paid by Fulton County Hospital Association from semiannual lease rental payments. In 2007 and 2006, approximately 100% and 90%, respectively, of the lease rental payments were contributed by Fulton County with the remainder derived from hospital revenues.

The following represents a progression of long term debt for 2007 and 2006:

	Balance December 31, 2006	Additional borrowings	Payments	Balance December 31, 2007	Current portion	Long-term portion
Revenue bonds payable						
Bond Series B	$ 950,000	$ -0-	$(465,000)	$ 485,000	$ 485,000	$ -0-
Association Bonds Series 2003	1,855,000	-0-	(95,000)	1,760,000	190,000	1,570,000
Loans payable						
Capital lease obligations	1,119,331	308,889	(333,353)	1,094,867	364,974	729,893
Unamortized bond discount	(28,999)	-0-	3,411	(25,588)	(3,411)	(22,177)
Total long term debt	$ 3,895,332	$ 308,889	$ (893,353)	$ 3,314,279	$ 1,036,563	$ 2,277,716

	Balance December 31, 2005	Additional borrowings	Payments	Balance December 31, 2006	Current portion	Long-term portion
Revenue bonds payable						
Bond Series B	$ 1,395,000	$ -0-	$(445,000)	$ 950,000	$ 465,000	$ 485,000
Association Bonds Series 2003	2,045,000	-0-	(190,000)	1,855,000	95,000	1,760,000
Loans payable						
Capital lease obligations	1,192,504	226,503	(299,676)	1,119,331	295,353	823,978
Unamortized bond discount	(32,410)	-0-	3,411	(28,999)	(3,411)	(25,588)
Total long term debt	$ 4,600,094	$ 226,503	$ (931,265)	$ 3,895,332	$ 851,942	$ 3,043,390

Aggregate maturities of long-term debt are as follows:

Year ending December 31,	Principal	Interest	Total
2008	$ 1,036,563	$ 117,318	$ 1,153,881
2009	582,186	83,185	665,371
2010	458,171	61,592	519,763
2011	281,323	47,446	328,769
2012	244,569	36,480	281,049
2013-2017	711,467	52,995	764,462
	$ 3,314,279	$ 399,016	$ 3,713,295

7. LINE OF CREDIT

The Hospital obtained a $700,000 line of credit during 2007. The line of credit is secured by certain assets of the Hospital. It is due December 1, 2008, and bears interest at the prime rate charged by the financial institution (7.25% as of December 31, 2007). The outstanding balance on the line of credit was $525,000 as of December 31, 2007.

8. COMPASSIONATE CARE

Charges excluded from patient service revenue under the Hospital's compassionate care policy were $479,717 and $342,455 for 2007 and 2006, respectively.

9. NET PATIENT SERVICE REVENUE

Patient service revenue for 2007 and 2006 consists of the following:

	2007	2006
Inpatient services	$ 9,370,895	$ 9,629,351
Outpatient services	35,322,072	29,942,356
Physician services	7,952,926	7,034,067
Gross patient service revenue	52,645,893	46,605,774
Contractual allowances	(19,356,996)	(15,579,184)
Charity care	(479,717)	(342,455)
Bad debt	(3,155,010)	(2,477,037)
Deductions from revenue	(22,991,723)	(18,398,676)
Net patient service revenue	$ 29,654,170	$ 28,207,098

10. DEFINED CONTRIBUTION PENSION PLAN

Plan Description

The Hospital has a defined contribution pension plan administered by Lincoln National Life and Aetna Life Insurance Company as authorized by Indiana Code 16-22-3-11. The plan provides retirement, disability, and death benefits to plan members and beneficiaries. The plan was established by written agreement between the Hospital Board of Trustees and the Plan Administrator.

Funding Policy and Annual Pension Cost

The contribution requirements of plan members are established by the written agreement between the Hospital Board of Trustees and the Plan Administrator. Plan members may contribute $12,000 of the annual covered salary. The Hospital is required to contribute a matching amount from 10% to 50% of the employees' contribution based on years of service. Employer contributions to the plan for the calendar year 2007 and 2006 were $167,142 and $161,668, respectively.

11. OPERATING LEASE

The Hospital has leases expiring at various times through 2011. Leases that do not meet the criteria for capitalization are classified as operating leases with related rentals charged to operating as incurred. Total rent expense for 2007 and 2006 was $415,312 and $167,499, respectively. Minimum future payments on leases for the years following December 31, 2007 are as follows:

Year Ending December 31,	Amount
2008	$ 325,698
2009	325,698
2010	325,698
2011	298,556
	$ 1,275,650

12. INVESTMENT IN AFFILIATED COMPANY

In 1997, the Hospital entered into an agreement to purchase 100 units of membership in Wynnfield Crossing, a limited liability company. In accordance with this agreement, the hospital invested $140,000 for an original 6.9% equity interest in Wynnfield Crossing. The investment is recorded on the cost method. The Hospital's investment in affiliated companies is included in the Other Assets category of the statement of net assets.

During 2007, the Hospital sold their portion of the investment. The balance of the asset was $-0- and $29,121 as of December 31, 2007 and 2006, respectively.

13. CONCENTRATION OF CREDIT RISK

Woodlawn Hospital is located in Rochester, Indiana. The Hospital grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors as of December 31, 2007 and 2006 was as follows:

	2007	2006
Medicare	20.5%	24.3%
Medicaid	9.6%	9.2%
Blue Cross	11.0%	9.6%
Other commercial payors	29.4%	30.3%
Self-pay	29.5%	26.6%
	100.0%	100.0%

14. SELF INSURANCE

The Hospital is self insured for employee health claims. A third party administrator processes the claims for the hospital. The Hospital maintains an estimated liability for the amount of claims incurred but not reported. The Hospital also maintains reinsurance including a stop loss for individual employees over $35,000 up to an aggregate amount of $965,000 a year. Substantially all employees are covered for major medical benefits. The total health claims expense was $1,812,044 and $1,660,015 for 2007 and 2006, respectively. Claim expenditures and liabilities of the fund are reported when it is probably that a loss has occurred and the amount of the loss can be reasonably estimated. These losses include an estimate of claims that have been incurred but not reported. Changes in the balance of claim liabilities during the past two years are as follows:

	2007	2006
Unpaid claims, beginning of fiscal year	$ 309,971	$ 520,292
Incurred claims and changes in estimates	1,812,044	1,660,015
Claim payments	(1,817,791)	(1,870,336)
Unpaid claims, end of fiscal year	$ 304,224	$ 309,971

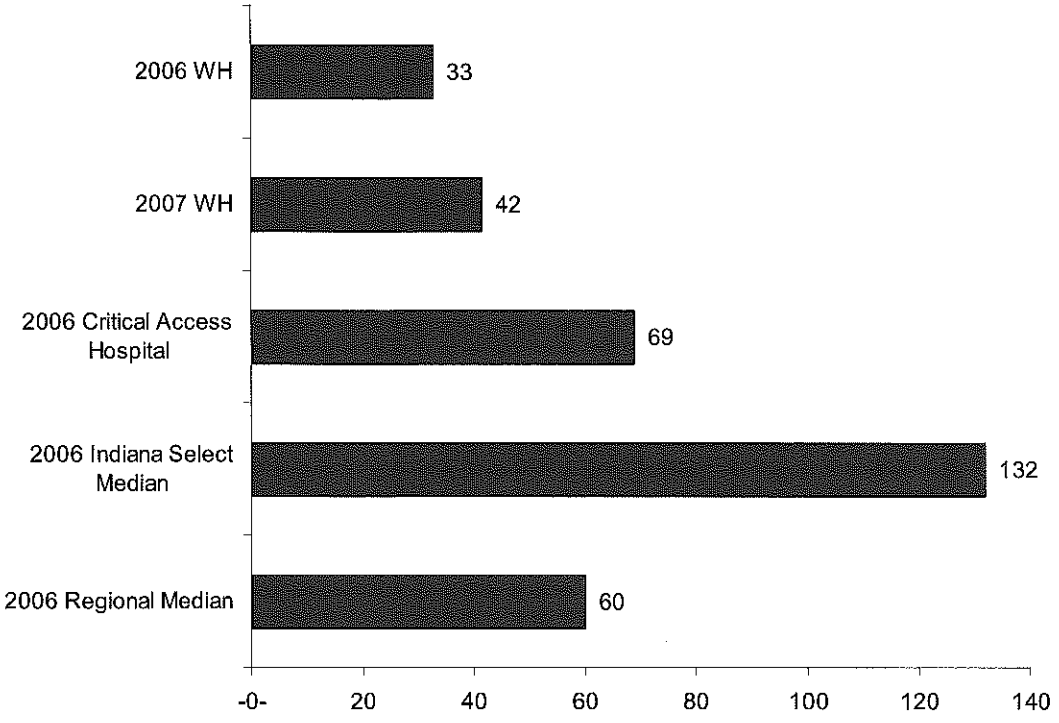
15. COMMITMENTS AND CONTIGENCIES

The Hospital has retained the services of an Architect as part of planning for a facilities expansion program.

Woodlawn Hospital
Days Cash on Hand (All Sources)

CPAs / ADVISORS

blue



Desired Position: High
U.S. Trend: Decreasing – Decreasing
U.S. Forecast: Increase

Formula

Unrestricted Current and Non-current Cash and Investments/[(Total Expenses less Depreciation and Amortization)/365]

Definition

Days cash on hand is a liquidity ratio that measures the number of days of cash operating expenses a hospital has covered by unrestricted cash, cash equivalents and marketable securities.

Performance Implications

High values indicate a greater ability to meet both short-term obligations and long-term capital replacement needs. Lower performing hospitals have lower values. Improvement can come from improved cash flow from operations and controlling purchases of property and equipment.

Woodlawn Hospital
Days in Patient Accounts Receivable, Net

CPAs / ADVISORS
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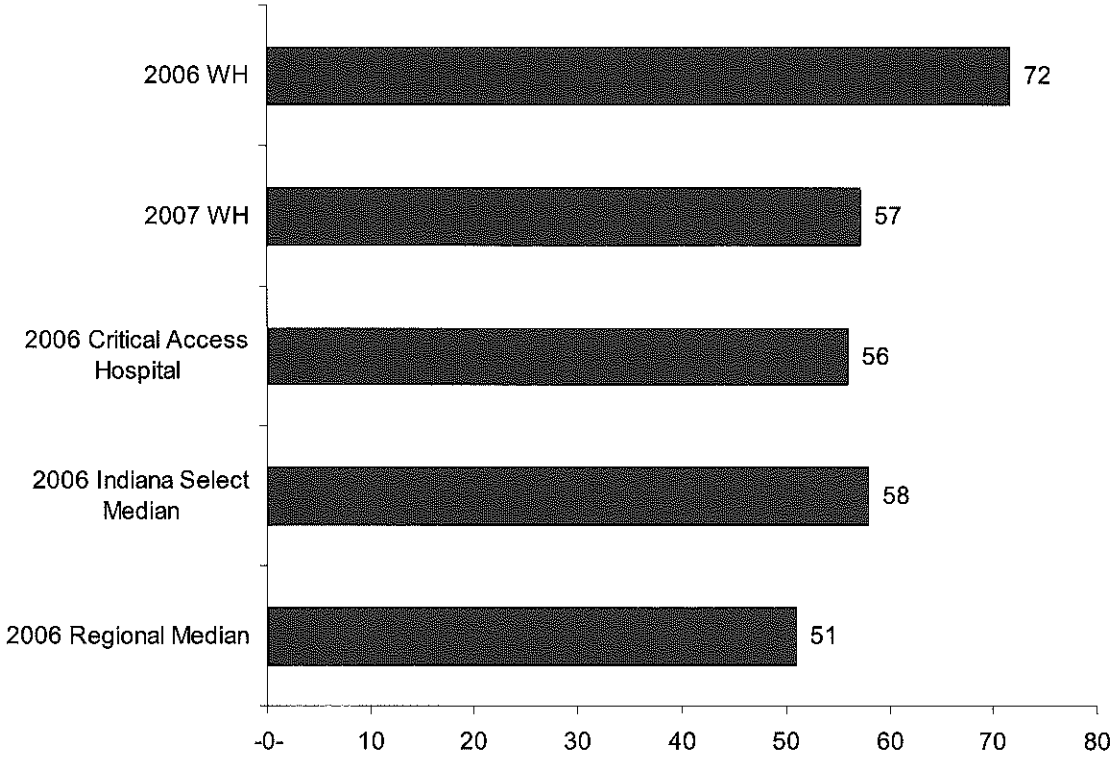

Desired Position: Low
U.S. Trend: Decreasing since 2000
U.S. Forecast: Stable

Formula

Net Accounts Receivable/(Net Patient Service Revenues/365)

Definition

Days in Accounts Receivable is a liquidity ratio which measures the average time that receivables are outstanding and is thus an indicator of the efficiency in collecting receivables.

Performance Implications

Payor mix can significantly affect the value of this ratio. Hospitals with high values have an excess investment in a non-earning asset. High-performing hospitals tend to earn higher margins and have higher values of cash and investments.

Woodlawn Hospital
Current Ratio

CPAs / ADVISORS

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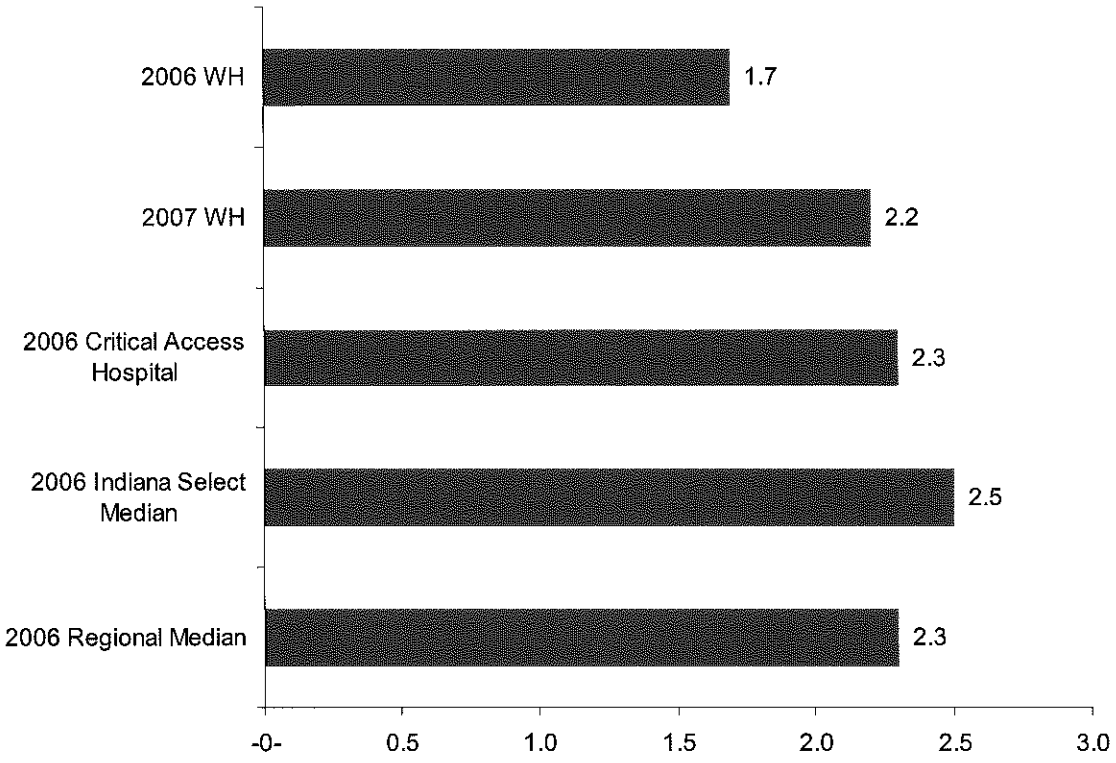


Desired Position: High
U.S. Trend: Stable
U.S. Forecast: Stable

Formula

Current Assets/Current Liabilities

Definition

Measures the Hospital's ability to meet short-term financial obligations.

