

BACKGROUND

- 6.1** The Health Authorities Act received Royal Assent on June 8, 2000. Section 6(3) of the Act provided for the creation of the Capital District Health Authority (CDHA). CDHA operates 10 health care facilities, including the Queen Elizabeth II Health Sciences Centre, the Nova Scotia Hospital, and the Dartmouth General Hospital. The organization employs approximately 750 physicians and 8,500 nursing, technical and other staff at 31 locations occupying approximately 4.2 million square feet of space.
- 6.2** CDHA is governed by a single board of directors currently consisting of sixteen members. All members of the Board of Directors are appointed by the Minister of Health. The Finance and Audit Committee, chaired by a Board member, reports to the Board. The day-to-day operations are administered by the Executive Management Team (EMT), consisting of the chief executive officer, eight vice presidents and the Medical Officer of Health.
- 6.3** CDHA receives the majority of its funding from the Department of Health (DOH). Most of the funding is portable, that is, funds are transferable between programs and capital. However, there is some non-portable funding as well. Non-portable funding is targeted for specific programs and is not transferable to other programs. Section 31 of the Health Authorities Act does not allow District Health Authorities (DHAs) to budget for a deficit.
- 6.4** The combined entity reported \$568.7 million in operating expenditures against \$568.8 million in revenues on the March 31, 2004 financial statements for a net operating surplus of \$13,000.
- 6.5** In 1997, the merger of the Victoria General Hospital, Nova Scotia Rehabilitation Centre and Camp Hill Medical Centre into the QEII Health Sciences Centre was followed by the merger of the three auxiliaries active at each site. This merged entity became Partners for Care (PFC). It was created to administer the revenue generating activities of the QEII Hospital. PFC is a not-for-profit organization governed by a separate Board.
- 6.6** In addition to PFC, there are seven foundations that provide capital funding to CDHA. In fiscal 2003-04 the foundations contributed \$1.5 million and PFC contributed \$1.25 million to CDHA's capital fund and \$2 million to operations.
- 6.7** Our most recent audit of the CDHA was in conjunction with a 2001 government wide audit of Financial Planning and Budgeting. The results of that audit were reported in the 2001 Report of the Auditor General. We have followed up on our recommendations from that audit in this Report.

- 6.8** CDHA receives revenues for services which are not insured under Nova Scotia Medical Services Insurance (MSI) and also from uninsured patients as well as third party payors. The accounting for revenues from patients who are not insured by MSI varies depending on whether the service delivered is on an inpatient or outpatient basis and whether the person is a resident of another Canadian province. Inpatient hospital services provided to residents of other Canadian provinces are recorded as recoveries by the DOH. For fiscal 2003-04 this amounted to \$30.8 million for all of Nova Scotia. All outpatient hospital services provided to non-Nova Scotians along with inpatient revenues from residents of other countries are recorded as revenue by the DHAs and IWK Health Centre. Total revenues for the DHAs and IWK, excluding Provincial funding, amounted to \$132.8 million for fiscal 2003-04 (see Exhibit 8.5, Chapter 8)
- 6.9** During the year, we also completed and reported on an audit of Revenue and Recoveries at the Department of Health, see Chapter 8 of this Report. There is a strong link between that audit and our audit of CDHA. Chapter 8 dealt with how the DOH bills other provinces, while our audit of CDHA gave us a more detailed understanding of CDHA's systems for billing and tracking revenues and how some of that information is conveyed to DOH for use in its billing processes.

RESULTS IN BRIEF

- 6.10** The following are our principal observations from this audit.
- Our audit testing revealed weaknesses in both the billing and credit management processes at the CDHA. Testing revealed weaknesses in certain billing processes including a need for interim billings.
 - A large bill (approximately \$642,000) had accumulated for a resident of another country and there was no documented understanding of how it would be paid. There is a need for the Department of Health and DHAs to reconsider existing policies for the provision of services to non-Canadians. Policies should require detailed reviews of individual cases by both the DHA and the Department of Health for appropriate action when charges or length of stay have reached specified targets.
 - Capital requirements are increasing annually and we continue to urge the development of a collaborative plan from the Department of Health and CDHA to develop an appropriate funding strategy for the longer-term capital requirements. The CDHA's 2004-05 budget submission shows deferred capital requests of \$87 million.
 - The financial statements of CDHA do not disclose its relationship with Partners for Care which recorded \$6.8 million from revenue-generating activities including parking lot fees in the 2003-04 fiscal year. The excess of revenue over expenses is transferred to the CDHA but financial statement disclosure of the relationship between Partners for Care and CDHA needs to be improved.

Similarly, there is a need to enhance the disclosure relating to funds transferred from the Foundations.

