

SARBANES-OXLEY LEADS TO SOXLITE FOR HEALTHCARE

The passage and implementation of Sarbanes-Oxley has changed the accounting environment forever. **Armanino McKenna LLP** and **HFS** have teamed together to form a group of experts in both healthcare and the Sarbanes-Oxley regulations for the proper implementation of **SoxLite** for healthcare facilities.

Background:

Sarbanes-Oxley codifies board, governance, management and auditor responsibility for maintaining board objectivity and auditor independence and providing accurate information to an organization's stakeholders. It is designed to restore public trust and confidence in the public securities market, improve corporate governance, promote ethical practices and hold management accountable for released financial information. With the implementation of these extensive regulations, not-for-profit organizations may be held to

the same standards as publicly traded organizations.

The healthcare industry has not been immune to financial oversight failures. According to an article in *USA Today*, healthcare is the second largest source of all financial restatements, representing 9.3 percent of all earnings restatements from 1971 to 2000.

Methodology:

SoxLite has been designed specifically for not-for-profit hospitals to:

- Enhance their community reputation
- Promote community trust and confidence
- Help discharge the Board's fiduciary responsibility
- Promote ethical business practices
- Provide added assurances for lenders and donors
- Ensure that hospital executives

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HFS CONSULTANTS ANNOUNCES THE INTRODUCTION OF OUR NEW NAME AND LOGO

HFS Consultants announced our new name and logo in early 2005. Since 1991, California healthcare facilities have made Healthcare Financial Solutions, now **HFS Consultants**, an integral part of their operations. Whether our clients needed a CFO or Business Office Manager, needed coding or billing assistance, started up a clinic or had reimbursement problems, we were there. Over the past decade, **HFS** has added services and developed a team of professionals to handle not only accounting and cost reporting issues, but

clinical, operational, revenue cycle management and other areas of expertise.

HFS services now include:

- **Hospital Turnarounds:** Comprehensive economic recovery programs, staffing and workflow redesign, cost control systems.
- **Hospital Management:** Interim and long-term, permanent executive staffing
- **Clinical Operations:** Clinical department review, new unit development, Title 22 and JCAHO assessment and education, HIPAA planning, staffing

improvement, compliance review.

- **Revenue Cycle Management:** Billing and patient accounting, workflow analysis, CDM review and updates, receivables management, billing systems review and planning.
- **Health Information Management:** Coding compliance, web-based and interim coding, operational assessments, coding education, clinical coded

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SOXLITE FOR HEALTHCARE

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are aware of material information emanating from a well-controlled environment

Two sections from the Sarbanes-Oxley regulations have particular implications to the healthcare industry: Section 302

– Corporate Responsibility for financial reports, and Section 404 – Management assessment of internal controls.

Armano McKenna has

experience performing 404 work for such companies as Robert Mondavi Corporation, OK International, Irwin Financial and other publicly-traded companies.

HFS utilizes their 20 plus years of healthcare con-



sulting to direct healthcare organizations in the nuances of their profession.

SoxLite has been developed to assist hospital management to:

- Develop written procedures stating their responsibility for establishing and maintaining an adequate internal control structure over financial reporting in accordance with GAAP.
- Identify the framework used by financial management.
- Prepare a summary on the effectiveness of the hospital's internal controls for financial reporting, based on management's evaluation as of the end of the fiscal year.
- Report any material weaknesses.
- Communicate with the hospital Board the results.

For more information on implementing these financial reforms within your organization, contact **Rich Gianello** at ext: 223.

NEW MEDICARE BONUS FOR PHYSICIAN SCARCITY AREAS

CMS published a Notice of Proposed Rulemaking ("NPRM") regarding the 2005 Physician Fee Schedule in the Federal Register on August 5, 2004 which included an additional 5% Medicare reimbursement for primary care and certain specialty physicians located in areas called "Physician Scarcity Areas" (PSA). These bonus payments are effective for services rendered between January 1, 2005 and December 31, 2007.