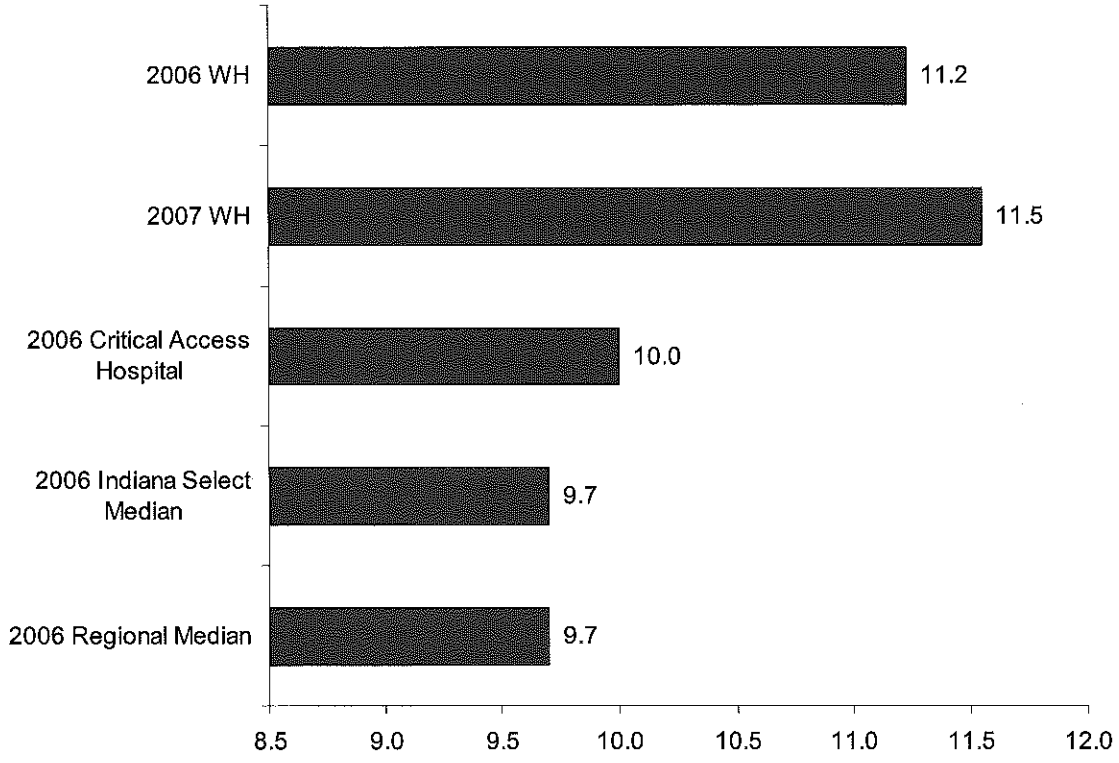
Performance Implications

There is a positive correlation between profitability and the Current Ratio. Hospitals that are more profitable are likely to have higher Current Ratio values. It may be difficult for hospitals with a consistently low Current Ratio to continue with inadequate total margins.

Woodlawn Hospital
Average Age of Plant

CPAs / ADVISORS

blue



Desired Position: Low
U.S. Trend: Increasing
U.S. Forecast: Increase

Formula

Accumulated Depreciation/Depreciation Expense

Definition

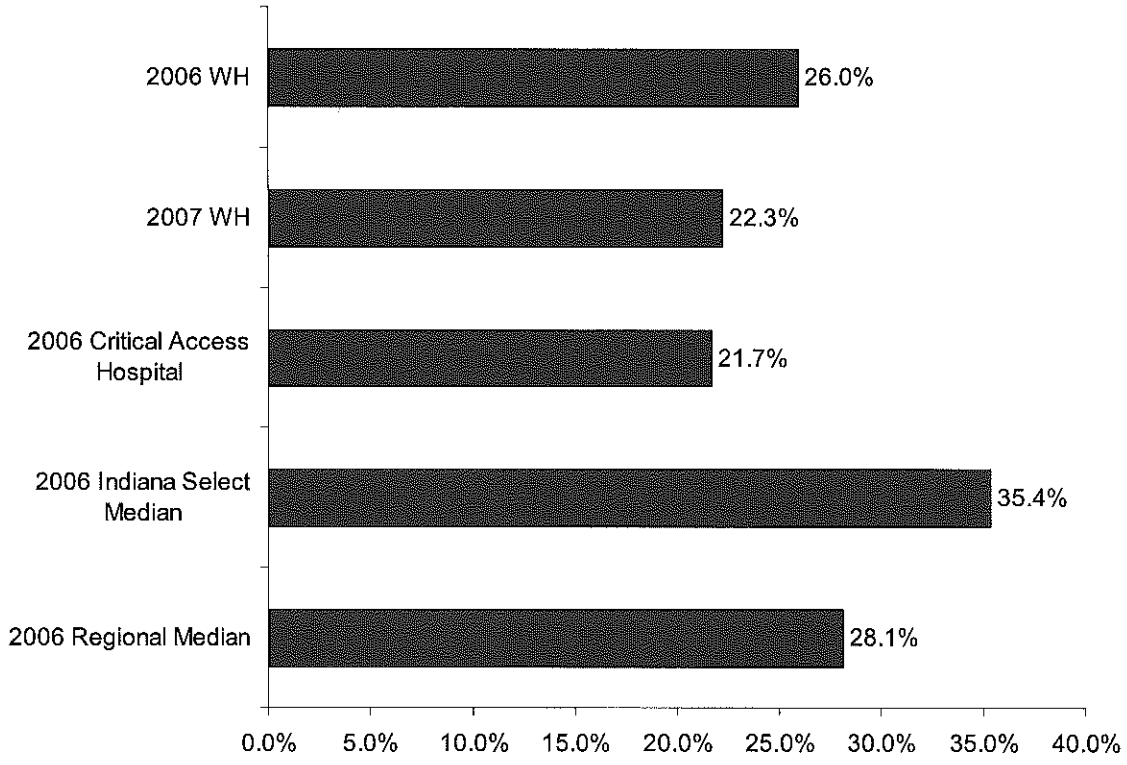
Measures the average age, in years, of a hospital's fixed assets.

Performance Implications

A steadily increasing value indicates resources are not being used to renovate the hospital. It may also indicate that significant capital expenditures may be required in the near future. Hospitals with older facilities typically have less debt. However, higher performing hospitals have significantly newer plants than lower performing hospitals.

Woodlawn Hospital
Long-Term Debt as a Percentage of Total Capital

CPAs / ADVISORS
blue



Desired Position: Preference
U.S. Trend: Increasing
U.S. Forecast: Slight decrease

Formula

Long-Term Debt / (Long-Term Debt + Net Assets)

Definition

This is a traditional measure of the extent to which a hospital has relied on debt vs. retained earnings and invested or donated capital. It provides a measure of the ability to carry additional debt.

Performance Implications

Higher values may limit future financing opportunities. Operating expense pressures, contribution declines and decreased investment returns have generally constrained growth in net assets, which have not kept pace with increasing debt.

Woodlawn Hospital
Debt Service Coverage

CPAs / ADVISORS
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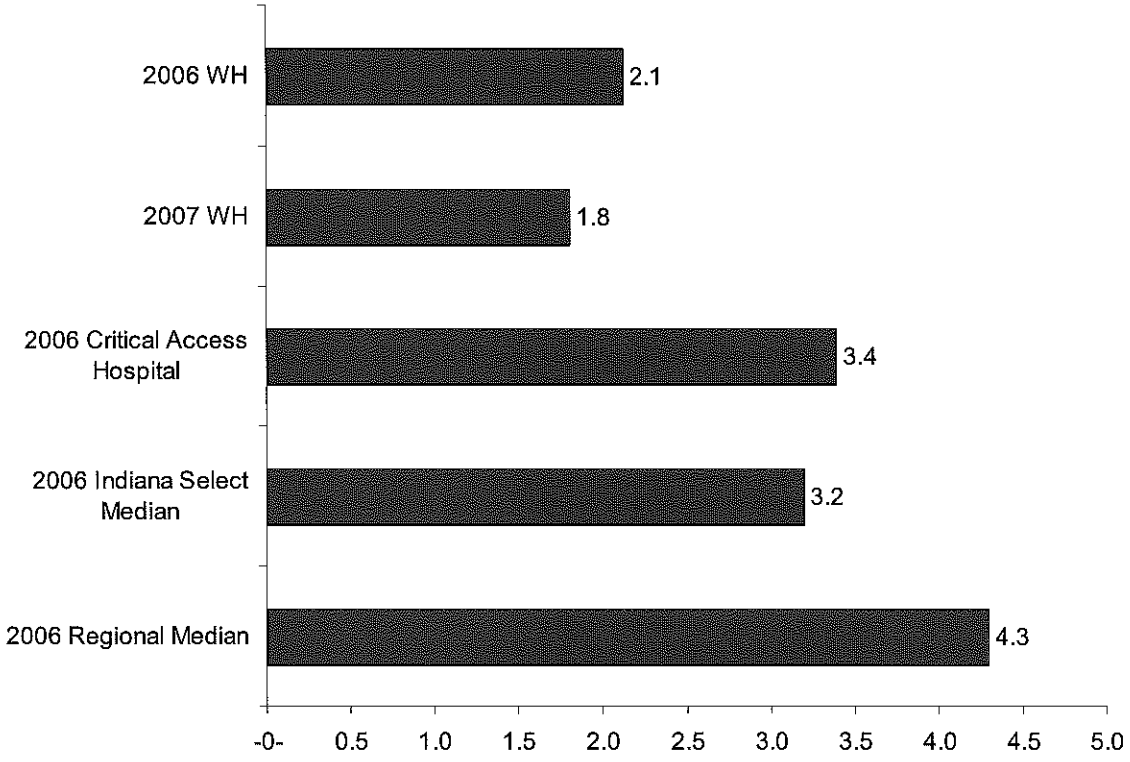

Desired Position: High
U.S. Trend: Decrease – Decreasing
U.S. Forecast: Decrease

Formula

(Total Excess of Revenues Over Expenses + Interest, Depreciation and Amortization)/(Principal Payments + Interest Expense)

Definition

This is a measure of the viability of a hospital. This ratio reflects the ability to fund annual debt service cash flow from net cash revenues.

Performance Implications

Many debt obligations require hospitals to maintain a debt service coverage ratio of at least 1.2 times maximum annual debt service. The ratio had tended to decrease in the past several years due to lower profitability.

Woodlawn Hospital
Return on Total Assets

CPAs / ADVISORS

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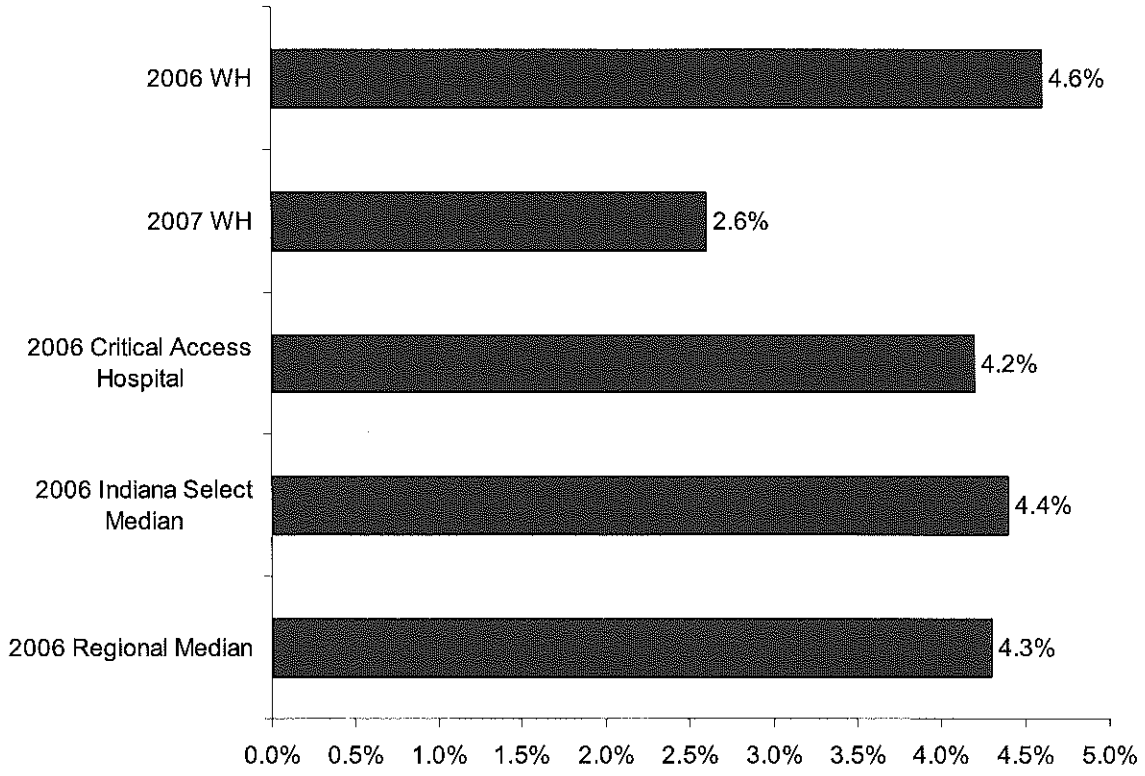

Desired Position: High
Hospital Trend: Increasing
U.S. Trend: Decreasing

Formula

Change in Net Assets/Total Assets

Definition

The Return on Total Assets is a profitability ratio which measures the amount of return per dollar of Total Assets and thus profitability in terms of asset efficiency.