- The majority of the recommendations from our 2001 audit have been addressed, however we noted that there are still a few outstanding.

AUDIT SCOPE

6.11 The objectives of this assignment were to:

- review and assess the accountability relationship between the CDHA and the seven Foundations and Partners for Care, compliance with legislation and policies, and financial statement disclosure;
- review the audited financial statements, management letters and related working paper files for the CDHA and Partners for Care to determine if there are any findings that should be reported to the House of Assembly;
- determine the adequacy of CDHA's systems for capital planning and prioritization of capital requests;
- follow up on findings from the 2001 audit of Financial Planning and Budgeting at CDHA;
- review CDHA leases and assess related accounting policies;
- determine whether there are any recommendations in the CDHA's most recent accreditation survey that should be reported to the House of Assembly; and
- determine CDHA's policies and adequacy of controls over major revenue sources and collection of accounts receivable.

6.12 We reviewed our audit plan with management of CDHA in late spring of 2004. Our audit criteria were obtained from recognized sources including the Auditor General of Canada's Guide: *Auditing the Planning Function and Processes*, the Canadian Institute of Chartered Accountants' *Handbook and Professional Engagement Manual*, the Criteria of Control Board's *Guidance on Control*, and the Canadian Council on Health Services Accreditation's *Standards for Comprehensive Health Services*.

6.13 Detailed audit testing was conducted from July to October 2004. Our audit consisted of examination of policies and procedures, review of reports and other documents deemed to be relevant, interviews with management and staff, and detailed audit testing for the revenue and receivables component.

PRINCIPAL FINDINGS

Revenues and Receivables

- 6.14** **Background and overall conclusion** - The billing process is administered by the Revenue and Collections Department at the CDHA.
- 6.15** The CDHA records revenues from sources including:
- non-Canadian residents;
 - uninsured (not medically necessary) services;
 - services provided to individuals who are not insured through MSI (groups such as RCMP, Veterans, Armed Forces);
 - preferred accommodation (semi-private/private rooms);
 - long-term care per-diem billings;
 - Federal Government and Workers' Compensation Board of Nova Scotia for patients insured by such programs; and
 - laboratory (e.g., water testing) and other support services.
- 6.16** The scope of our audit included all of these items with the exception of recoveries from services sold to other DHAs (e.g., lab services).
- 6.17** For fiscal 2003-04, approximately \$43 million dollars had been recorded as revenue for CDHA from these sources. Our audit testing covered the period April 1, 2004 to July 31, 2004 and encompassed approximately \$15 million from the same sources for the four-month period. CDHA's receivables at March 31, 2004 aggregated \$22 million of which \$5.6 million (25.5%) was outstanding for 90 days and over. CDHA indicated that the majority of the overdue accounts are low risk and will be collected from entities such as the Federal Government, reciprocal billings to other provinces and the Workers' Compensation Board. Other overdue accounts include \$1.4 million from non-Canadians and \$0.9 million for preferred accommodation with 70% of those amounts due from insurance companies.
- 6.18** We selected a sample of 60 billings to determine the Health Authority's compliance with policies governing revenue generation and to make an assessment on the adequacy of key internal controls. In developing our audit procedures, we focused on the key controls which address whether all invoices are recorded, the invoices are mathematically accurate, reflect correct charges and rates, and are recorded in the correct period. We also considered the controls surrounding accounts receivable; whether all accounts receivable balances are recorded, recorded correctly and collected by credit management staff in accordance with documented collection policies and guidelines. Our audit testing revealed weaknesses in both the billing and credit management processes at the CDHA.
- 6.19** CDHA uses the STAR patient registration system. In October of 2003, an additional module was added to the present system to enhance its billing and credit management features. Previous to the new module, there were many

systems being used for the billing of different revenue and these systems did not work well together.

- 6.20** **Timeliness of billing** - The STAR billing system produces an invoice within seven business days of the patient discharge date being entered into the system. The reciprocal billing process is currently four months behind. Previously it had been six months in arrears due to changes in data required for submission of reciprocal billings. These changes necessitated modifications to CDHA systems. Management indicated that CDHA is not always given sufficient notice of changes to enable completion of system modifications before new requirements come into effect and that this is frequently a cause of delays in issuing billings.
- 6.21** **Need for interim billings** - The system automatically records the revenue earned on a daily basis by patient. Certain patients require a series of treatments, in some cases requiring more than one year to complete. In these cases, the system accrues the revenue amount but does not prepare an invoice until a discharge date has been recorded. Thirty days following recording of the discharge date, an invoice is prepared by the system. Our testing identified three transactions, where the patients are in series treatments, for which no interim invoice had been prepared.
- 6.22** In addition, we also identified one case where the patient was not a series patient, but a long-term patient, and because there was no discharge date, the patient had not been invoiced for 18 months. Management indicated that CDHA has recently started a new process for invoicing patients in series or long-term treatments.