Physician Scarcity Areas are defined as geographic service areas which have been identified as having the lowest ratios of primary care physicians to civilian population totals. This is a new category used to identify counties and zip codes around the country which have insufficient numbers of physicians providing primary care.

Primary Care Physicians are defined as: Family Practice, General Practice, OB/GYN, and Internists. Specialists are eligible for the bonus with the exception of: Dentists, Chiropractors, Podiatrists

and Optometrists.

Areas have been defined by county and then by specific zip codes within each county. Only counties and zip code areas which meet specific ratios are eligible for the Medicare reimbursement bonus. If you are located within a listed zip code, there are no additional requirements for billing to your intermediary other than listing the zip code of the facility on the form. If you are located within a listed county, you must use the modifier "AR" on your billing forms.

For California, there are 245 eligible zip codes throughout the state. Whole counties within California that are eligible for the bonus include: Alpine, Calaveras, Glenn, Imperial, Lake, Mariposa, Modoc, Sierra, Tehama and Trinity. Note that all listed counties have been previously defined as rural or

frontier by either the State of California Office of Statewide Development and Planning or by HRSA. There are several additional counties in which specialists are eligible for the bonus: Colusa, Lassen,

Plumas and Siskiyou.

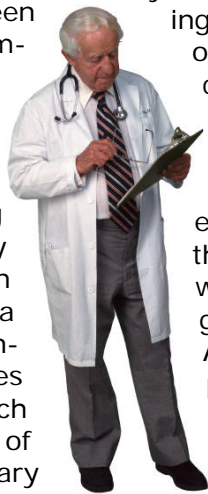
For those facilities within a designated Health Professional Shortage Area ("HPSA"), billing to Medicare will no longer require the use of the QB or QU modifier, effective January 1, 2005. If you are in a recently designated HPSA, you must bill using the above modifiers to identify your area until HRSA adds your HPSA to the official designation listing posted on their website.

It is important to note that providers in some designated HPSA's will be eligible for both the PSA (5%) and HPSA (10%) Medicare bonus payments. Medicare will pay both bonuses if:

The provider is providing primary care services within a designated PSA county and a designated HPSA,

The provider is located within a rural portion of a Metropolitan Statistical Area ("MSA").

If you would like more information on PSA's, HPSA's, MSA's or need assistance in determining your eligibility based on zip code location, please call **Bill Deane** at ext: 246.



INTRODUCING OUR NEW NAME AND LOGO

(Continued from page 1)

data analysis and documentation services.

- **Accounting:** Financial statement preparation, budgeting, business planning and litigation support.
- **Mergers, Acquisitions and Financing:** M&A analysis, market/feasibility studies, financial structuring for bonds, appraisals and business valuations.
- **Licensing and Program Development:** Licensing, change of ownership, HPSA/MUA, Critical Access Hospital, RHC, FQHC,

primary care clinic and swing beds development, OSHPD reporting and physician practice evaluation.

- **Reimbursement:** Medicare, Medi-Cal and OSHPD cost report preparation and appeals, SNF and RHC rate setting, reimbursement maximization, disproportionate share, reimbursement impact analysis.
- **Recruitment and Interim Staffing:** Interim staffing (CEO, CFO, Controller, Business Office Manager, HIM Director, Coder, Biller, Director of Nursing), executive recruitment.

- **Physician Practice Management:** Operational and financial reviews, strategic alliances with area facilities, contract negotiations, physician recruitment and retention, productivity analysis, changes in scope of services.

Count on our team's skills and knowledge, gained through years working for every kind of health-care situation.

Questions about our services? Contact us at 510-768-0066, E-mail: info@hfsconsultants.com, or visit our website at: www.hfsconsultants.com

HAVING TROUBLE WITH OVERTIME AT YOUR FACILITY?

Many hospital CFO's have difficulty keeping track of one of the highest cost components in their system; Labor. Large facilities with cost centers located across large campuses and multiple product lines make it difficult to accurately forecast your labor costs.