Performance Implications

Hospitals with a newer plant and/or a larger asset base are challenged to maintain commensurate profitability with related charges such as higher depreciation and interest. Maximizing non-operating income and increasing asset efficiency both result in higher values for Return on Total Assets.

Woodlawn Hospital
Return on Net Assets

CPAs / ADVISORS

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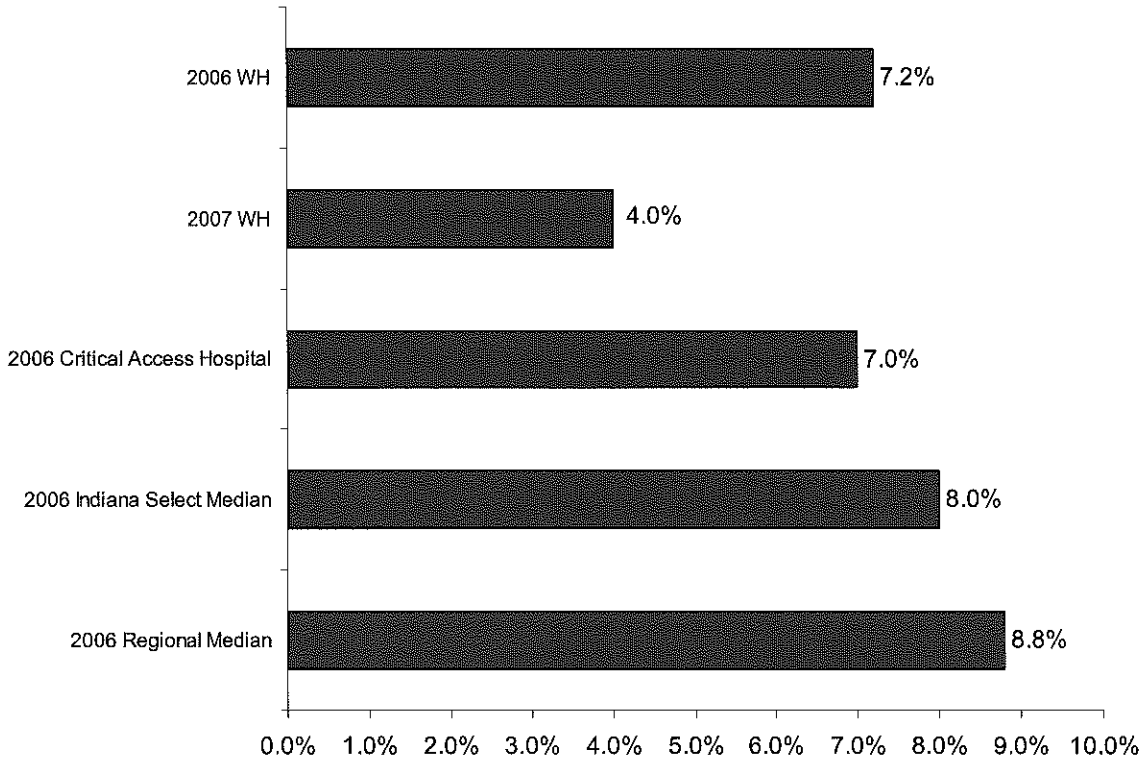

Desired Position: High
Hospital Trend: Increasing
U.S. Trend: Slight Decreasing

Formula

Change in Net Assets/Net Assets

Definition

The Return on Net Assets is a profitability ratio which measures the amount of return per dollar of net assets and thus profitability of net assets invested.

Performance Implications

Total margins have a significant impact on this ratio as net assets are a smaller base for return ratios. Capital structure and the level of debt can also have an impact on the ratio performance.

Woodlawn Hospital
Operating Margin

CPAs / ADVISORS

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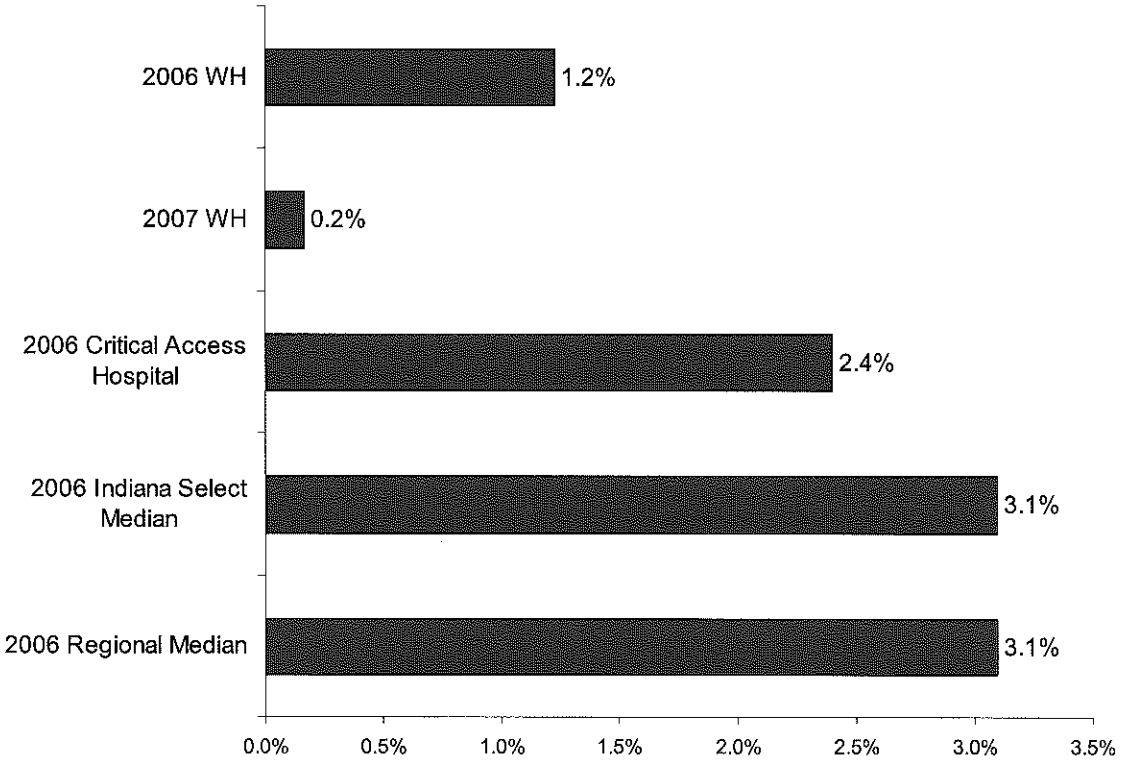

Desired Position: High
U.S. Trend: Decreasing
U.S. Forecast: Stable

Formula

Income From Operations/Total Operating Revenue
Based on net revenue rather than gross revenue.

Definition

The Operating Margin indicates the amount of return per dollar of operating revenues.

Performance Implications

This ratio represents the hospital's ability to generate a profit from operations. Improving operating profitability has been the factor contributing most to the increase in total margin for the high-performance hospitals and declines in operating profitability have caused the decline in total margin for the low-performance hospitals. High-performing hospitals have substantial cost and price advantages over low-performing hospitals.

Woodlawn Hospital
Total Margin

CPAS / ADVISORS

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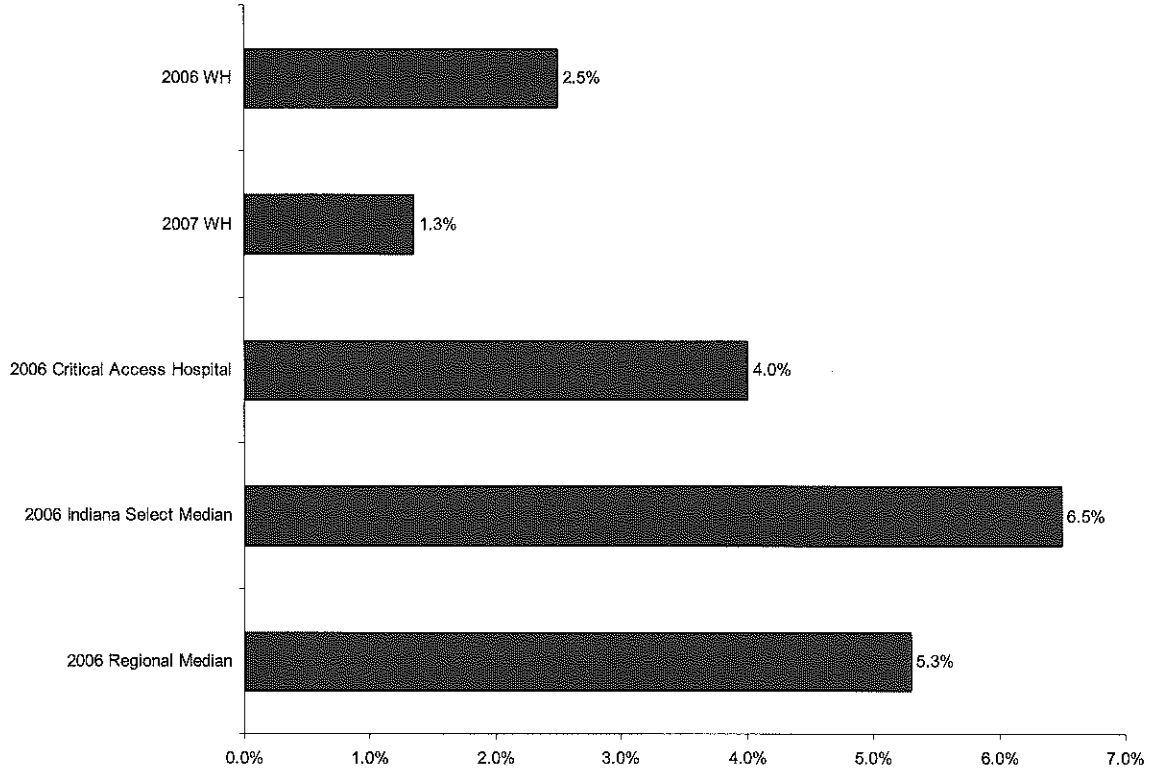

Desired Position: High
U.S. Trend: Decreasing – Decreasing
U.S. Forecast: Stable

Formula

Total Changes in Net Assets/Total Operating and Nonoperating Revenues
Based on net revenue rather than gross revenue.

Definition

The Total Margin Ratio indicates the amount of return per dollar of revenue and support and thus the ability to generate profit from both operating and nonoperating activities.

Performance Implications

Improving operating profitability is the factor contributing most to the increase. Strategies for cost containment, revenue realization, uncompensated care control and non-operating gains all play a factor in improvement. Long-term a hospital needs to generate a 4% margin to remain viable.

Woodlawn Hospital
Contractual Allowance Percentage

CPAs / ADVISORS

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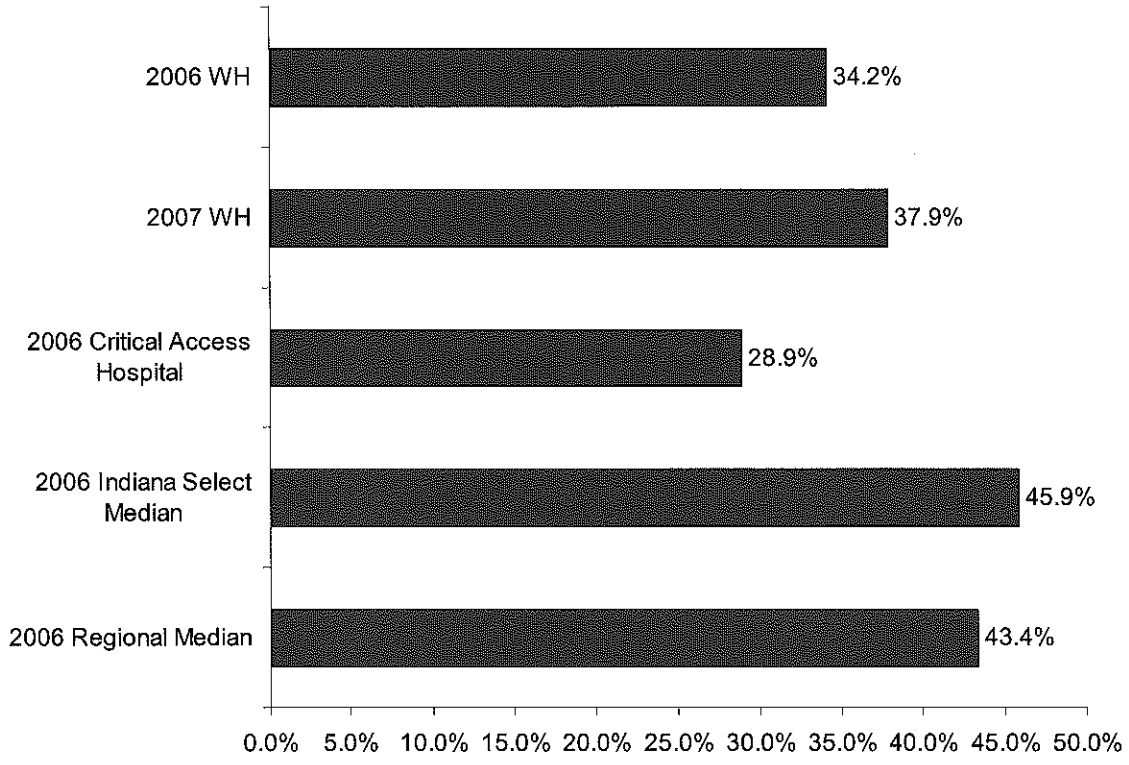

Desired Position: Low
U.S. Trend: Increasing significantly
U.S. Forecast: Increase

Formula

Contractual Allowances/Gross Patient Service Revenue

Definition

The percentage of gross patient revenue that is discounted to third-party payors.

Performance Implications

High-performance hospitals have similar gross prices on a case mix-adjusted basis compared to low-performance hospitals, however, they have higher net prices. Lower write-offs in high-performance hospitals are either a reflection of a better payer mix, especially private insurance, with lower discounting, or better coding of cases.