Recommendation 6.1

We recommend that CDHA establish policies and related system processes regarding timing of interim billings in cases where there has been no discharge date for extended time periods. We also recommend terms and conditions be arranged and documented with the parties in these cases.

- 6.23** **Prepayments** - In certain circumstances patients are required to make deposits prior to the CDHA providing uninsured services. We found, in one sample, the system had no way of handling these situations and that a customer complaint eventually resulted in the deposit being properly credited to his account. This was determined to be a transitional problem when CDHA changed billing systems and it has since been rectified.
- 6.24** **Billing rate tables** - The electronic system uses billing rate tables to produce invoices, for all billings except miscellaneous. Only two officers of the Revenue and Collections Department have authority to change the rate tables. Our examination of rates used in our sample revealed that the actual master rate schedule is not formally dated and approved. In addition, when rate schedules are updated, there is no formal requirement for sign off by the responsible officials.

Recommendation 6.2

We recommend that CDHA institute a requirement for formal sign off that billing rate updates have been entered correctly. Documentation supporting the changes should be retained.

- 6.25** **Parking revenue** - Partners for Care is responsible for parking revenues at the QEII (2003-04 - \$3.9 million). We noted controls over parking revenue were not satisfactory. The Victoria General locations have mechanized parking ticket issuing devices, but the booths and devices do not operate 24 hours a day. When not operating, the gate is left open. As a result, issued tickets are not returned and, therefore, cash cannot be properly reconciled to tickets issued. The mechanized devices provide no totals of cash to be accounted for and parking lot staff use cash boxes rather than cash registers. Our testing revealed weaknesses in verification and in complete reconciliation of tickets issued with cash deposited at those locations.

Recommendation 6.3

We recommend complete reconciliation of parking tickets issued with cash deposited and appropriate documentation of the process.

- 6.26** **Credit management** - Our examination of the CDHA's revenue collections process revealed that documented collection policies and procedures are not being implemented by credit management staff. The credit management policies are noted as draft and have not been formally accepted by management. The policy is not current with the new system. The methodology for targeting accounts for collection activity is not defined. While overdue account selection is usually based upon the dollar amount involved, the time period that an account has been outstanding or a specific request from management, we found that the actual selection of accounts for follow up is subjective. Documentation of collection efforts by collections staff has not been compliant with the draft policy.

Services Provided to Non-Canadians

- 6.27** The Department of Health allows District Health Authorities to set their own billing rates for residents of other countries. At CDHA, non-Canadians are charged \$3,200 per inpatient day while uninsured Canadians are charged \$1,173. The charges for non-Canadians sometimes become very significant and the collectibility of these amounts may be uncertain.
- 6.28** During our testing, we encountered one very significant non-resident account which raises concerns about the policies of the Department of Health and CDHA relating to non-Canadians. The specific situation is summarized as follows.

- The individual, who was not a Canadian citizen or landed immigrant, was admitted to CDHA in February 2003 while visiting family in Nova Scotia. The patient was not covered by Nova Scotia Medical Services Insurance.
- Between 2001 and January 2003 the individual accessed various medical services at CDHA which were paid for by the patient. During the period from February 2003 to fall 2004, there were three hospital stays, one of which exceeded 180 days.
- When we examined the account on CDHA's internal accounts receivable system, the amount owing was approximately \$191,000. It appeared that the patient had not always been charged the non-resident rate and that not all inpatient days had been charged. For one stay, the patient should have been billed for 94 days and was actually charged for 62. In total the patient's account on the accounts receivable system appeared to have been undercharged by \$451,000 and should have had an outstanding balance of \$642,000 at the time of our audit. Management explained that CDHA had initially used the correct non-resident rate but had later adjusted the account to reflect the collection risk and to avoid overstating CDHA's revenue as explained in paragraph 6.29 below.
- The patient had private health insurance. An amount of \$59,600 was billed to the insurance company in March 2003 and a payment of \$53,048 was received in April 2004. CDHA management was unclear on whether the lifetime maximum of the policy had been paid or whether additional amounts were eligible to be claimed. An additional claim of \$296,075 was filed with the insurance company on September 19, 2003 and remains unpaid. Management indicated that the \$296,075 claim had been submitted to the insurance company twice. The insurance company had not been billed for additional outstanding amounts of \$306,925. During our audit in the fall of 2004, CDHA contacted the insurance company again and resubmitted the documentation that had been previously submitted along with additional charges of \$306,925. The insurance company has now been billed at the correct rate. The insurance company was unwilling to discuss the case with CDHA management over the phone.
- The patient signed a "Statement of Financial Responsibility" upon admission. There were no payments from the patient or the family after 2002.
- The patient passed away in the fall of 2004.