HFS has developed a Labor Productivity model that might be of interest to you.

How does it work?

All hospitals have productivity standards that are structured by department type on an hourly basis. The productivity standards vary according to the type of patient care and service offered in that department. These standards are used for benchmarking and are based on national facility data.

HFS employs a model developed in-house to input hours worked daily within a department, including any overtime or purchased services such as registry or temporary help. This model feeds into the pay cycle for the facility, and provides a summary Daily Labor Productivity Report.

What are the benefits?

A CFO can now pull out a productivity report by daily activity, by cost center which details the labor hours versus the productivity standards. With a keystroke, management can now view how much overtime is being paid in any cost center for any specified period of time. This provides valuable feedback used to research and evaluate departmental issues.

This model can be tailored to any size facility for any amount of cost centers. For more information on how these productivity reports can help you, please call **Randy Grossman** at ext: 310.



CUTS IN MEDICARE MAY BE INEVITABLE

Recent years have featured a rising Federal Budget deficit, prompting some legislators to call for "budget reconciliation", which translates to finding some mechanism for at least reducing the deficit. Although legislators are loathe to discuss it publicly, one of the targets is the Medicare program.

The most recent 2003 Medicare law contains a provision which could greatly impact expenditures. Under the provision, *if during any seven year rolling period (six years forward, six years back or a combination) Medicare outlays exceed Medicare revenues, the President must issue to Congress a "Medicare*

Funding Warning (MFW)". The MFW would be issued as part of the President's annual budget message to Congress. Congress would then have **15 days** to introduce remedial legislation to address the funding shortfall. If that is unsuccessful, automatic program cuts would be triggered which will impact all portions of the Medicare program, including cuts in benefits, changes in eligibility and reductions in payments to providers.

For the current fiscal year, Medicare is in a funding deficit. Therefore, the first MFW should be issued by President Bush in **February 2007**. It will be interesting to see how Congress reacts to this Medicare provision.



POST ACUTE CORNER

UPDATE ON CHANGES TO THE "75%" RULE FOR REHAB ADMISSIONS

What is the "75% Rule"?

The "75% Rule" is one of the conditions that an Inpatient Rehabilitation Facility (IRF) must meet in order to demonstrate and maintain its status as a designated rehabilitation facility. The rule refers to the diagnostic case mix of patients admitted to the unit or hospital. Specifically, 75% of all patients admitted to the program must fall into a specified list of diagnostic groups.

These changes went into effect for cost-reporting periods beginning on or after July 1, 2004.

The "New" Rule

The new rule includes several changes and additions to the original, including the following:

- Modification of the original 10 diagnostic categories to 13 ("CMS 13").
- Establishment of a methodology to determine compliance, including an administrative presumption for facilities with a majority of Medicare patients.
- A temporary provision to allow the presence of certain comorbidities or patient conditions to apply toward compliance.

Of greatest significance is the change of the allowable diagnostic categories and qualifying patient conditions. While the number of categories increased, the net effect of the change was to introduce more specificity in regards to which patients qualify for inpatient rehabilitation, most notably for patients with primary orthopedic diagnoses.

The new rule also provided a timeline for a graduated implementation of the threshold. In the initial review period beginning July 1, 2004, facilities had to demonstrate that 50% of admitted patients fell into the designated categories. The required threshold will increase gradually in successive cost reporting periods, ending

at 75% in 2007.

Implications

As currently written, the "New 75% Rule" has important implications for IRF planning and operations.

Most significantly, the number of prospective patients will decrease, as many patients with uncomplicated orthopedic diagnoses, in particular joint replacement patients, will no longer qualify. Rehab units accustomed to admitting large numbers of these patients will likely need to adjust admission criteria and reduce census projections. Marketing strategies will likely also change, as rehab programs compete with each other for a smaller group of eligible patients. In addition, programs will need to address changes in operations and staffing, as patient case mix and acuity change.

Other portions of the continuum of care will also be affected, as patients previously admitted to acute rehab programs are diverted to other levels of care, or remain in the acute setting for longer stays.