Woodlawn Hospital
Salary per Full-Time Employee (FTE)

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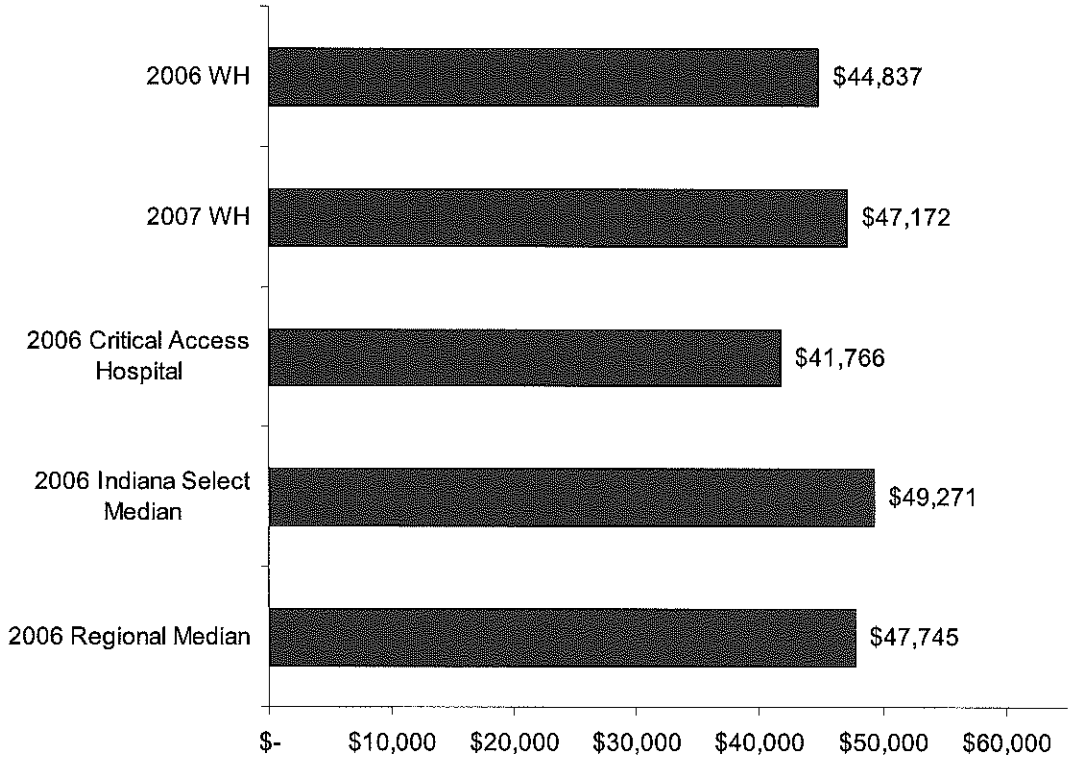

Desired Position: Preference
U.S. Trend: Increasing
U.S. Forecast: Inflationary increase

Formula

Salaries and Wages/Number of Full-Time Employees

Definition

Measures the relative cost of the largest resource item used in the hospital industry.

Performance Implications

High-performance hospitals have higher salary structures when compared to low-performance hospitals. Control over salaries and wages and supply costs is one of the most effective ways to improve profit margins.

Woodlawn Hospital
Revenue per Full-Time Employee (FTE)

CPAs / ADVISORS
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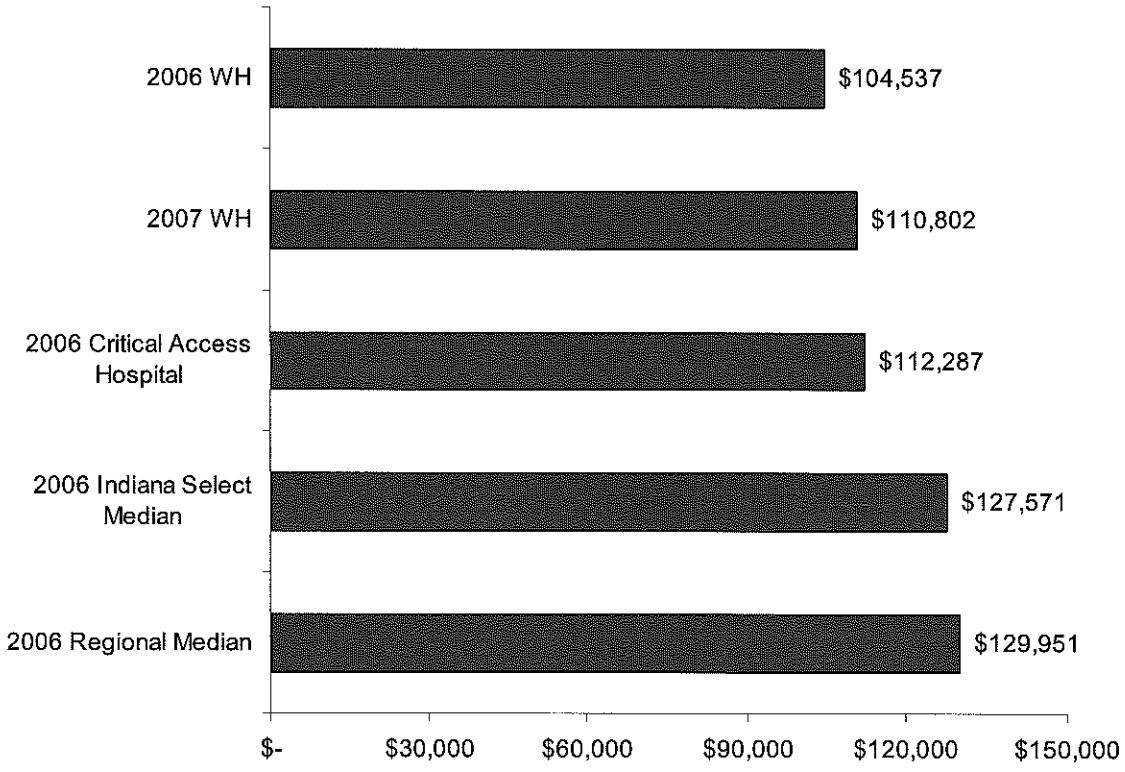

Desired Position:
U.S. Trend: Increasing Sharply
U.S. Forecast: Increase

Formula

Total Revenues / Number of Full-Time Employees

Definition

Measures the productivity to compare performance across different industries.

Performance Implications

High performance hospitals have higher values for Total Revenue Per FTE than low-performance hospitals and the gap appears to be widening. The ultimate measure of productivity is value created per FTE, and high-performance hospitals are doing exceptionally well in this area.

Woodlawn Hospital
Total Asset Turnover

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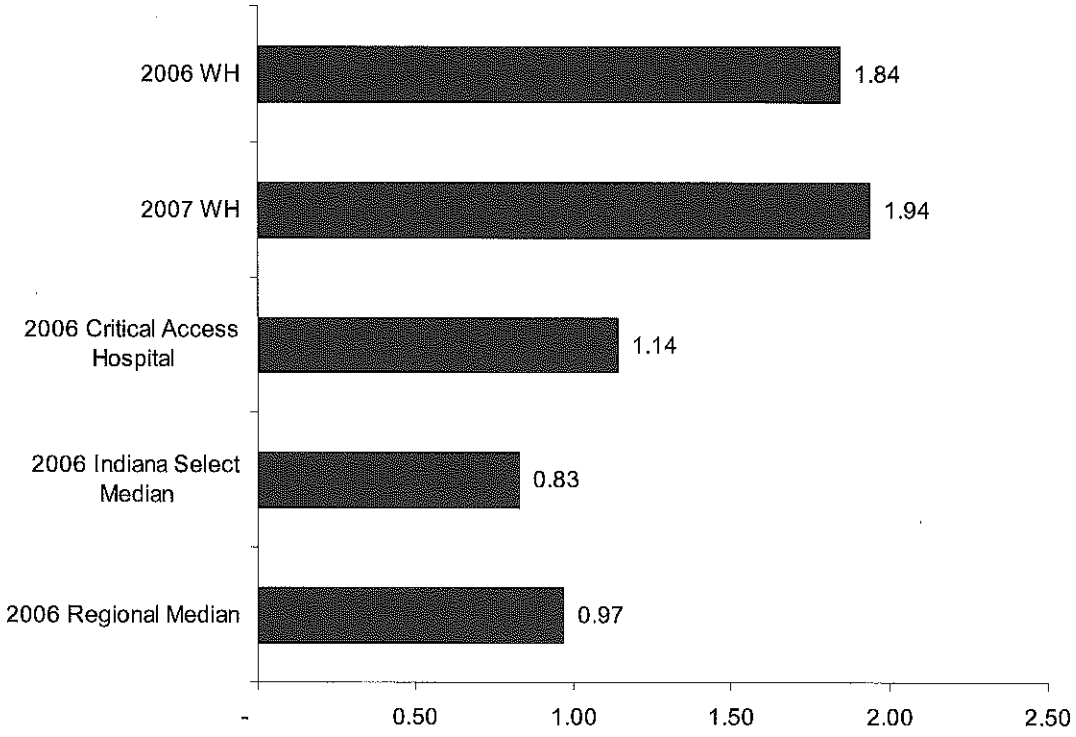

Desired Position: High
U.S. Trend: Increasing
U.S. Forecast: Increase

Formula

Total Revenue / Total Assets

Definition

Total asset turnover provides an index of the number of revenue dollars generated per dollar of asset investment.

Performance Implications

Low performance hospitals tend to have higher asset turnover ratios due to high performance hospitals larger investment balances and newer plant. However it is important to gain efficiency with a ratio approaching 1 to 1 as services continue to migrate to the outpatient setting.

Woodlawn Hospital
Salaries, Wages and Benefits as a Percentage of Operating Revenue

CPAs / ADVISORS
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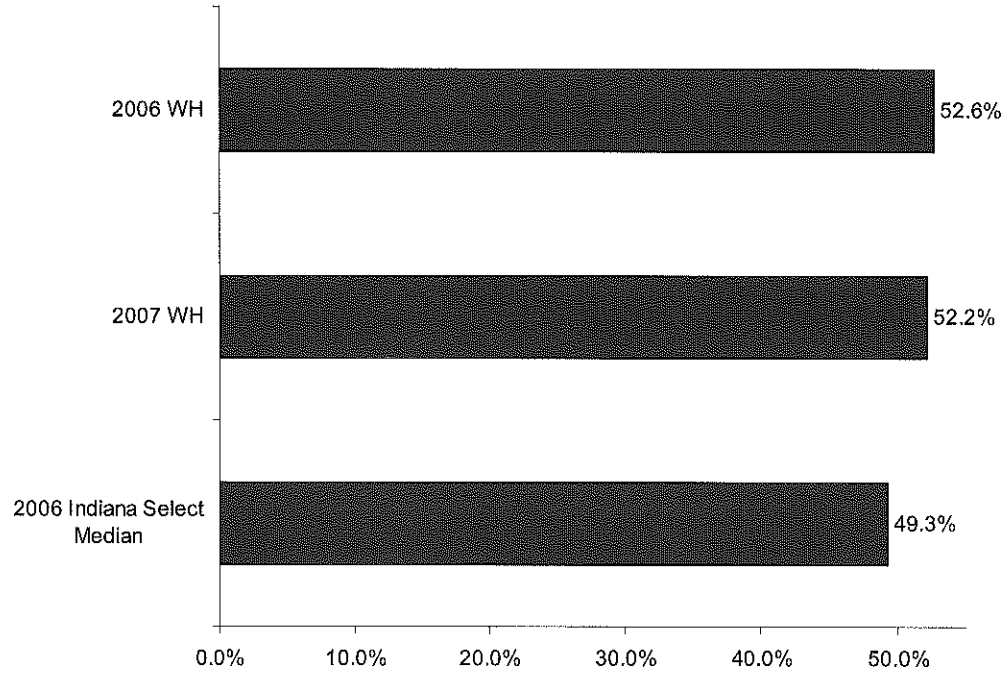

Desired Position: Low
U.S. Trend: Slight Increase
U.S. Forecast: Increase

Formula

Total Salaries, Wages and Employee Benefits / Operating Revenue

Definition

This ratio provides an indicator of the labor cost in generating operating revenue.

Performance Implications

Lower values are desired. Higher percentages may indicate lower staff productivity and efficiency. Salaries, wages and benefits are the highest annual cost hospitals incur, thus it is essential to monitor those costs as a percentage of the revenue being generated. Close monitoring of staffing and productivity levels will help to keep this percentage low.

Woodlawn Hospital
Employee Benefits as a Percentage of Salaries and Wages

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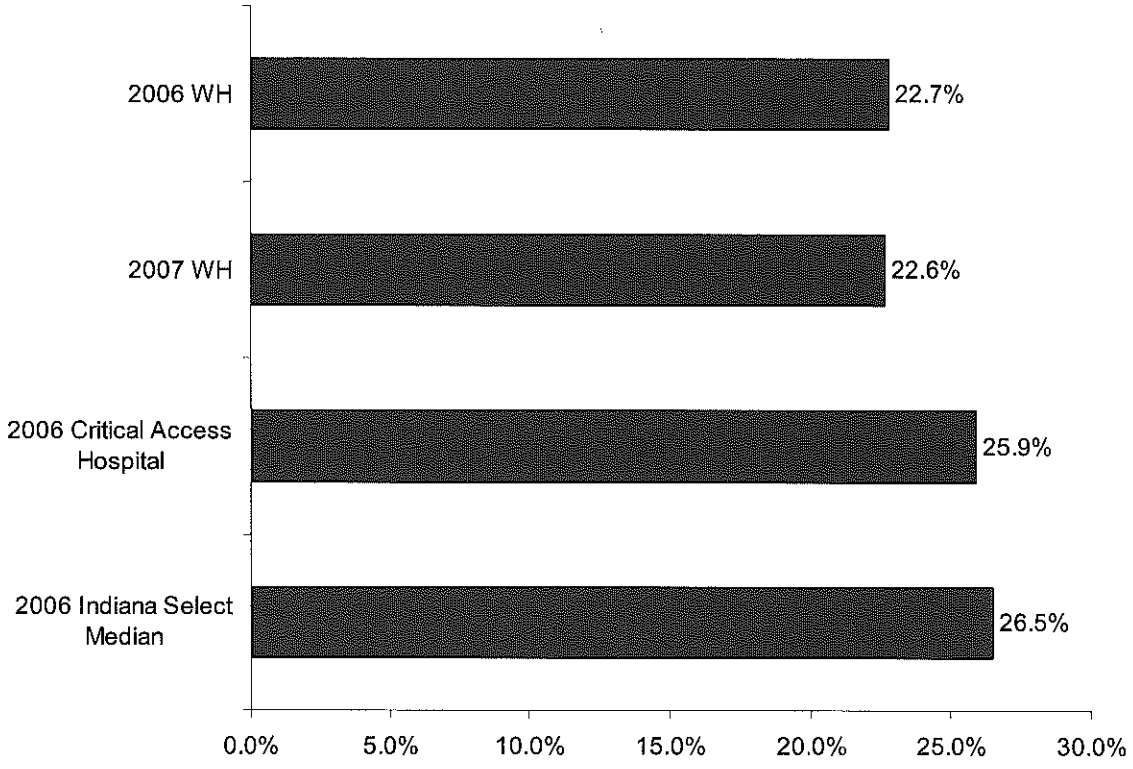

Desired Position: Preference
U.S. Trend: Increasing
U.S. Forecast: Increase

Formula

Employee Benefits/Salaries & Wages

Definition

The employee benefits ratio provides a measure of the relationship of benefits to salaries and wages.