6.29 Several credit management weaknesses were identified with this one account. Responsibility for payment was not clearly established at the time of admission or upon subsequent re-admission. Interim billings were not issued on a timely basis and followed up. Management realized that there was significant risk associated with this account as the account balance accumulated. In order to ensure that revenue was not overstated on the CDHA financial statements, the patient's account on the hospital's internal accounts receivable system was adjusted to the resident rate. For another stay, the full number of days was not charged. It would have

been more appropriate for management to charge the full amount and then follow appropriate procedures to have the uncollectible amounts approved and expensed as bad debts.

- 6.30** The Department of Health has a policy which gives direction to DHAs on international patients. DHAs are responsible for financial recovery of the account. There is need for the Department of Health and DHAs to reconsider existing policies for the provision of services to residents of other countries. Policies should require detailed reviews of individual cases for appropriate action when charges or length of stay have reached specified targets.

Recommendation 6.4

We recommend that the Department of Health and CDHA reconsider existing policies regarding the provision of services to non-Canadians and modify as required. Policies should address necessary guarantees and credit authorizations, billing frequency and rates, and formal reviews of individual cases by the DHA and Department of Health when charges reach a specified amount or length of stay exceeds a certain number of days.

Recommendation 6.5

We recommend that CDHA update and strengthen its credit management policies and procedures including credit authorization.

Capital Assets

- 6.31** We reviewed the CDHA's prioritization and planning process for capital assets and concluded that it is adequate. However, in the 2001 Report of the Auditor General we had recommended CDHA and DOH develop a common perspective on longer-term capital requirements and develop appropriate funding. This recommendation has not been addressed. See paragraph 6.49 of this chapter which deals with follow up on the 2001 audit findings.
- 6.32** CDHA staff and management follow formal procedures and criteria for capital equipment prioritization. A committee consisting of medical staff, a vice-president, clinical directors, bio medical engineers and material management staff assign priorities based upon established criteria. Information technology hardware and software is prioritized by the Information Technology Director based upon strategic directions, operational commitments, systems upgrades and continuation of mission critical systems. The Executive Management Team prioritizes the capital renovations based on clinical priorities and needs identified in previous reviews. Emergency situations arise, in areas of equipment safety or break down, which impact on the priorities list.
- 6.33** Budget presentations to the EMT include prioritized lists and estimated costs. The procedures also require a challenge and review process to be completed

at the Executive Management Team level. Once approved, funds are released at three intervals during the year. Periodic reporting against the approved budget is provided to senior management and the Board. Emergency situations are dealt with as needed.

- 6.34** In 2001, CDHA created a discussion paper that outlined the investments required in capital from fiscal 2002 to 2006. The paper also indicated possible funding alternatives. A five-year capital projects plan for information technology assets was developed in 2002. This was then used in the creation of the Information Management Strategic Plan approved by the Board of Directors in January 2003.
- 6.35** A summary of the capital needs is included in the annual Business Plan submitted to the Department of Health. It should be noted that the business plan for 2004-05 has not yet been approved by the Department of Health. The plan shows the deferred capital requests total. The 2004-05 budget submission shown in Exhibit 6.2 reflects deferred capital needs of \$87.2 million for capital funds compared to the 2001-02 budget submission which showed a deferred capital request of \$44.3 million. The deferred capital requirements have increased significantly over prior years due to lack of funding. In addition, equipment book value is less than 30% of cost which indicates that a significant portion is near the end of its useful life. As of April 2000, the Department of Health allocated capital equipment funding to the portable funding base. This gives CDHA the responsibility to determine the allocation between operating costs and capital requirements as necessary. Management noted that CDHA was not provided any capital funding by the Department of Health other than a portion of the \$15 million Federal Medical Equipment fund and some specific funding related to emergency purchases.

Related Parties

- 6.36** Within CDHA, there are seven foundations and one auxiliary. These related parties provide funding to specific sites through fundraising activities. The foundations are:
- QEII Health Sciences Centre Foundation
 - Dartmouth General Hospital Charitable Foundation
 - Cobequid Community Health Centre Foundation
 - Hants Community Hospital Foundation
 - Musquodoboit Valley Health Foundation
 - Mental Health Foundation of Nova Scotia
 - Twin Oaks/ Birches Health Care Charitable Foundation
- 6.37** Each of the foundations is governed by a Board of Directors separate from each other and CDHA.
- 6.38** The one auxiliary for CDHA is Partners for Care. Partners for Care is a volunteer based, nonprofit, charitable organization dedicated to generating income through business initiatives such as parking lot revenues from the QEII Hospital sites and retail space leasing. It has its own Board of Directors. The income is transferred

to CDHA to benefit patients. See Exhibit 6.4 for a summary of PFC's financial statements for fiscal 2002-03 and 2003-04.

