



**MOORE STEPHENS
LOVELACE, P.A.**

CERTIFIED PUBLIC ACCOUNTANTS

**INDEPENDENT ACCOUNTANT'S PRELIMINARY REPORT ON
APPLYING AGREED-UPON PROCEDURES TO INDIGENT CARE
REIMBURSEMENT SUBMISSIONS**

To the Trustees of North Lake County Hospital District:

We have performed the procedures enumerated below, which were agreed to by you, solely to assist you with respect to the compliance of submissions received under HB 1299 (the "Bill") for the period October 1, 2012 through December 31, 2012.

The Board of Trustees (the "Board") of North Lake County Hospital District (the "District") is responsible for the approval and disbursement of funds under the Bill.

This agreed-upon procedures engagement will be conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of the procedures is solely the responsibility of the Board. Consequently, we make no representation regarding the sufficiency of the procedures described below, either for the purpose for which this report has been requested or for any other purpose.

Purpose of the Procedures

Any provider receiving funds from the District is subject to a verification of its records related to the patients for whom payment is sought to ensure compliance with the Bill. The District must conduct verification procedures of providers receiving payments in excess of ten percent of the District's tax revenue in each year and may perform verification of any other provider submissions under the Bill to ensure compliance and accountability to the taxpayers. If, upon completion of the verification procedures, it is determined that payments were made by the District that are not in compliance, the District is entitled to a recoupment of the amounts in question. We were retained by the District to perform certain agreed-upon procedures designed to meet these verification requirements of the Bill.

Agreed-upon Procedures

It was agreed that our engagement would be limited to the following procedures:

- 1) Determine a statistically valid sample size (producing results that could be extrapolated with a 95% confidence level) for each healthcare provider.

- 2) Interview the provider personnel responsible for the preparation of the indigent care report and update our understanding of the sources of information used to prepare the report and the controls used by the provider to ensure that each eligible indigent encounter is recorded and that each recorded indigent encounter is eligible, properly valued and medically necessary.
- 3) Obtain the quarterly report submitted by each provider identifying their indigent care encounters. Verify the accuracy of any mathematical calculations in the reports and, on a test basis, agree the report information to the provider's source documents.
- 4) For each sample encounter, agree the encounter information to its source in the provider's system. Additionally, obtain the patient file and review it for:
 - a) Documentation supporting patient eligibility - that is, qualification pursuant to the provisions of the Florida Health Care Responsibility Act, Section 154.304(9), Florida Statutes, and the Florida Health Care Indigency Eligibility Certification Standards, Florida Administrative Code, Rule 59H-1.0035(30).
 - b) Documentation that the recipient of the indigent care for which payment is sought is a resident of the District.
 - c) Documentation supporting medical eligibility - that is, the presence in the file of an appropriately authorized script or order from an appropriately licensed healthcare practitioner.
- 5) For each sample encounter, look up the procedure code on the Medicare fee screen. Using the cost-to-charge ratio from the provider's most recently filed cost report, determine the lower of the Medicare reimbursement rate for identical or substantially similar care in the territory of District or the cost incurred by the provider in the delivery of such care.
- 6) Communicate with the provider's compliance officer regarding the results and findings of the provider's most recently completed accreditation and peer reviews and audits by government agencies or others that may indicate that unnecessary procedures may have been performed and report such findings, if any, to District's management.
- 7) Obtain a written representation letter from the provider's management stating that they have reviewed the quarterly indigent care report, accept responsibility for it and certify, under penalty of perjury, that the eligibility verification procedures adopted by the District have been complied with and that they, in good faith, believe that the persons for which they are claiming indigent care reimbursement from the District are qualified under the Bill.
- 8) Report to the District the results from performing these agreed-upon procedures.

- 9) Annually, report to the District summarizing the results of the agreed-upon procedures and present the extrapolation of any payments that were made by the District that were not in compliance with the provisions of the Bill.

Findings:

The following providers submitted funding requests under the Bill for the period October 1, 2012 through December 31, 2012:

- Florida Hospital Waterman
- Central Florida Health Alliance - d/b/a Leesburg Regional Medical Center
- St. Luke's Medical Clinic
- Central Florida Health Alliance - d/b/a Community Medical Care Center
- Florida Hospital Waterman - d/b/a FHW Community Primary Health Clinic
- Community Health Center
- LifeStream Behavioral Center

We have summarized the data submissions and totaled them into allowable amounts subject to field audit.

Our work to date has been limited to organizing the submitted data, applying Medicare reimbursement rules and summarizing the data into amounts requested. We have not yet completed the patient eligibility testing procedures. That being said, preliminary amounts by provider are as follows:

<u>Provider</u>	<u>Amount</u>
Florida Hospital Waterman	\$ 775,835
Leesburg Regional Medical Center	489,841
St. Luke's Medical Clinic	3,517
Community Medical Care Center	51,123
FHW Community Primary Health Clinic	55,390
Community Health Center	44,002
LifeStream Behavioral Center	132,136
Totals	<u>\$1,551,844</u>

We recommend that the District release the provider payments listed above. If our final testing conclusion shows that a provider was overpaid, a true-up will be withheld from the next quarter's payment.

Other Matters

We conducted the provider training sessions that were discussed in the last District Board meeting, and we received positive feedback from the providers. Some providers held off on submitting their claims until after the training. That understandable reluctance has, at least in part, resulted in a delay in our testing.

Comments on Scope Limitations of our Work

Our work consisted of the performance of agreed-upon procedures. We were not engaged to, and did not, conduct an audit or examination, the objective of which would be the expression of an opinion. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

Pursuant to Florida law, this report is a public record and its distribution is not limited. Auditing standards generally accepted in the United States of America require us to indicate that this report is intended solely for the information and use of the District's Board of Trustees and is not intended to be, and should not be, used by anyone other than the District's Board of Trustees.



MOORE STEPHENS LOVELACE, P.A.
Certified Public Accountants

Orlando, Florida
March 18, 2013