Performance Implications

Generally, lower values are desired. However, many hospitals consciously maintain higher benefits as a tool to reduce employee turnover costs. Also, benefits can vary widely depending on the hospital's culture and values. Employee health insurance costs, which have experience double digit increases over the past several years, have been the primary driver of employee benefits expense.

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June 12, 2008

Board of Trustees
Woodlawn Hospital
Rochester, Indiana

Board of Trustees:

We have audited the financial statements of the Woodlawn Hospital (the Hospital) for the year ended December 31, 2007, and have issued our report thereon dated as of the date of this letter.

Professional standards require that we provide you with the following information related to our audit.

OUR RESPONSIBILITY UNDER U.S. GENERALLY ACCEPTED AUDITING STANDARDS

As stated in our engagement letter, our responsibility, as described by professional standards, is to express an opinion about whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with U.S. generally accepted accounting principles. Our audit of the financial statements does not relieve you or management of your responsibilities.

Our responsibility is to plan and perform the audit to obtain reasonable, but not absolute, assurance that the financial statements are free of material misstatement. As part of our audit, we considered the internal control of the Hospital. Such considerations were solely for the purpose of determining our audit procedures and not to provide any assurance concerning such internal control.

QUALITATIVE ASPECTS OF ACCOUNTING PRACTICES

Management is responsible for the selection and use of appropriate accounting policies. In accordance with the terms of our engagement letter, we will advise management about the appropriateness of accounting policies and their application. The significant accounting policies used by the Hospital are described in Note 1 to the financial statements. No new accounting policies were adopted and the application of existing policies was not changed during the year. We noted no transactions entered into by the Hospital during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the financial statements in a different period than when the transaction occurred.

Accounting estimates are an integral part of the financial statements prepared by management and are based upon management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the financial statements were the disclosures pertaining to:

- Allowance for doubtful accounts
- Contractual allowances
- Estimated third-party settlement
- Estimated health insurance claims incurred but not reported

You should determine that those charged with governance are informed about the process used by management to formulate particularly sensitive accounting estimates and about the basis for your conclusions regarding the reasonableness of the estimates. Management's estimate related to the allowance for bad debts and the contractual allowances are based on payer history and the aging of the accounts receivable. We evaluated the key factors and assumptions used by management to develop the estimates in determining that they are reasonable in relation to the financial statements taken as a whole

The disclosures in the financial statements are neutral, consistent, and clear.

Certain financial statement disclosures are particularly sensitive because of their significance to the financial statement users. The most sensitive disclosures in the financial statements are:

- Patient Accounts Receivable and Net Patient Service Revenue
- Assets Limited As To Use
- Deposits and Investments
- Capital Assets
- Long-Term Debt
- Self-Insured health insurance

DIFFICULTIES ENCOUNTERED IN PERFORMING THE AUDIT

We encountered no significant difficulties in dealing with management in performing and completing our audit.

CORRECTED AND UNCORRECTED MISSTATEMENTS

Professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. Management has corrected all such misstatements.

The following adjustments were posted during the audit process working with management and will be posted by management:

- Contractual and bad debt allowances were increased by approximately $540,000 to reflect the estimated net realizable value of the accounts receivable.
- Estimated third-party settlements receivable was increased by approximately $1,092,000 for the Medicaid Disproportionate Share Hospital program and Medicare reimbursement estimates.
- Cash was decreased by approximately $104,000 to adjust to the reconciled balance

DISAGREEMENTS WITH MANAGEMENT

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of the audit.

MANAGEMENT REPRESENTATIONS

We have requested certain representations from management that are included in the management representation letter dated as of the date of this letter.

OTHER AUDIT FINDINGS OR ISSUES

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the

Association's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

INTERNAL CONTROL MATTERS

In planning and performing our audit of the financial statements of the Hospital as of and for the year ended December 31, 2005, in accordance with U.S. generally accepted auditing standards, we considered the Hospital'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 Hospital's internal control. Accordingly, we do not express an opinion on the effectiveness of the Hospital's internal control.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and would not necessarily identify all deficiencies in internal control that might be significant deficiencies or material weaknesses.

A control deficiency 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 misstatements on a timely basis. A significant deficiency is a control deficiency, or combination of control deficiencies, that adversely affects the entity's ability to initiate, authorize, record, process, or report financial data reliably in accordance with generally accepted accounting principles such that there is more than a remote likelihood that a misstatement of the entity's financial statements that is more than inconsequential will not be prevented or detected by the entity's internal control.
A material weakness is a significant deficiency, or combination of significant deficiencies, that results in more than a remote likelihood that a material misstatement of the financial statements will not be prevented or detected by the entity's internal control.

RECOMMENDATIONS FOR THE 2007 AUDIT

During the course of an audit, we frequently become aware of matters which are opportunities to strengthen internal controls or improve operating efficiency or effectiveness. The following current year recommendations are not considered to be significant deficiencies or material weaknesses as defined by U.S. generally accepted auditing standards.

Cash reconciliation

During the audit process management asked us to assist in looking at the bank reconciliations. We noted that the Hospital has several bank cash accounts and several general ledger cash accounts that are reconciled together. This can complicate the reconciliation process. We recommend the Hospital consider establishing one bank account for each general ledger account to facilitate the reconciliation process.

We also noted that management had identified the differences between the bank balance and the book balance. However, management had not adjusted for certain of the differences. Working with management a related adjustment was posted. We recommend that on a monthly basis management post adjustments to reconcile differences to the general ledger balance.

Accounts Receivable Allowance

Allowances relating to client accounts receivable include two components; contractual allowances and bad debt allowances. Contractual allowances are applied to accounts receivable to adjust the accounts to amounts expected to be realized when the accounts are adjudicated. These allowances arise from differences between the Hospital's established rates and the amounts expected to be paid by Medicare, Medicaid, commercial insurers, and other payors. The bad debt allowance adjusts accounts receivable to management's estimate of the amount to ultimately be collected from self pay clients and the other payors accounts receivable which have reached a certain age since discharge.

Management prepares an analysis for the contractual allowances and bad debt allowances. However, management was not updating the collection experience within the model on a routine basis and then adjusting to the model on a monthly basis. We recommend that management update and assess the information used in the application of the accounts receivable model quarterly and adjust to the model on a monthly basis.

Segregation of Accounting Duties

A good system of internal control provides for a proper segregation of the accounting functions. Proper segregation is not always possible in a small organization, but limited segregation to the extent possible can and should be implemented to reduce the risk of errors or fraud.

Following are some items that the Hospital may be doing but are not evidenced by some form of approval such as a manager's initials on the approved document:

- Review of the payroll registers for approval prior to the processing of payroll checks.
- Review of the time keeping change report.
- Review of Invoices prior to the processing of cash disbursement checks.

Following are some items noted during our audit that we believe the Hospital may want to consider implementing:

- An individual outside the accounts receivable function be assigned to collect and list receipts for deposits.
- An individual independent of the check preparation, approval, and signing function should be responsible for mailing checks.
- Establish a disbursement threshold for which all disbursements over a specific amount would require two signers.
- Maintain detail records for compensated absence that reconcile to the general ledger.
- Receipt of the bank statement unopened by management and reviewed prior to giving it to accounting personnel to complete the reconciliation.
- Outline in the purchasing policy any restrictions on purchases that might be considered a conflict of interest.
- Periodically test subsequent transactions to monitor cut-off procedures.
- Periodic review of purchasing prices by someone external to materials management.

Investment and Depreciation Fund Policy

As the investment and depreciation fund policy state, investments in certificates of deposit with the various financial institutions throughout the state should be made with

federal insurance limits and the state insurance pool in mind and accordingly should not exceed $100,000 per institution for the protection of the Woodlawn Hospital Depreciation Fund. The Hospital currently has a few certificates of deposit that exceed the $100,000 limit and is therefore not in compliance with the policy.

The maturities on the certificates of deposit mostly range from 30 to 90 days. Due to the significant number of certificates and the time frame of the maturities, managing the investments creates an administrative burden over the course of a year.

Management and the Board may want to consider investing in other types of investments within the guidelines of the state statutes and revising the policy accordingly.

Expense Reports and Credit Card

During our review of the controls surrounding expense reports, we noted that certain of the reports did not include the proper approval as noted in the Hospital's policy. We would recommend that the approval process be followed as outlined in the policy. The reports may have been reviewed we just did not note a written approval.

In addition, during review of the expense reimbursement and credit card policies, both policies do not appear to address procedures for approval of upper management's expense reports and credit card statements. We did note that the CFO approves the CEO's expense report. As a matter of best practice, the CEO would approve the CFO's expenses and a member of the Board would approve the CEO's expenses. These approvals could take place as is administratively practical.

Compassionate Care Adjustments

During our audit, we selected 5 compassionate care adjustments to test. Out of the 5 adjustments, supporting documentation could not be located for one of the adjustments. There were no exceptions noted in the other 4 adjustments tested.

Accounting for Fulton County Hospital Association

A separate trial balance for the Fulton County Hospital Association is not being maintained. The Association was formed for the exclusive purpose of financing and constructing facilities for the Hospital. There is activity that takes place within the Associations accounts throughout the year. The activity and the related accounts have been included in the audited financial statements. We understand that the activity is

fairly limited and is pass-through in nature. However, we recommend the trial balance be maintained and included within the Hospitals financial statements on a monthly basis.

Information Technology Controls

During the audit we reviewed the general and application controls in place over Information Technology (IT). There are areas where additional controls could be assessed and implemented related to IT and operational controls. Some of the items that we noted were that IT personnel are not prohibited from initiating or authorizing transactions, intrusion detection systems are not in place on the internal network to monitor for intrusions to the Hospital network, system administrator logs are not tested for completeness and accuracy or reviewed for unusual entries, and the contingency plan has not been tested for adequacy in the event of a disaster. We recommend management assess the processes and procedures and implement related monitoring and compensating controls where feasible.

CURRENT ISSUES AFFECTING NOT-FOR-PROFIT ORGANIZATIONS

This section of the letter is not required by professional standards. However, we want to inform you about issues of importance to the not-for-profit and healthcare community in order to assist you in continuing to plan proactively for the future of the Organization. The purpose of this section of this letter is to inform you as to the status of certain emerging developments which will affect not-for-profit and healthcare organizations.

IRS Releases Good Governance Practices Guidelines for Not-For-Profits

In early 2007, the Internal Revenue Service ("IRS") issued a set of guidelines designed to help ensure that members of a 501(c)(3) organization's governing board are familiar with and understand their roles and responsibilities and actively promote good governance practices within the organization. While compliance with these guidelines is not required for tax exempt status, the IRS indicates that adoption of some of the guidelines as best practices will aid an organization's success in pursuing exempt status and earning public support.

The guidelines address nine specific issues. The following is a brief summary of each recommendation:

Mission Statements: Adopt a clearly articulated statement that shows why the organization exists, what it hopes to accomplish, and what activities it will undertake, where, and for whom.

Codes of Ethics: Adopt and regularly evaluate a code of ethics and whistleblower policies that communicate a strong culture of legal compliance and ethical integrity.

Due Diligence: Ensure that policies are in place to help directors meet their duty of care, and ensure that directors are fully informed about the organization's activities, goals, and financial status.

Duty of Loyalty: Adopt and regularly evaluate a conflict of interest policy, which requires directors and staff to act solely in the interests of the organization. Directors and staff should be required to disclose annually in writing any known financial interest that the individual, or a member of the individual's family, has in any business entity that transacts business with the organization.

Transparency: Maintain full and accurate disclosure of the organization's mission, activities, and financial performance, and make this information available to the public on the organization's website and/or by request.

Fundraising Policies: Adopt and monitor policies to ensure that solicitation complies with the law and that materials are accurate, truthful, and candid.

Financial Audits: The governing board should approve annual budgets and regularly review current financial statements, as well as having an annual audit conducted by an independent auditor.

Compensation Practices: Compensation for services performed should be reasonable. Charities may pay reasonable compensation for services provided by officers and staff. In determining reasonable compensation, a charity may wish to rely on the rebuttable presumption test of IRC Section 4958 and Treasury Regulation Section 53.4958-6.

Document Retention Practices: Adopt a written policy establishing standards for the integrity, retention, and destruction of paper and electronic files. The policy should cover backup procedures, archiving of documents, and regular check-ups of the reliability of the system.

Principles for Effective Practice – Draft Recommendations from the Panel on the Nonprofit Sector

The Panel on the Nonprofit Sector is an independent effort by charities and foundations to ensure that the nonprofit community remains a vibrant and healthy part of American society. Formed by the Independent Sector in October 2004 at the encouragement of the U.S. Senate Finance Committee, the Panel in 2005 and 2006 provided recommendations for Congress and the not-for-profit sector to improve the oversight and governance of charitable organizations.

In early 2007, the Panel's Advisory Committee on Self-Regulation developed initial draft principles for effective practice after examining over 50 systems of self-regulation and accreditation that monitor charitable organizations.

After receiving public comments on that initial draft, it produced a second set of draft principles. The Advisory Committee now invites public comment on its second draft of 29 principles and the staff drafts of two additional principles, which are arranged in the following five categories:

- Facilitating Legal Compliance and Public Disclosure - responsibilities and practices, such as implementing conflict of interest and whistleblower policies that will assist charitable organizations in complying with their legal obligations.
- Effective Governance - policies and procedures a board of directors should implement to fulfill its oversight and governance responsibilities effectively.
- Strong Financial Oversight - policies and procedures an organization should follow to ensure wise stewardship of charitable resources.
- Responsible Fundraising - policies and procedures organizations that solicit funds from the public should follow to build donor support and confidence.
- Staff Drafts of Additional Principles – principles regarding risk management practices and adoption of a code of ethics.

We are sharing this information with you to illustrate the consistency of focus between the IRS guidelines and those of the Panel on the Nonprofit Sector. Effective not-for-profit governance, accountability and compliance are receiving unprecedented focus at the present time.

IRS Releases the Redesigned Form 990

On December 20, 2007, the IRS released the 2008 Form 990, *Return of Organization Exempt from Income Tax*, the informational form filed by public charities and other tax-exempt organizations. Organizations will begin using the new Form 990 for tax years beginning in 2008 (returns filed in 2009).