- 6.39** Our audit work focused on Partners for Care (PFC) and the two largest Foundations: the QEII Foundation and the Dartmouth General Hospital Foundation. We reviewed the legal documentation on each of these entities, the applicable financial statements and various policies and procedures. We concluded that these organizations fit the definition of related parties according to generally accepted accounting principles (GAAP) because CDHA has an economic interest in them. Accordingly, the CDHA's financial statements should include a note which describes the relationship between the CDHA and its related parties and any transactions between the parties during the year to demonstrate transparency and accountability for funds.
- 6.40** Although we acknowledge that funds transferred from related entities to the CDHA are included in CDHA's financial statements and may not be material in relation to CDHA as a whole, the accounting for funds from these organizations is not always clear. For example, for 2003-04, CDHA reported as operating income \$2 million of the \$3.25 million earned and transferred by PFC. This figure was not specifically identified as being transferred from PFC. The remaining \$1.25 million was reported as part of the capital fund contributions from Foundations. Again, it would not be apparent to a reader that the funds came from PFC.
- 6.41** We note that senior management of the Department of Health was not involved when Partners for Care was first created. Disclosure in a note to the financial statements would help to ensure that stakeholders and the general public are aware of any related organizations.

Recommendation 6.6

We recommend that CDHA disclose its related party relationship with the Foundations and Partners for Care, including transactions between the related parties during the year, in the notes to CDHA's financial statements.

- 6.42** *Achieving common objectives* - According to their documented objectives, each foundation was created to provide optimal health care for people within the CDHA; however, currently, they are all operating and planning independently of each other and CDHA. Each of the foundations makes its own decisions related to items or funding provided to CDHA. Recently the foundations have created a committee to determine ways to cooperatively maximize the benefits for each of their sites as well as, collectively, for CDHA.

Financial Statement Audit

- 6.43** CDHA and PFC financial statements are audited by an independent public accounting firm. In addition to expressing their opinion on the reasonableness of the financial statements, the external auditors also complete professional reporting

requirements to those having oversight responsibilities - the Audit and Finance Committee. We reviewed the financial statements and other information including management letters and the auditor's working papers for the year ended March 31, 2004. We found no additional matters to report to the House of Assembly.

Leases

- 6.44** Under the Provincial Finance Act, DHAs must seek Governor in Council approval for capital leases. As part of this audit, we reviewed the largest operating lease CDHA had recorded on its financial statements to ensure it qualified as an operating lease according to the CICA Handbook. This lease is for data storage equipment and requires an average annual payment of \$2.5 million and has an outstanding commitment of \$12.8 million. CDHA requested the external auditor to provide an opinion on the classification of the lease based upon criteria in the CICA Handbook. The external audit opinion concluded that the lease is an operating lease. We concur with the opinion and conclude that the lease is appropriately recorded on the financial statements of CDHA. Since it is an operating lease, Governor in Council approval is not required.

Accreditation

- 6.45** The Canadian Council on Health Services Accreditation (CCHSA) conducts an accreditation review on CDHA every three years. In the accreditation process, a self-assessment is completed by the health care organization by comparing its methods and services against a set of national standard criteria. At CDHA, this process is coordinated by the Quality Committee which includes representation from the CDHA's Board of Directors. These criteria are compiled by the CCHSA, which then independently performs the same assessment on the organization. The result is a report with an overall rating for the organization and a set of recommendations issued for those areas that need improvements.
- 6.46** The Canadian Council on Health Services Accreditation is currently accrediting DHAs as a whole rather than individual hospitals. An accreditation report was done for the Central Regional Health Board (CRHB) in 2000. Separate accreditation reports were issued in 2001 for the Queen Elizabeth II Health Sciences Centre and the Nova Scotia Hospital.
- 6.47** The previous accreditation reviews resulted in an evaluation of *accreditation with report*, which was one level less than the best possible evaluation. There are 96 accreditation recommendations for CDHA to implement. CDHA is submitting status reports on implementation of the recommendations internally as well as to CCHSA as required. The first review of the CDHA is planned to occur in fall 2004.

Follow up from 2001 Audit

- 6.48** During our audit, we followed up on implementation of recommendations from our 2001 Report related to financial planning and budgeting.

- 6.49** Based on discussions with management and a review of relevant documentation, we concluded that the majority of recommendations have been adequately addressed. The two major recommendations not fully dealt with involve deferred capital requirements and, due to the significant dollars involved, we continue to make these recommendations:
- CDHA and the Department of Health should collaborate and develop a common perspective on the longer-term capital requirements, and
 - CDHA and the Department of Health should develop an appropriate funding strategy for the longer-term capital requirements.
- 6.50** Exhibit 6.1 shows the status of implementation of each of the specific recommendations.