Provider Response

Following publication of the revised rule, the provider community expressed serious concerns about its effect on the provider and patient community. They argued that clinical care and patient needs have changed significantly since the creation of the rule in 1984, and there is now a need to develop new criteria that more closely reflect the current status of rehabilitation care. Implementation of the revised rule as written will severely limit patient access to necessary rehabilitative services.

In response, at the end of 2004 Congress passed a provision prohibiting CMS from revoking Medicare certification of IRFs certified

prior to June 30, 2004, until the Government Accountability Office (GAO) was able to issue a report on the clinical appropriateness of the diagnosis categories listed in the rule, and until the Secretary of Health and Human Services determined either that the report was not inconsistent with the rule as written or issued a new interim rule.

Current Status

The highly anticipated GAO report was published in April 2005. Rather than resolve the outstanding questions about the pending 75% Rule, it raised new issues and recommended continued research and investigation. However, CMS has determined that the results do not conflict with the rule, and has reiterated its plan to proceed with implementation.

With the support of the rehab industry, providers are actively lobbying their Representatives and Senators to support "The Preserving Patient Access to Inpatient Rehabilitation Hospitals Act of 2005", a bipartisan act that would freeze the compliance threshold at 50%, and establishes a National Advisory Council on Medical Rehabilitation.

Recommendations

Rehabilitation programs and units will benefit from a review of their current patient population, in order to determine their compliance with current thresholds, and their ability to meet increased compliance thresholds in the future.

Rehabilitation facilities may want to contact their legislators to urge their support for pending legislation.

If you would like more information about the 75% Rule or would like to discuss how your facility might be affected by the change, please contact **Pat Blaisdell** at ext. 226.

PROPOSED INPATIENT REHAB PPS RATE REVISIONS FOR FY 2006

CMS has published the proposed rule changes for the prospective payment system for inpatient rehabilitation facilities (IRFs). The proposed rule includes several refinements and changes to the PPS system and represents the first significant update since PPS implementation in 2002. The changes are effective for discharges on or after October 1, 2005.

CMS has collected approximately two years of inpatient rehab data from facilities since the implementation of PPS in 2002. With this information, they have begun the process of refining their calculations for these types of patient care. These changes are reflected in many categories and are highlighted below:

- The Case Mix Group ("CMG") classifications have been adjusted and reduced in number. The CMG is a tool similar to acute care DRGs, and categorizes patients according to the amount of care they require.
- The calculation of patient CMG has been changed, with the development of the FIM Weighted Motor Score. CMG classification is based on the "functional impairment" ("FIM") of the patient, which is the measure of caregiver burden. These weights reflect the labor intensity of the patient care, and increase or reduce the CMG.

- The relative weights for CMGs have been adjusted as well. These weights reflect the amount of resource use for each patient category, and determine case reimbursement.
- The Targeted Length of Stays ("TLOS") figures have also been adjusted, with significant decreases in the published targets. Facilities which manage their patient care to the published TLOS figures will need to adjust their methodologies.
- The Outlier Loss Threshold of compensation has been significantly reduced. Outliers provide additional reimbursement for patient care when certain cost parameters have been exceeded. The threshold has been reduced from \$ 11,211 plus CMG payment rate to \$ 5,132 plus CMG payment rate.
- The list of qualifying co-morbidities (i.e. morbidities affecting reimbursement) has been modified.

These changes are meant to clarify patient conditions and more accurately reflect the type of patient care required and the associated reimbursement. The projected impact of these changes varies widely from patient to patient, and will likely affect facility reimbursement to varying degrees, depending upon their patient mix. IRFs are currently actively evaluating the impact of the proposed changes on their reimbursement and operations. For additional information, please contact **Pat Blaisdell** at ext: 226.

2006 UPDATE TO THE SNF PPS

On August 4, 2005, CMS published the final ruling for the October 1, 2005 SNF PPS. The ruling includes the increase in the number of RUG categories to accommodate patients with rehabilitation and medical issues from the 44-group to the 53-group mode. These new RUGs will go into effect beginning January 1, 2006.