The 2008 Form 990 is based on the Form 990 Discussion Draft that was released to the public for comment on June 14, 2007. The IRS received approximately 700 emails and letters totaling approximately 3,000 pages of written comments during the draft's 90-day comment period. The new form incorporates many recommendations made in the public comments.

The current Form 990 consists of a nine-page core accompanied by Schedules A and B, in addition to thirty-six possible attachments. The 2008 Form 990 consists of an eleven-page core form that must be completed by each Form 990 filer. In addition, the form's sixteen schedules are designed to require reporting of information only from those organizations that conduct particular activities.

The form moves key information to the front page, creating a revealing snapshot of the Organization and its finances. Page one disclosures include a description of the organization's mission or most significant activities, and a two-year summary of revenues and expenses.

Areas of added emphasis include questions related to governance, management, and financial reporting. Examples of some new questions that will have to be answered on the 2008 Form 990 include:

- Does the Organization have a written conflict of interest policy? If so, are officers, directors or trustees, and key employees required to disclose annually interests that could give rise to conflicts? Does the organization regularly and consistently monitor and enforce compliance with the policy? If yes, describe how this is done.

- For the CEO, Executive Director, other officers or key employees, did the process for determining compensation include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?

- Does the Organization have a written whistleblower policy?

- Does the Organization have a written document retention and destruction policy?

- Was a copy of the Form 990 provided to the Organization's governing body before it was filed?

- Were the Organization's financial statements compiled, reviewed, or audited by an independent accountant? If so, does the Organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?

- The Organization must identify how it makes its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection.

- The Organization must describe whether (and if so, how) it makes its governing documents, conflict of interest policy, and financial statements available to the public.

The IRS expects to release draft instructions for the new form early in 2008.

The IRS also announced a graduated transition period for smaller organizations. These organizations will be allowed to file the Form 990-EZ instead of the Form 990. For the 2008 tax year (returns filed in 2009), organizations with gross receipts over $1.0 million or total assets over $2.5 million will be required to file the Form 990.

For the 2009 tax year (returns filed in 2010), organizations with gross receipts over $500,000 or total assets over $1.25 million will be required to file the Form 990. The filing thresholds will be set permanently at $200,000 gross receipts and $500,000 total assets beginning with the 2010 tax year. Also, starting with the 2010 tax year, the IRS will increase the filing threshold for organizations required to file Form 990-N (the e-postcard) from $25,000 to $50,000.

"This phase-in process will allow organizations to become familiar with the new Form 990," Lerner said.

The IRS also announced a phase-in of the form's new hospital and tax exempt bond schedules. Certain identifying information will be required for the 2008 tax year, with completion of the entire schedules required for the 2009 tax year. In response to the nonprofit sector's safety and security concerns regarding disclosure of certain foreign workers and volunteers, the IRS revised the form to permit reporting of foreign activities by region, rather than by country, until other safeguards may be implemented to protect the privacy interests of such persons.

"We believe the transition relief we are providing is appropriate and meaningful, and will ease the concerns raised by commenters," said Lerner.

IRS Report on Exempt Organizations Executive Compensation

In March 2007, the Internal Revenue Service released findings from the 2004 Executive Compensation Compliance Initiative conducted by the Exempt Organizations Office of the Tax Exempt and Government Entities Division. Part I of the project included compliance check letters sent to 1,223 organizations, while Part II of the project involved examinations of 782 organizations. A partial summary of findings from the project follows:

- The compliance checks uncovered significant reporting errors and omissions in specific areas, particularly excess benefit transactions and transactions with disqualified persons. Over 30% of compliance recipients amended their Forms 990, while 15% of the compliance check recipients were selected for examination.
- Examinations completed to date do not evidence widespread concerns other than reporting.
- Where problems were found, significant dollars of excise taxes (aggregating $21 million) are being assessed.
- High compensation amounts were found in many cases, but were generally substantiated based on appropriate comparability data.
- Only 51% of organizations attempted to satisfy all three prongs to establish the rebuttable presumption of reasonableness of compensation for disqualified persons (approval by independent governing body, reliance on comparable data, and adequate documentation).
- Changes in the Form 990 series are necessary to reduce errors in reporting and to enable the IRS to identify compensation issues.

This communication is intended solely for the information and use of management, the Board of Directors and its relevant committees and others within the Hospital, and is not intended to be and should not be used by anyone other than these specified parties. We appreciate this opportunity to be of service and extend our thanks to everyone at the Hospital for their cooperation and assistance. We would be pleased to discuss any of the above matters with you at your convenience.

Sincerely,

Blue & Co., LLC

2008 Quest for Excellence
Key Performance Indicators for Best Performers

The Key Performance Indicators (KPI) listed below are based upon Blue & Co.'s experience pursuing excellence in hospital receivables. We recommend that KPI's be measured on a monthly basis and adjusted as goals are met.

KPI	Benchmark	How Do We Rank?	Purpose of Data
A/R > 90 Days	20%		Monitor account follow-up processes and practices for extreme efficiencies.
Gross Cash Collections to Total Revenue	64%		Total revenue being collected.
Bill Hold Days	3		Time frame that bills are held in order to collect accurate data input, medical record coding and charges.
Percentage of Unbilled Receivable	<10%		Strictly monitor in-house, recurring and missing diagnosis accounts.
Average Daily Revenue in Medical Records	3.5		Total days in revenue that are held for coding delays.
Registration Error Rate	2%		Registration error rate as a percentage of total registrations.
Percentage of Bad Debt to Gross Revenue	2.5%		Monitor uncollectible accounts to ensure they have been appropriately handled.
Charity Percentage to Gross Revenue	2.5%		Monitor charity write-off and ensure financial counseling is accomplished.
Net A/R Days	46		Average days to collect the receivable.
Percentage Clean Claims from Bill Editor	95%		Number of errors on accounts due to data input, charging and coding.
Return on Worker's Compensation, Third Party Liability and Auto Insurance Accounts	85%		Effectiveness of difficult third party liability claims collection.
Up-front Deductible and Co-payment Collections	80%		Improvements to cashflow, acknowledging the financial obligation with the patient at the time of service.
Average Daily Revenue in Credit Balances	<1%		Credit Balances negatively effect the total A/R.
Claim Denial Rate	4%		Total denied claims as a percentage of total claims.
Percentage of Scheduled Services that are Pre-registered	95%		Improving patient information data gathering including demographics, medical necessity and insurance eligibility.
Percentage of Self-pay Patients that Receive Financial Counseling	95%		Providing patients with payment options and/or charity consideration.
Hospital-wide Education Regarding Charity Policy and Payment Options for Patients	100%		Ensuring that Hospital Payment and Charity Care Policies are well understood by all hospital staff.

HEALTHCARE INDUSTRY DEVELOPMENTS

This section describes certain of the more pervasive risks that are in play in the healthcare industry today. We have identified those risks, which we believe to be most pertinent to the Hospital (the Hospital). The industry developments assist us in our assessment of the business risks in conjunction with our audit of the Hospital.

ECONOMIC AND INDUSTY DEVELOPMENTS

Economic activities relating to factors such as interest rates, consumer confidence, overall economic expansion or contraction, inflation, and labor market conditions are likely to have an impact on the entity's financial statements being audited.

The U.S. real gross domestic product (GDP), the broadest measure of economic activity, measures output of goods and services by labor and property within the United States and increases as the economy grows. According to the Bureau of Economic Analysis, GDP increased at an annual rate of 2.9 percent in 2006, consistent with the pace of growth experienced in 2005 when GDP increased by 3.1 percent. During the first quarter of 2007, GDP increased by an annual rate of only 0.6 percent. However, according to second quarter preliminary estimates, GDP increased at an annual rate of 4.0 percent.

The unemployment rate remained relatively unchanged during 2006, holding between 4.4 percent and 4.8 percent, with an annual average rate of 4.6 percent representing approximately 7 million people. The 2006 rates represent the lowest annual rate and total number of jobless since 2000, according to the U.S. Department of Labor Bureau of Labor Statistics. During the first half of 2007, the unemployment rate averaged 4.5 percent. This data further demonstrates the economic growth the U.S. has experienced since the beginning of 2006.

After a period of rising rates during the first half of 2006, the Federal Reserve kept its target for the federal funds rate at 5.25 percent during its last 10 meetings (June 2006—August 2007). At that time, the Federal Reserve indicated future federal fund rate adjustments would likely depend upon the outlook for economic growth and inflation. Since its August 2007 meeting, and in response to shaky financial market conditions, the Federal Reserve announced that it would provide reserves as necessary through the open market to facilitate the orderly functioning of financial markets by promoting trading in the federal funds market at rates close to the 5.25 percent target rate. The Federal Reserve then announced on August 17, 2007 that financial market conditions had deteriorated, and tighter credit conditions and increased uncertainty has the potential to restrain economic growth. The Federal Open Market Committee (FOMC) is closely monitoring the situation and is prepared to act as necessary to mitigate adverse effects on the economy arising from the disruptions in financial markets. Shortly after this August 17th release, the Federal Reserve approved actions to decrease the discount rate at the Federal Reserve Banks of Boston, Philadelphia, Cleveland, Richmond, Atlanta, Chicago, Minneapolis, Kansas City, Dallas, and St. Louis from 6.25 percent to 5.75 percent. This narrows the spread between the primary credit rate and the target federal funds rate to 50 basis points.

Technology

New technologies are continually being developed that may have a significant impact on financial results of healthcare organizations in the future. In addition, healthcare organizations are expanding their investment in technology in ways that may have received less attention. For example, they may want to achieve greater staff efficiency and productivity, improvements to patient care quality and safety, compliance with regulatory requirements, facility and equipment modernization, and information processing and sharing. Other uses of technology by healthcare organizations include electronic medical records, bar coding medical supplies, and bedside laboratory testing. Health care organizations are also entering into remote hosting agreements with vendors. The U.S. Department of Health and Human Services (HHS) continues to announce efforts to promote the use of IT in healthcare, including initiatives to promote creation of electronic health records (EHR) for Americans. In fact, the American Health Information Community recently recommended that EHR adoption be its top priority and made plans to standardize secure and widely available solutions for accessing current and historical laboratory results and interpretations in the near future.

As we plan our audits, we consider in particular the effects of IT on internal control and our ability to obtain sufficient competent evidential matter to provide a reasonable basis for forming an opinion. We consider the guidance in AU section 319, *Consideration of Internal Control in a Financial Statement Audit* (AICPA, *Professional Standards*, vol. 1; and AU sections 326A and 326, *Evidential Matter* (AICPA, *Professional Standards*, vol. 1).

Auditors may find their healthcare organization clients are using off-balance-sheet financing arrangements, such as operating leases, to finance their IT equipment acquisitions. Auditors should determine that the accounting guidance in Financial Accounting Standards Board (FASB) Statement of Financial Accounting Standards No. 13 , *Accounting for Leases*, as amended and interpreted for classification of leases as operating leases, capital leases, or sale-type leases, is being followed. FASB Statement No. 13, paragraph 1, states that a lease is an agreement conveying the right to use property, plant, and equipment (land or other depreciable assets), usually for a stated period of time. Emerging Issues Task Force (EITF) Issue No. 01-8, "Determining Whether an Arrangement Contains a Lease," provides guidance on how to determine whether an arrangement contains a lease that is within the scope of FASB Statement No. 13.

Auditors should consider the guidance in Statement of Position (SOP) 98-1, *Accounting for the Costs of Computer Software Developed or Obtained for Internal Use*, on accounting for the costs of computer software developed or obtained for internal use, and for determining whether the costs of computer software developed for internal use are capitalizable.

Complex Financing Structures and Access to Capital

Healthcare organizations are dependent on external sources of funds to satisfy their capital needs. Many healthcare organizations finance acquisitions, additions, and renovations with long-term debt. Health care organizations may have more complex structures that use swaps or other derivative instruments to meet their financing objectives, such as changing their liabilities from fixed-rate borrowings to variable rate borrowings, or vice versa. Auditors should determine that the method specified by generally accepted accounting principles (GAAP) to determine the value of derivatives is being followed. When auditing derivatives, auditors should follow the guidance in AU section 332, *Auditing Derivative Instruments, Hedging Activities, and Investments in Securities* (AICPA, *Professional Standards*, vol. 1.

Interpretation No. 1, "Auditing Investments in Securities Where a Readily Determinable Fair Value Does Not Exist"), to AU section 332 (AICPA, *Professional Standards,* vol. 1, AU sec. 9332.01—.04) provides guidance regarding the adequacy of audit evidence, with respect to the existence and valuation assertions in AU section 332 (AICPA, *Professional Standards* , vol. 1); in confirmations received from third parties, where a readily determinable fair value does not exist, and the auditor determines auditing procedures should include verifying the existence and testing the measurement of the investments. For example, an entity may have an investment in a hedge fund that is reported at fair value for which a readily determinable fair value does not exist. Further, the hedge fund may own interests in investments in limited partnership interests or other private equity securities for which a readily determinable fair value does not exist.

As part of the auditor's procedures in accordance with AU section 332 (AICPA, *Professional Standards*, vol. 1); an auditor typically would satisfy the existence assertion through either confirmation with the hedge fund, examination of legal documents, or other means. In confirming existence, the auditor may request the hedge fund to indicate or confirm the fair value of the entity's investment in the hedge fund, including the fair value of investments held by the hedge fund. In some circumstances, the hedge fund will not provide detailed information about the basis and method for measuring the entity's investment in the hedge fund, nor will they provide information about specific investments held by the hedge fund. Audit Interpretation No. 1 illustrates examples of information auditors may receive in a third-party confirmation (in the aggregate or on a security-by-security basis) and provides interpretative guidance for auditors about the adequacy of audit evidence provided in those examples.

Costs of Providing Health Care Services

Governments and private employer providers of healthcare insurance continue to focus on the costs of healthcare. A number of employers announced reductions or eliminations of healthcare coverage to employees or retirees. There are government- and private-sector initiatives to promote consumer-directed healthcare and expand use of health savings accounts.

Uninsured patient charges, billings, and collections have been in the spotlight in recent years. Your healthcare organization clients may be continuing to evaluate their policies and procedures for providing patient care for the uninsured.

Scrutiny on Uninsured Patient Charges and Billings

Healthcare organizations may very well continue to see increases in the levels of care provided to the uninsured. Unemployment, the rise in health insurance coverage, and changes in requirements for participation in governmental healthcare programs are contributing to the dilemma. Uninsured patient charges, billings and collections have received attention from the U.S. Congress, the Centers for Medicare and Medicaid Services (CMS) and the Office of Inspector General (OIG). A number of healthcare organizations are addressing actions by tax authorities and lawsuits that challenge their tax exempt status. In response, healthcare organizations should be evaluating their policies and procedures for compliance.