CONCLUDING REMARKS

- 6.51** The Capital District Health Authority received approximately \$500 million from the Province in 2003-04 which represented almost 90% of its total revenue. Accordingly, accountability for the use of public funds, including transparency and implementation of appropriate internal controls, should be an important aspect of CDHA's operations.
- 6.52** CDHA has acted upon many of the recommendations from our previous audit of financial planning and budgeting. One area that has not been addressed is the need for the Department of Health and CDHA to develop a funding strategy for the CDHA's significant equipment and facility requirements.
- 6.53** The scope of the current audit was primarily limited to one aspect of CDHA's operations - accounting for non-Provincial revenues which totaled approximately \$60 million for 2003-04. We noted weaknesses in the systems for billing and collecting from uninsured patients.
- 6.54** Nova Scotia's DHAs do not have *case costing* systems and, therefore, are unable to accumulate costs related to providing services to a specific patient. Uninsured patients are billed on the basis of a *per diem* rate based on residency and accommodation choice regardless of the actual cost incurred in the provision of services to that patient. Other Canadian jurisdictions experience the same problems with lack of *case costing*.
- 6.55** Some of the CDHA's revenues originate from donors to its Foundations or from revenue sources, such as parking, that have become the responsibility of Partners for Care (formerly hospital auxiliaries). We have recommended clear disclosure of transactions with the seven Foundations and Partners for Care to enhance accountability for revenues from those sources.
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Status of Recommendations from Auditor General's 2001 Financial Planning Audit

Exhibit 6.1

Recommendations	Implementation Status
<p>Business Planning and Budgeting Processes - For the business planning and budgeting process, performance targets should be established.</p>	<p>Completed The Quality Committee issued the Operational Measures Indicators Report in September 2002. This document was used in the preparation of the strategic plans and included in the development of the Business Plan for 2004-05. The report includes 53 indicators; currently there are 20 for which targets have not been assigned.</p>
<p>Appropriate Governance and Management Structure - Policies and procedures should require documentation and communication of assumptions, and a discussion of related risks and sensitivities.</p>	<p>Partially Implemented Procedures require that as part of the business planning process, budget assumptions information be included in the Business Plan. DOH does not require related risks and sensitivity analysis to be documented in the business plan.</p>
<p>Sound Financial Reporting Standards</p>	
<p>The Department of Health should communicate appropriate assumptions to the DHAs.</p> <p>The DHAs should communicate assumptions underlying budget submissions to the Department.</p>	<p>Completed Correspondence from the Department to the DHAs at the start of the business planning process includes assumptions to be utilized by the DHAs. DHAs' submitted business plans include a section on Business Planning Assumptions used in developing the budget.</p>
<p>Senior management should develop and communicate overall budget assumptions to the Board, prior to the commencement of the budget preparation process.</p>	<p>Completed Executive Management Team document the assumptions used in preparing the budget presentation for the Finance and Audit Committee. The minutes and the presentation are included in the package sent to the Board.</p>
<p>Directors and managers should be required to document operational plans to achieve budget reductions communicated by senior management.</p>	<p>Completed Senior management has documented plans in collaboration with the responsible management to achieve budget reductions. Updates detailing how each area is achieving these reductions are prepared.</p>
<p>When feasible, objective, external support should be provided for assumptions.</p>	<p>Partially Implemented Phone surveys were completed with the major drug suppliers to determine the increase in the cost of drugs. Documentation of the surveys was not kept. Fuel cost assumptions were determined by reviewing the contract in place until November 2004.</p>

Recommendations	Implementation Status
<p>There should be a formal sign off on the budget recommendations at each level in the process.</p>	<p>Completed At each level of management, various forms of evidence of approval were found. Evidence of recommendation from Executive Management Team, to Finance and Audit Committee and to the Board was clearly indicated.</p> <p>The budget was presented to the Board and the F&A Committee by EMT on October 10, 2003. There was no formal Board approval at that time. As with other DHAs, DOH funding discussions continued as late as December 31, 2003 and, according to legislation, the Board of Directors cannot approve a deficit budget.</p>
<p>CDHA should consider the feasibility of establishing an internal audit function which could play a role in quality control during the budget process.</p>	<p>Not implemented CDHA believes the quality control function is being met. CDHA directs as much of its funding as possible to patient care and creating an internal audit function is not an initiative it will pursue at this time.</p>
<p>Sound Monitoring Process</p>	
<p>Monitoring reports in the required format should be provided to the Department of Health on a timely basis.</p>	<p>Completed As mentioned in the 2001 audit report, this monitoring had started in September 2001 and was in the same format as the budget required.</p>
<p>Forecasting policies and procedures should be established.</p>	<p>Not Completed Development of policies is being reviewed but not yet in place.</p>
<p>Operational plans and strategies to achieve budgetary targets should be formalized.</p>	<p>Completed As mentioned above, senior management has documented plans in collaboration with the management responsible to achieve budget reductions. Updates detailing progress towards achieving these reductions are prepared.</p>
<p>Capital Budgeting Process</p>	
<p>CDHA and the Department of Health should collaborate and develop a common perspective on the longer-term capital requirements.</p>	<p>Not Completed The Department of Health works closely with all DHAs in their requests for capital. DHAs/IWK capital project requests and those included in the annual business plan submissions are reviewed by the Department as received.</p>
<p>CDHA and the Department of Health should develop an appropriate funding strategy for the longer-term capital requirements.</p>	<p>Not Completed The Department prepares a five-year plan to determine its funding requirements. Feedback is provided back to the DHA to advise of its status and priority.</p>