Background

RUGs scoring for PPS rates were the first of the post acute services to go into effect in July of 1998. Since that time patient scores from the MDS comprehensive assessment established which category of care the patient received, which in turn determined the PPS rate which the provider would be paid on a scheduled per diem.

The scoring system had several flaws, particularly for those patients with both highly resource intensive medical and rehabilitation needs. The nine new RUG

codes will attempt to meet the needs of these patients. The new RUG codes will be RUX, RUL, RVX, RVL, RHX, RHL, RMX, RML, and RLX.

Implications

The addition of the nine new codes will not increase the overall PPS reimbursement for all codes. The additional codes are designed to be "budget neutral". Therefore, CMS will be reducing the reimbursement rates in the other RUG levels to accommodate the inclusion of the new codes.

A new grouper has been developed and is available for vendor updates. All providers should expect software updates soon and should stay in touch with the technical support services of their vendors. Of issue to the provider associations was that CMS did not provide this new grouper prior to the close of the comment period to identify the actual financial im-

pact to the budget neutral stance of these additional RUG codes.

Other changes initially proposed, such as eliminating the grace days, the 14-day look back period, and Section T will remain with the new version of the MDS until the comprehensive 3.0 is complete.

Conclusions

The addition of the nine new RUG scores is an attempt by CMS to better identify specific patient conditions which were lacking in the original RUG scoring. Due to the budget neutrality of the reimbursement, other RUG code scoring combinations must have reduced payments. At this writing, it is still unclear whether the new codes will properly place patient conditions into categories which will correctly reflect those conditions and reimburse the facilities appropriately.

WHAT A PROVIDER SHOULD KNOW ABOUT THE FHA/HUD 242 PROGRAM (FIRST IN A SERIES OF FOUR ARTICLES)

Currently many hospitals throughout the U.S. are aging and are due for substantial renovation or replacement. Additionally hospitals in California are required to meet certain structural standards under SB 1953 with deadlines for structural compliance by 2013. Given these current conditions, most hospitals must determine how to access capital markets for the necessary funding. One possible route into the capital market may be through the FHA/HUD 242 Program. The following article presents some baseline information that may answer whether the FHA/HUD 242 Program may be appropriate for your facility.

The Background and Nature of FHA/HUD 242 Program

Since its inception in 1968 as a bricks-and-mortar program to support construction and modernization projects, the Federal Housing Administration (FHA) of the U.S. has insured 325 hospital mortgages and loans in excess of 10 billion dollars. Historically the 242 program has been used primarily in New York and New Jersey, however recently FHA has been actively diversifying portfolios into other states. By increasing the 242 Program staff significantly over the last five years, processing and turn-around time on the program, 242 applications has improved dramati-

cally.

Program 242 is authorized by Section 242 of the National Housing Act and is administered by the Division of Facilities Loans (DFL) in the Office of Special Programs (OSP) in the Health Resources and Services Administration under an agreement between its parent, the Department of Health and Human Services (HHS) and the Department of Housing and Urban Development (HUD). HUD is responsible for setting all of the policies and procedures for the program, providing legal and other support services, and for making the final decision on Program 242 applications. HHS is under contract with HUD, and is responsible for providing the underwriting services and architectural/engineering monitoring services.

How Does the FHA/HUD 242 Program Work?

It is important to remember that the FHA/HUD 242 Program is mortgage insurance only, not actual financing. This type of mortgage insurance enhances the applicant hospital's creditworthiness because the debt is backed by the U.S. government. With this type of guarantee FHA/HUD approved lenders will finance debt as investment grade debt (AA or AAA). Without this guarantee, hospital debt will often be characterized as "junk" grade with associated high financing costs. FHA/HUD insured mortgages usually obtain the lowest interest rates available in their segment of the market. Only lenders who are approved as FHA multifamily mortgagors can submit applications for FHA hospital mortgage insurance and FHA/HUD can only issue hospital mortgage insurance commitments to such lenders.