Reimbursement from Medicaid Programs

For states experiencing budget shortfalls, Medicaid programs may be the target of cost containment measures such as benefit changes, program eliminations, lower funding levels (for federal match), and higher eligibility requirements, despite the strong demand for healthcare services.

REGULATORY DEVELOPMENTS

Office of Inspector General

Office of Inspector General: Publications: Work Plan and Semiannual Report

The OIG of HHS investigates and monitors the Medicare and Medicaid programs. On the HHS OIG Web site at http:///www.oig.hhs.gov, you can access two publications that can be helpful in obtaining information about current projects and investigative activities of the OIG: the OIG Work Plan Fiscal Year 2007 and the OIG October 1, 2005, to March 31, 2006, Semiannual Report.

The Work Plan includes a section with ongoing and proposed OIG projects planned for CMS. The projects planned for CMS are presented by categories that include hospitals (Medicare and Medicaid); home health (Medicare); nursing homes (Medicare); managed care (Medicare); physicians and other health professionals (Medicare); Medicaid administration, including upper payment limit programs; and other services (Medicare and Medicaid). Some of those projects are presented in the following table.

Category	Project
Medicare hospitals	• Examine Medicare inpatient capital payments, including the accuracy and appropriateness of the current methodology used to update the capital rates. • Review the appropriateness of FY 2002 base-year costs for a selected number of Medicare-dependent hospitals. • Review the extent to which admissions to inpatient rehabilitation facilities met specific regulatory requirements and whether the facilities billed for services in compliance with Medicare regulations. • Determine whether audit adjustments for direct and indirect graduate medical education for fiscal intermediaries made while settling Medicare cost reports were properly reflected in the revised Medicare reimbursement. • Determine whether payments were made for inpatient admissions for dialysis services when the physicians' orders stated the level of care as admission to observation status. • Determine the appropriateness of payments for provider-operated nursing and allied health education programs. • Determine whether hospital and Medicare controls are adequate to ensure the accuracy of the hospital wage data used for calculating wage indices for the inpatient PPS. • Review payments to inpatient rehabilitation facilities under the PPS to determine the extent to which they were made in accordance with Medicare regulations. • Determine the accuracy of Medicare payments for inpatient rehabilitation stays when patient assessments are entered late. • Examine Medicare payments made to organ procurement organizations and identify and review controls and cost containment practices used by organ procurement organizations to acquire organs for transplant. • Review payments made to hospitals for new services and technologies. • Review payments to psychiatric facilities under the inpatient psychiatric facility PPS to determine the extent to which they were made in accordance with Medicare laws and regulations. • Review payments under the long-term care hospital PPS to determine the extent to which these payments were made in accordance with Medicare laws and regulations.
Medicaid hospitals	• Determine whether Medicaid state agencies' methods of computing inpatient hospital cost outlier payments result in reasonable payments. • Review several states' disproportionate share hospital payments to selected hospitals to verify that the states calculated the payments according to their approved state plans and that the payments to individual hospitals did not exceed the limits imposed by the Omnibus Budget Reconciliation Act of 1993. • Determine whether states are appropriately determining hospitals' eligibility for Medicaid disproportionate share hospital payments.

Medicaid administration	•Determine the extent to which state Medicaid agencies have contracted with consultants through contingency fee payment arrangements and the impact of these arrangements on the submission of questionable or improper claims to the federal government. • Identify (1) the extent to which Medicaid Statistical Information Hospitals data submitted are complete, (2) barriers to submitting data encountered by the states, and (3) oversight activities conducted by CMS to ensure complete data submission. • Determine whether states have eliminated the use of inappropriate financing mechanisms involving supplemental payments available under the upper payment limits.

Centers for Medicare and Medicaid Services:

Deficit Reduction Act of 2005

On February 8, 2006, the President signed the Deficit Reduction Act of 2005 (DRA). This legislation affects many aspects of healthcare entitlement programs, including both Medicare and Medicaid.

The DRA provides states with much of the flexibility they have sought over the years to make significant reforms to their Medicaid programs. Combined with other options in Medicaid, states will be able to reconnect their healthy populations to the larger health insurance hospital, transform long-term care from an institutionally based, provider-driven Hospital to a person-centered and consumer-controlled model. There are great opportunities for covering more people at a lower cost and with greater continuity of coverage.

Under the provisions of the DRA, Congress directed CMS to establish the Medicaid Integrity Program (MIP). This significantly increased the resources available to CMS to combat fraud, waste, and abuse in the Medicaid program. The DRA provides for a five-year Comprehensive Medicaid Integrity Plan (CMIP) to be written to guide MIP development and operations.

The plan details the two major operational requirements of the MIP: (1) to use the contractors to review provider activities, audit claims, identify overpayments, and conduct provider education and (2) to provide effective support and assistance to states in their efforts to combat provider fraud and abuse. While the DRA requires that the CMIP be revised in five-year cycles, CMS will review and update the plan annually. CMS will also report to Congress annually on the use and effectiveness of the funds appropriated for MIP.

Other

On August 1, 2007, the Centers for Medicare and Medicaid Services (CMS) issued a final rule that takes significant steps to improve the accuracy of Medicare's payment under the acute care hospital inpatient prospective payment system (IPPS), while providing additional incentives for hospitals to engage in quality improvement efforts. The IPPS payment reforms would restructure the inpatient diagnosis-related groups (DRGs) to account more fully for the severity of each patient's condition. In addition, the rule includes important provisions to ensure that Medicare no longer pays for the additional costs of certain preventable conditions (including certain infections) acquired in the hospital.

U.S. Department of Health and Human Services:

Value-Driven Health Care

The HHS has focused a spotlight on healthcare transparency. They feel consumers deserve to know the quality and cost of their healthcare, and they feel healthcare transparency provides consumers with the necessary information, and the incentive, to choose healthcare providers based on value.

According to the HHS Web site, www.hhs.gov, healthcare transparency is built on four interconnected cornerstones.

Connect the Hospitals: Every medical provider has some hospital for health records. Increasingly, those hospitals are electronic. Standards need to be identified so all health information hospitals can quickly and securely communicate and exchange data.

Measure and publish quality: Every case and every procedure has an outcome. Some are better than others. To measure quality, we must work with doctors and hospitals to define benchmarks for what constitutes quality care.

Measure and publish price: Price information is useless unless cost is calculated for identical services. Agreement is needed on what procedures and services are covered in each episode of care.

Create positive incentives: All parties—providers, patients, insurance plans, and payers—should participate in arrangements that reward both those who offer and those who purchase high-quality, competitively priced healthcare.

Internal Revenue Service:

Community Benefit Survey

The IRS sent Form 13790, *Compliance Check Questionnaire for Tax- Exempt Hospitals*, to approximately 550 tax-exempt hospitals. The purpose of this inquiry was to gather additional information about hospital community benefit programs. This compliance check initiative investigates compliance by tax-exempt hospitals with the community benefit standards of Revenue Ruling 69-545. Additionally, the inquiry is focused on compensation practices for individuals such as voting board members and for certain other governance individuals. Revenue Ruling 69-545 indicated that the promotion of health could be a charitable purpose. In making this determination, the IRS considered factors including whether the hospital treated all persons requiring emergency treatment without regard to ability to pay; whether the hospital provided care to everyone in the community with the ability to pay for services; and whether the hospital used the surplus of receipts over disbursements to improve patient care quality, expand the facilities, and provide additional education, training, or research opportunities.

In June 2007, the IRS released its draft Form 990. The discussion draft constitutes a significant redesign of the Form, which has not been overhauled since 1979. The IRS anticipates using the redesigned form for the 2008 tax year (returns filed in 2009). The proposed redesign does not affect the other forms in the IRS Form 990 series. The redesigned form is based on enhancing transparency, promoting tax compliance, and minimizing the burden on the filing organization.

Updates to 409A and 457(f) Plans

Reforms were made to Section 409A and 457(f) of the IRS Code. Section 409A applies to amounts deferred after December 31, 2004, and amounts deferred prior to that date but not yet vested on that date. Participants in plans affected by this rule may be subject to immediate taxation on all amounts deferred, plus penalty, if the plans do not comply with the requirements of Section 409A.

Tax-exempt entities are able to offer nonqualified deferred compensation plans to employees, which are covered by Section 457 of the IRS Code. Among the key provisions of Section 457(f) is that in order not to be subject to immediate taxation, deferred compensation must be subject to a substantial risk of forfeiture. Section 457(f) plans are also subject to Section 409A of the IRS Code.

Private Activity Bonds

In December 2005, the IRS published final regulations affecting issuers of tax-exempt bonds, amending Section 141 of the Internal Revenue Code (IRC), to provide rules on the application of the private activity bond tests to refunding issues. The final regulations apply to bonds sold on or after February 17, 2006, and subject to the January 16, 1997, final regulations relating to the definition of private activity bonds and related rules. Among other matters, the final regulations provide that, in general, for the application of the private activity bond tests, a refunding issue and a prior issue are tested separately under IRC Section 141, and the determination of whether a refunding issue consists of private activity bonds does not depend on whether the prior issue consisted of private activity bonds. The final regulations also amend regulations under IRC Sections 145, 149, and 150 by providing rules on certain related matters. Visit the IRS Web site at http:///www.irs.gov to obtain the final regulations.

Enforcement Project for Compensation Practices

In 2004, as part of its Tax Exempt Compensation Enforcement Project, the IRS announced an enforcement effort to identify and halt abuses by tax-exempt organizations that pay excessive compensation and benefits to officers and other insiders. Executive compensation continues to be a key focus area for the IRS. The IRS, seeking information about compensation practices and procedures, contacted nearly 2,000 charities and foundations. Particular areas of focus included the compensation of specific officers and various kinds of insider transactions.

Pension Protection Act of 2006

In August 2006, the Pension Protection Act of 2006 became law. This Act amends the tax and Employee Retirement Income Security Act provisions affecting pension plans and other compensatory arrangements. The key provisions of the legislation are that it:

- Requires companies that underfund their pension plans to pay additional premiums
- Extends a requirement that companies that terminate their pensions provide extra funding for the pension insurance system.
- Requires that companies measure the obligations of their pension plans more accurately.
- Closes loopholes that allow under funded plans to skip pension payments.
- Raises caps on the amounts that employers can put into their pension plans so they can add more money during good times and build a cushion that can keep their pensions solvent in lean times.
- Prevents companies with underfunded pension plans from digging the hole deeper by promising extra benefits to their workers without paying for those promises up front.

This section describes certain guidance from the healthcare audit and accounting arena. We have identified those pronouncements, which we believe may be relevant now or at some point in the future to the Hospital. The audit and accounting developments assist us in assessing the audit risk in conjunction with our audit of the Hospital.

NEW AUDITING AND ATTESTATION PRONOUNCEMENTS

Presented in this table is a list of auditing and attestation pronouncements, Guides, and other guidance.

Statement on Auditing Standard	Effect on Existing Standards
SAS No. 102 , *Defining Professional Requirements in Statements on Auditing Standards* SSAE No. 13 , *Defining Professional Requirements in Statements on Standards for Attestation Engagements* (December 2005) (Not applicable to audits conducted in accordance with PCAOB standards)	These standards established two categories of professional requirements that are identified by specific terms. The words *must* or *is required* are used to indicate an unconditional requirement. The word *should* is used to indicate a presumptively mandatory requirement. (The words *may, might, could,* and *should consider* represent actions that auditors have a professional obligation to consider.) The provisions of SAS No. 102 and SSAE No. 13 were effective upon issuance. It is the ASB's intention to make conforming changes to AICPA literature over the next several years to remove any language that would imply a professional requirement where none exists.
SAS No. 103 , *Audit Documentation* (December 2005) (Not applicable to audits conducted in accordance with PCAOB standards)	SAS No. 103 (AICPA, *Professional Standards*, vol. 1) supersedes SAS No. 96, *Audit Documentation*, and amends SAS No. 1, section 530, *Dating of the Independent Auditor's Report* (AICPA, *Professional Standards*, vol. 1, AU sec. 530). It is effective for audits of financial statements for periods ending on or after December 15, 2006, with earlier application permitted. This SAS establishes standards and provides guidance to an auditor of a nonissuer on audit documentation.
SAS No. 104—No. 111 , *Risk Assessment Standards*	See " Spotlight on the AICPA Risk Assessment Standards" below.

SAS No. 112 , *Communicating Internal Control Related Matters Identified in an Audit* (May 2006) (Not applicable to audits conducted in accordance with PCAOB standards)	SAS No. 112 (AICPA, *Professional Standards*, vol. 1) supersedes SAS No. 60, *Communication of Internal Control Related Matters Noted in an Audit.* It establishes requirements and provides extensive guidance about communicating matters related to an entity's internal control over financial reporting identified while performing an audit of financial statements. SAS No. 112 also requires that certain communications be in writing. It is effective for periods ending on or after December 15, 2006.
SAS No. 113, *Omnibus Statement on Auditing Standards—2006*	SAS No. 113 includes various revisions to existing SASs.
SAS No. 114 , *The Auditor's Communication With Those Charged With Governance*	SAS No. 114 (AICPA, *Professional Standards*, vol. 1) establishes standards and provides guidance on the auditor's communication with those charged with governance in relation to an audit of financial statements. It supersedes SAS No. 61, *Communication With Audit Committees* (AICPA, *Professional Standards*, vol. 1, AU sec. 380A). It is effective for periods beginning on or after December 15, 2006.
SSAE No. 14 , *SSAE Hierarchy*	This Statement identifies the body of attest literature, clarifies the authority of attest publications issued by the AICPA and others, specifies which attest publications the practitioner must comply with and those he or she should be aware of when conducting an attest engagement, and amends the 11 attestation standards to conform them with the use of terms established in SSAE No. 13.

SAS No. 103 (AICPA, *Professional Standards*, vol. 1, AU sec. 339) supersedes SAS No. 96 of the same name. The SAS also amends paragraphs .01 and .05 of AU section 530, *Dating of the Independent Auditor's Report* (AICPA, *Professional Standards*, vol. 1). The amendment requires that the auditor's report not be dated earlier than the date on which the auditor has obtained sufficient appropriate audit evidence to support the opinion on the financial statements. As defined in the footnote to paragraph .01, sufficient appropriate audit evidence includes, among other things, evidence that the audit documentation has been reviewed and that the company's financial statements, including disclosures, have been prepared and that management has asserted that they have taken responsibility for them. Consider how this guidance affects the process followed on your engagements, including the review of audit documentation and financial statements, obtaining management's representations, and analyzing subsequent events and how this affects the date of the audit report.

SAS No. 112 (AICPA, *Professional Standards*, vol. 1, AU sec. 325) supersedes SAS No. 60, *Communication of Internal Control Related Matters Noted in an Audit*, as amended.