Capital Equipment and Renovations Budget Submissions - 2001-02 and 2004-05

Exhibit 6.2

	2001-02	2004-05
	(\$ thousands)	
Request		
Capital Equipment	\$ 27,700	\$ 56,000
Information Technology	16,600	10,000
Capital Renovations	9,250	40,600
Total Request	\$ 53,550	\$ 106,600
Funding – Expected		
Department of Health	\$ 3,900	\$ 16,400
Foundations	2,725	1,000
Partners for Care	2,000	2,000
Other	600	-
Total Projected Funding	\$ 9,225	\$ 19,400
Deferred Capital Requests	\$ 44,325	\$ 87,200

CDHA Shareable Revenue - 2003-04

Description	Amount
Federal Government	\$ 980,232
Workers' Compensation Board	1,301,788
Non-Resident	5,010,349
Non-Canadian Resident	1,106,775
Uninsured Residents & Non-Medically Necessary	5,458,480
Outpatient Revenue	\$ 13,857,624
Dept. of Veterans Affairs	16,455,150
Federal Government	947,601
Workers' Compensation Board	2,264,998
Non-Resident	7,153
Non-Canadian Resident	2,366,586
Uninsured Residents & Non-Medically Necessary	106,607
Inpatient Revenue	\$ 22,148,095
Preferred Accommodations	7,089,924
Veterans' Meals & Accommodations	1,357,834
Alternative Long-Term Care	854,502
Other Inpatient Revenue	\$ 9,302,260
Restaurant Revenue	5,403,608
Interest	2,552,521
Utilities	1,268,172
Parking	2,055,361
Other Revenues	3,559,932
Other Revenue	\$ 14,839,594
Total	\$ 60,147,573

Partners for Care - Summary of Financial Statements

Exhibit 6.4

Balance Sheet	2004	2003
Assets	\$ 1,254,704	\$ 2,033,950
Liabilities	714,919	1,295,571
Surplus	539,785	738,379

Income Statement	2004	2003
Revenues	\$ 6,802,708	\$ 6,674,538
Cost of Sales	1,868,550	1,884,096
Expenses	1,882,752	1,741,752
Operating Lease Payments to CDHA	2,000,000	-
Priority patient equipment transfers (to CDHA)	1,250,000	3,000,000
(Decrease) Increase in Surplus	\$ (198,594)	\$ 48,690

CAPITAL HEALTH'S RESPONSE

We have reviewed the detail and recommendations in the Auditor General's Report and make the following comments in sequence of the principal findings format:

Revenue and Receivables

6.20 Timeliness of Billing

The four month delay in billing is a result of the Department of Health agreeing to a change in policy with the other provinces that requires the expiry date be included on the billings for "Out of Province Patients". This change was agreed to by the Department of Health without consultation with Capital Health, thus the impact on our system was not considered. Capital Health's in-patient system collects this information for in-patient stays, but many of the out-patient systems required programming changes which created a delay. Subsequently, Department of Health removed the health care expiry requirement for laboratory billings, which has removed many of the delay issues.

We would recommend Department of Health implement a process of consultation for policy decisions that may impact directly on Capital Health systems.

6.21 Need for Interim Billings

We have subsequently implemented a process to ensure interim billings to patients receiving services over extended time periods. We will also be developing a policy to cover this process.

6.23 Prepayments

Our billing system and ongoing operations do accept and appropriately allocate prepayments from patients/customers.

As noted the sample found related to a transitional period of changing from one billing system to another.

No action required.

6.24 Billing Rate Tables

All changes to billing rates are documented and approved by the Capital Health Executive Management Team before implementation.

As a result of the Auditor General's comments, we have developed a process to review all rates with approved rates and have the Manager, Revenue sign and date all future changes and retain necessary documentation.