Uses for FHA/HUD-Insured Mortgages

FHA/HUD-insured mortgages may be used for construction financing, re-modeling and modernization projects, equipment purchases and expansion projects. FHA/ HUD-insured mortgages can also be used for new and existing hospitals and also in conjunction with purchases of existing hospitals. In order to qualify for FHA/HUD mortgage insurance FHA/HUD requires a first-lien position on the entire plant, property and equipment. Also all current long-term debt must be refinanced under the FHA/HUD-insured mortgage. All accounts receivable financing programs must be eliminated or severely limited.

Restrictions on Uses for FHA/ HUD-Insured Mortgages

FHA/HUD cannot insure debt for "stand-alone" ancillary projects, medical office buildings and outpatient surgery centers, except as part of insuring the debt of the entire hospital. A standard refinancing of existing debt is not possible under current regulations unless it is done in conjunction with construction/modernization projects. At least 20% of the proceeds from the refinance must be used for the construction/modernization project. Additionally "Pick-up" projects, where construction has already begun, are not eligible for FHA-insured mortgages.

Minimum Applicant Eligibility Requirements

Qualified applicants can be for-profit or not-for-profit hospitals licensed or regulated by the State, municipality or other political subdivision. Historically FHA/HUD has

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WHAT A PROVIDER SHOULD KNOW ABOUT THE FHA/HUD 242 PROGRAM

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insured financing for individual hospitals rather than group financings. However FHA/HUD is willing to evaluate mortgage insurance applications for system financings. Additionally the hospital's "Project" must have a clear community need.

At least 50 % of the care must be for general acute patients only. This means that skilled nursing care, acute psychiatric and rehabilitative care in licensed acute care facilities are not eligible to meet the 50% rule. Through the end of the "Project" and for two fiscal years thereafter, the hospital must continue to qualify under the 50 % rule.

The applicant must be in the position to grant the FHA/HUD-insured lender a first-lien position on the entire hospital and must be able to make monthly payments into a Mortgage Reserve Fund that will build to a balance equal to one year of debt service after five years and two years of debt service after 10 years.

Over the last three full fiscal years, the hospital's average operating margin must have been equal to or greater than \$1.00 (breakeven). Over the last three full fiscal years, the hospital's average debt service coverage ratio must be equal to or greater than 1.25.

States with Certificate of Need (CON) requirements must already have an issued or pending CON when the application for mortgage insurance is submitted. States without CON requirements must select a FHA/HUD approved feasibility consultant to develop the feasibility study that will be submitted with the application for

FHA/HUD mortgage insurance.

Applicability to Small Rural Hospitals

Historically FHA/HUD-insured mortgages under Program 242 have not been available to small rural hospitals due to the difficulty in meeting the financial projection requirements as described previously. Under the federal critical access hospital program rural hospitals who qualify as Critical Access Hospitals (CAH's) can now receive cost-based Medicare reimbursement for their capital expenditures (depreciation and

interest expense). This additional reimbursement will generally improve the CAH's financials enough to meet the financial requirements of the program. Also, FHA has recently simplified the feasibility study to be mostly a debt capacity analysis (for CAH's only). There is generally no demand study required in a debt capacity analysis and FHA will arrange and pay for the feasibility study on behalf of the CAHs.

Coverage, Cost and Conditions

The maximum mortgage amount may not exceed 90% of the estimated replacement cost of the hospital including the installed equipment. Real Estate can provide the 10% equity requirement. The maximum mortgage term is 25 years. One-time HUD application, commitment and inspection fees usually equate to 0.8% of the mortgage amount. Other fees include financing fees (of up to 3%