SAS No. 112 requires the auditor to evaluate identified control deficiencies and determine if they, individually or when combined, are significant deficiencies or material weaknesses. These terms are defined consistent with PCAOB Auditing Standard No. 2, *An Audit of Internal Control Over Financial Reporting Performed in Conjunction With an Audit of Financial Statements* (AICPA, *PCAOB Standards and Related Rules*, AU sec. 320). The term *reportable condition* is no longer used. The SAS also requires that these communications now be in writing. Common control deficiencies may include:

- Segregation of duties issues (especially common among smaller companies)
- Potential for management override
- Inadequate process and controls over revenue recognition
- Lack of controls over the process by which estimates are determined and recorded
- Lack of a process and controls to properly identify, consolidate, and disclose variable interest entities

Spotlight on the AICPA Risk Assessment Standards

In March 2006, the AICPA's ASB issued eight SASs that provide extensive guidance concerning the auditor's assessment of the risks of material misstatement in a financial statement audit, and the design and performance of audit procedures whose nature, timing, and extent are responsive to the assessed risks. Additionally, the SASs establish standards and provide guidance on planning and supervision, the nature of audit evidence, and evaluating whether the audit evidence obtained affords a reasonable basis for an opinion regarding the financial statements under audit. The following table lists the eight SASs and their effects on existing standards.

Statement on Auditing Standard	Effect on Existing Standards
SAS No. 104 , *Amendment to Statement on Auditing Standards No. 1*, Codification of Auditing Standards and Procedures *("Due Professional Care in the Performance of Work")*	This Statement amends SAS No. 1, *Due Professional Care in the Performance of Work* (AU section 230).
SAS No. 105 , *Amendment to Statement on Auditing Standards No. 95*, Generally Accepted Auditing Standards	This Statement amends SAS No. 95, *Generally Accepted Auditing Standards* (AU section 150).
SAS No. 106 , *Audit Evidence*	This Statement supersedes SAS No. 31, *Evidential Matter* (AU section 326A).
SAS No. 107 , *Audit Risk and Materiality in Conducting an Audit*	This Statement supersedes SAS No. 47, *Audit Risk and Materiality in Conducting an Audit* (AU section 312A).
SAS No. 108 , *Planning and Supervision*	This Statement supersedes SAS No. 1, *Appointment of the Independent Auditor* (AU section 310), and supersedes SAS No. 22, *Planning and Supervision* (AU section 311A).
SAS No. 109 , *Understanding the Entity and Its Environment and Assessing the Risks of Material Misstatement*	This Statement supersedes SAS No. 55, *Consideration of Internal Control in a Financial Statement Audit* (AU section 319).
SAS No. 110 , *Performing Audit Procedures in Response to Assessed Risks and Evaluating the Audit Evidence Obtained*	This Statement supersedes SAS No. 45, *Substantive Tests Prior to the Balance-Sheet Date* (AU section 313), and together with SAS No. 109, supersedes SAS No. 55, *Consideration of Internal Control in a Financial Statement Audit* (AU section 319).
SAS No. 111 , *Amendment to Statement on Auditing Standards No. 39*, Audit Sampling	This Statement amends SAS No. 39, *Audit Sampling* (AU section 350).

Key Provisions of the New Standards

The SASs emphasize the link between understanding the entity and assessing risks and the design of further audit procedures. The SASs introduce the concept of risk assessment procedures, which are deemed necessary to provide a basis for assessing the risk of material misstatement. Risk assessment procedures, along with further audit procedures that consist of tests of controls and substantive tests, provide the audit evidence to support the auditor's opinion of the financial statements. According to the SASs, the auditor should perform risk assessment procedures to gather information and to gain an understanding of the entity and its environment, including its internal controls. These procedures include inquiries, analytical procedures, and inspection and observation. Assessed risks and the basis for those assessments should be documented; therefore, auditors may no longer default to maximum control risk for an entity's risk assessment without documenting the basis for that assessment. The SASs also require auditors to consider and document how the risk assessment at the financial statement level affects individual financial statement assertions so that auditors may tailor the nature, timing, and extent of their audit procedures to be responsive to their risk assessment. It is anticipated that generic audit programs will not be appropriate for all audit engagements because risks vary among entities.

Effective Date and Implementation

The SASs are effective for audits of financial statements for periods beginning on or after December 15, 2006; earlier application is permitted. In most cases, implementation of the SASs will result in an overall increased work effort by the audit team, particularly in the year of implementation. To implement the SASs appropriately, it is anticipated that many firms will have to make significant revisions to their audit methodologies and train their personnel accordingly. Readers can obtain the SASs and the related AICPA Audit Risk Alert, *Understanding the New Auditing Standards Related to Risk Assessment* (product no. 022526kk), at www.cpa2biz.com.

Charity Care

Charity care is a type of uncompensated care that results from a provider's policy to provide healthcare services free of charge to individuals who meet certain financial criteria. Health care organizations establish their own criteria for charity care, and must determine whether the individual patient meets the criteria. Readers should refer to the Audit and Accounting Guide *Health Care Organizations* for current guidance on accounting for charity care. The Health Care Expert Panel is currently working with the AICPA Accounting Standards Executive Committee (AcSEC) to provide updated guidance on recognition for patient revenues.

Distinguishing charity care from bad-debt expense (or allowance, for governmental healthcare entities) requires the exercise of judgment. Each organization establishes its own criteria for charity care consistent with its mission statement and financial ability. Auditors should be aware that many healthcare organizations are reviewing and changing their charity care policies.

The following are examples of questions for auditors to consider when auditing charity care:

- What is the organization's policy for charity care?
- How is that policy enforced?
- What determines if a patient is not able to pay?

- How is the amount of charity care determined? Is it based on discounted rates or full charge rates?
- What if the patient can make a partial payment?
- When is charity care determined to take place, before substantial collection efforts or after it is sent to collection?
- Does charity care exclude services provided where payment is accepted under a third-party arrangement that is less than the full charged rates?

Much attention has been placed on this area for nonprofit hospitals from Senate Finance Committee investigators and the IRS. Tax-exempt hospitals are being exposed to a new initiative of the IRS to focus on how providers are satisfying the community benefit standard.

The IRS adopted the community benefit standard in a Revenue Ruling in 1969, and it is the basis on which hospitals derive their tax-exempt status under IRS Code Section 501(c)(3). There is growing concern among Congress and the IRS about the justification by nonprofit hospitals of their tax-exempt status.

According to the *Washington Post*, Senate Finance Committee investigators have found that nonprofit hospitals routinely overcharge or deny care to patients who cannot afford to pay for medical care while the hospitals' executives receive what some deem to be excessive compensation and abundant perks. These findings also raise suspicion over whether hospitals will continue to enjoy tax-exempt status. The Senate Finance Committee's investigators said that although many of the 10 hospitals in the 15-month review insist that they are offering free care or reduced prices for low-income patients, the hospitals are not informing patients about such assistance, leaving many of the poorest patients struggling to pay large hospital bills even though they would qualify for free or reduced-cost care. The investigators further found that while the law allowing tax-exempt status requires charity care in exchange, the rule does not specify the amount of community benefit that must be provided or how poor the patients must be to qualify.

Patient Accounts Receivable

Due to the increased focus on charity care, some auditors may want to pay particular attention to patient accounts receivable. Uninsured patient charges, billings, and collections are under increased federal scrutiny, and, in response, healthcare organizations may be reevaluating their policies and procedures for establishing charity care criteria, setting charges to self-pay patients, and billing and collecting related receivables. Auditors may need to determine whether there have been any changes in accounting policies. When auditing estimates, auditors should be familiar with AU section 342, *Auditing Accounting Estimates* (AICPA, *Professional Standards*, vol. 1; and for audits conducted in accordance with PCAOB standards: AICPA, ***PCAOB Standards and Related Rules***), which provides guidance on obtaining and evaluating sufficient competent evidential matter to support significant accounting estimates used in a client's financial statements.

Alternative Investments

Over the past several years, certain entities, including healthcare organizations, have dramatically increased their investment in financial instruments that do not have a readily determinable market value. These investments are commonly referred to as alternative investments. Generally, these entities are required by GAAP to carry these investments at fair value. The continued increase in the percentage of alternative investments to both net assets and total investment portfolio subjects these entities to complex fair value accounting and has exposed their investment portfolios to greater risk and volatility.

Due to the increased risk of misstatement inherent with these investments, the Audit Issues Task Force of the ASB established the Alternative Investments Task Force. The task force was charged with providing additional guidance to auditors of investor entities as to how the auditor may obtain sufficient appropriate audit evidence to conclude that the financial statements are free of material misstatement. As a result, the Alternative Investments Task Force has developed and issued a Practice Aid for auditors titled *Alternative Investments - Audit Considerations.* The task force believes that this nonauthoritative Practice Aid will assist auditors in auditing alternative investments. The Practice Aid includes guidance on:

- General considerations pertaining to auditing alternative investments
- Addressing management's financial statement existence assertion
- Addressing management's financial statement valuation assertion
- Management representations
- Disclosure of certain significant risks and uncertainties
- Reporting

The Practice Aid also includes the following appendices:

Appendix 1: Example Confirmation for Alternative Investments
Appendix 2: Illustrative Examples of Due Diligence, Ongoing Monitoring and Financial Reporting Controls

Malpractice

Increases in malpractice insurance costs, legislation allowing caps on malpractice awards, and medical and technological breakthroughs that result in the performance of more complex and riskier procedures are some of the issues that healthcare organizations have to consider when evaluating insurance coverage. Health care organizations may respond by opting to increase deductibles or increase the extent of risk retained as a result of changes in policy terms. Other responses may include changes in actuaries or assumptions to determine malpractice losses or establishing captive insurance entities to provide malpractice insurance.

The existence of an insurance policy, by itself, is no assurance that the risk of financial loss is transferred. The extent of risk transfer is important in determining whether a liability should be recognized. The auditor may review the insurance contracts and determine the extent of the risk retained by the provider. Specific auditing procedures to consider include the following:

- Determine the type (such as occurrence basis or claims-made) and level (per occurrence or in the aggregate) of insurance protection the provider has obtained.

- Determine if the coverage actually transfers the malpractice risks. Is the insurance with a related party (for example, a captive insurance company)? Does it provide for retrospective premiums or similar adjustments?

Once the extent of the risk retained is understood, the auditor will be able to determine the nature, extent, and timing of other auditing procedures.

RECENT ACCOUNTING PRONOUNCEMENTS AND RELATED GUIDANCE

Presented in this table is a list of accounting pronouncements and other guidance issued since of last year.

FASB Statement No. 155	*Accounting for Certain Hybrid Financial Instruments—an amendment of FASB Statements No. 133 and 140*
FASB Statement No. 156	*Accounting for Servicing of Financial Assets—an amendment of FASB Statement No. 140*
FASB Statement No. 157	*Fair Value Measurements*
FASB Statement No. 158	*Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans—an amendment of FASB Statements No. 87, 88, 106, and 132(R)*
FASB Interpretation No. 48	*Accounting for Uncertainty in Income Taxes—an interpretation of FASB Statement No. 109*
FASB EITF Issues (Various dates)	Go to www.fasb.org/eitf/ for a complete list of EITF Issues.
FASB Staff Positions (Various dates)	Go to www.fasb.org/fasb_staff_positions/ for a complete list of FASB Staff Positions (FSPs). Some of the recently issued FSPs address issues relating to FASB Statements No. 143 and No. 150 , among others, and FASB Interpretation 46(R) .
AICPA Technical Practice Aids 2130.09—.35 (December 2005) (Nonauthoritative)	These Practice Aids cover various topics on the application of SOP 03-3, *Accounting for Certain Loans or Debt Securities Acquired in a Transfer* to Debt Securities.

AICPA Technical Practice Aids 5600.07—.17 (November 2005) (Nonauthoritative)	These Practice Aids cover various lease topics.
AICPA Technical Practice Aids 6910.16—.20 (January 2006) (Nonauthoritative)	These Practice Aids cover nonregistered investment partnerships.

Below is some additional information on selected recent accounting pronouncements and related guidance.

FASB Statement No. 157

This FASB Statement defines fair value, establishes a framework for measuring fair value in GAAP, and expands disclosures about fair value measurements. This Statement applies under other accounting pronouncements that require or permit fair value measurements because the FASB previously concluded in those accounting pronouncements that fair value is the relevant measurement attribute. Accordingly, this FASB Statement does not require any new fair value measurements. However, for some organizations, the application of this FASB Statement will change current practice.

FASB Statement No. 158

This FASB Statement improves financial reporting by requiring an employer to recognize the overfunded or underfunded status of a defined benefit postretirement plan (other than a multiemployer plan) as an asset or liability in its statement of financial position and to recognize changes in that funded status in the year in which the changes occur through comprehensive income of a business entity or changes in unrestricted net assets of a not-for-profit organization. This FASB Statement also improves financial reporting by requiring an employer to measure the funded status of a plan as of the date of its year-end statement of financial position, with limited exceptions.

An organization with publicly traded equity securities shall initially apply the requirement to recognize the funded status of a benefit plan and the disclosure requirements as of the end of the FY ending after December 15, 2006. An employer without publicly traded equity securities shall initially apply the requirement to recognize the funded status of a benefit plan and the disclosure requirements as of the end of the FY ending after June 15, 2007.

FASB Exposure Draft for Not-for-Profit Organizations Related to Mergers and Acquisitions

FASB recently issued an ED for not-for-profit organizations related to mergers and acquisitions. The accounting for mergers and acquisitions may have a material impact on the financial position for not-for-profit healthcare organizations in the current and future periods. Under current standards, there are two accounting methods permitted. The methods result in significantly different financial statement results for transactions that are similar. This proposed FASB Statement would eliminate pooling of interests as a method of accounting for not-for-profit organizations. It would also require them to apply the acquisition method to any merger or acquisition.

Derivatives Implementation Group Issue No. G26

In October 2006, FASB posted a tentative conclusion in Derivatives Implementation Group (DIG) Issue No. G26, *Cash Flow Hedges: Hedging Interest Cash Flows on Variable-Rate Assets and Liabilities That Are Not Based on a Benchmark Interest Rate*. This issue clarifies that in a cash flow hedge of a variable-rate financial asset or liability, the designated risk being hedged cannot be interest-rate risk unless the cash flows of the hedged transaction are explicitly based on that same benchmark interest rate.

Pension Disclosures-an amendment of GASB Statements No. 25 and No. 27

This Statement more closely aligns the financial reporting requirements for pensions with those for other postemployment benefits (OPEB) and, in doing so, enhances information disclosed in notes to financial statements or presented as required supplementary information (RSI) by pension plans and by employers that provide pension benefits.