6.25 Parking Revenue

We are currently challenged at the Victoria General site in regards to the aged technology and the fact that there is no business case to operate the booths 24 hours a day. We have contracted CanPark to provide parking services and they are reviewing the option of installing the technology currently in place at the Robie Street Parking Garage.

Interim solutions such as reconciliation as noted, more frequent counts, surprise counts, etc. are being reviewed.

6.26 Credit Management

Given the sensitivity around billing individual patients/clients, we apply our credit management policy and processes carefully. Each issue we encounter is reviewed to ensure reasonableness in terms of the credit policy application, especially before forwarding accounts to one of the two collection agencies Capital Health utilizes for overdue accounts. We make every effort to work with the patient/client to ensure reasonable repayment terms whenever possible.

This policy also applies to a very small component of our Accounts Receivables. Our receivables totaled \$22 million at year end of which 98% (\$21.6M) applied to amounts owing from the Federal Government, Workers Compensation Board and Insurance companies. 2% (\$500K) related to patient billings of which 70% (\$350K) was billed to insurance companies.

We have spent the past year installing a new billing module which ensures more efficient flow of billing data from our various systems and more readily available detail.

We are now in position to redraft the Credit Management policy and will be submitting it to Executive Management Team in January 2005 for approval.

6.28,29,30 Non-Canadian Patient

The non-Canadian patient referred to was a very unique and complex situation of which we were totally aware. The patient was a United States citizen who was very ill and subsequently died from this illness.

Up until the last in-patient stay, we were satisfied that the charges would be covered by the patient's insurance company as expenses previously submitted had been paid. The patient made several visits to the QEII from 2001 to 2004 when the patient passed away.

Visits up to 2003 were out-patient and emergency room visits, which were charged directly to the patient and paid.

Due to medical diagnosis, the patient was admitted as an in-patient from June 22 to December 22, 2003, a total of 183 days. An interim invoice was submitted to the patient's insurance company with several attempts made to contact and collect on the charge. As the invoice to the insurance company had not been paid it was Management's concern that the patient had exhausted all financial means.

At this point, as the patient was still an in-patient, it was determined that allowing the rate to be charged at the out-of-country rate of \$3,200/day would lead to an overstatement of revenue. A management decision was made to adjust the account to the inter-provincial rate of \$1,173/day, while still billing the

insurance company the full out-of-country rate. The patient continued to receive services until a final in-patient stay from September until the date of death. We felt this accounting treatment to be consistent with GAAP and section 3400 of the CICA Handbook that deals with recording revenue when there is uncertainty of ultimate collection.

Various management and clinical levels were consulted in this case including social workers and the Department of Health in attempting to find an alternative placement for this person in a long-term care facility, without success.

Our challenge in this particular case, was, having an out-of-country patient who could pay for services to a certain level at first, became an in-patient with a serious illness, no option for payment and no option for discharge or alternate placement. Once a patient is admitted into our system there is a legal obligation upon the facility and the physician to provide services regardless of the patient's ability to pay until the patient meets the criteria for discharge. Under both the Canadian and US laws a hospital cannot refuse emergency services to a patient when required even if they do not have the ability to pay for these services.

As noted, we continue to invoice and deal with the insurance company re further payments. We have also recognized the balance of this account in the "Allowance for Doubtful Accounts" so that there are no future negative impacts on revenue. In future we will, as suggested by the Auditor

General, escalate out-of-country billing issues to the Department of Health for advice and action.

Capital Assets

We are pleased to note that the Auditor General understands the significance of the capital under funding we are experiencing at Capital Health.

We have constant unmet needs in medical equipment, infrastructure and information technology.

We fully endorse the Auditor General's recommendation that Capital Health and the Department of Health collaborate and develop a common perspective on the long term capital requirements and further that we develop a long-term funding strategy.

Related Parties

We agree with the Auditor General's comments on "Related Parties" and will be providing the note disclosure in the annual audited financial statements for Capital Health.

Financial Statement Audit

Capital Health is audited by an external audit firm and has a clean audit opinion.

No action required.

Leases

As noted the Auditor General confirms that Capital Health has treated leases in an appropriate manner.

No action required.

Accreditation

Noted for information with no action required.

Follow-up From 2001 Audit

We agree that the two major recommendations not fully dealt with from the 2001 audit are with respect to Capital Health and Department of Health collaborating and developing a common perspective and funding strategy for long-term capital requirements.

In conclusion, we thank the Auditor General for their support in their extensive process (1000 hours in audit time) and also thank our staff for the time they committed to this process, over and above all their regular duties.

We are pleased with the results and recommendations and understand that on the collection side with individual clients, we will constantly be challenged with our mission of providing healthcare for the sick and collecting money owed.