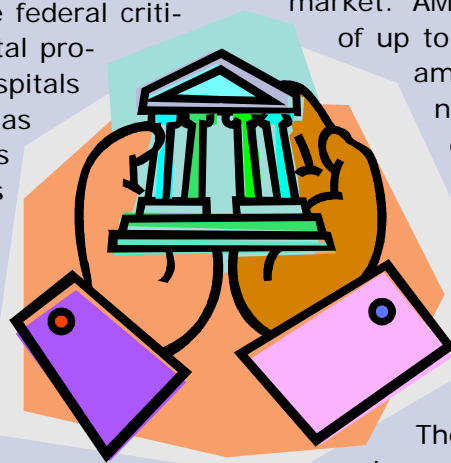
of the mortgage amount), attorney's fees and feasibility consultant fees (if applicable). FHA/HUD insures 99% of the loan amount and there is no limit on the amount that can be insured. The interest rate on the mortgage is determined by the credit rating of the hospital within the current market. AMPO (working capital) of up to 2% of the mortgage amount is available for not-for-profit applicants. FHA mortgage insurance may be obtained for tax-exempt or taxable borrowings. Prepayment of the loan is generally permitted

The annual mortgage insurance premium is based on one-half (0.5%) of the average monthly amortized unpaid principle balance for the forthcoming year.

The FHA/HUD 242 Program Sounds Right for My Hospital, What's the Next Step?

HFS has experience as the feasibility consultant for FHA/HUD 242 applications. If the FHA/HUD 242 Program sounds right for your hospital or you have questions and would like additional information about the program, please contact Marion Schales at ext: 290.

Next Newsletter: Additional FHA 242 Program topics to be covered in upcoming issues of the HFS quarterly newsletter: **The FHA/ HUD 242 Program Sounds Right for My Hospital, Next Steps: How to Find an FHA/ HUD Approved Lender and Preparation of the Feasibility Study.**



HEALTH CARE SAFETY NET AMENDMENTS OF 2002 IMPACT HPSA DESIGNATIONS

Section 302 requires that all federally qualified health centers (FQHCs) and rural health clinics (RHCs) (as defined by the Social Security Act) that meet the NHSC charges for services requirements "be automatically designated as having a shortage of health professionals." No earlier than 2008, and every six years thereafter, the health centers or clinics must demonstrate that they meet the requirements for designation as specified in Federal regulations issued after October 2002.

What does this mean?

All section 330 funded health centers (including migrant and public housing), as well as non-funded but certified FQHCs and RHCs that meet the "charges for service" requirements will be considered as Health Professional Shortage Areas (HPSA). In six years, they will have to provide actual data to show they meet the designation criteria, but in the meantime they are deemed a HPSA.

The "charges for services" requirements are:

- Entities may not deny health services to individuals or discriminate in the provision of services because of inability to pay or because payment for services would be made under Medicare or Medicaid (Medi-Cal in CA).

- Entities must prepare a schedule of fees for payments consistent with locally prevailing rates or changes and be designed to cover the entity's reasonable cost. Entities must also prepare a corresponding schedule of discounts, including waivers, to be applied to fees and payments (a sliding fee scale).
- Entities must accept assignments of beneficiaries under Medicare and enter into agreements with the State agency administering the Medicaid and S-CHIP program for payment of services.

Does this affect the site's ability to receive NHSC recruitment and retention assistance?

To qualify for NHSC assistance, a facility must be located in an HPSA. Since all FQHCs and qualified RHCs are now deemed in an HPSA, they would be eligible to submit a Recruitment and Retention (R&R) Assistance application to the NHSC. If their R&R Assistance application is approved, these sites would be eligible to post vacancies on the NHSC Opportunities List to assist them in their recruiting efforts.

Will these sites be eligible service sites for NHSC Scholars and/or Loan Repayers?

Placement of NHSC Scholarship and Loan Repayment participants must give priority to HPSAs of greatest shortage. The NHSC will continue to use HPSA scores to identify HPSAs of greatest shortage. Sites that were not considered an HPSA prior to the Health Care Safety Net Amendments may have a minimal score, making them a very low priority for placement of NHSC Scholars or potential loan repayers.

These sites may submit data to obtain an HPSA score that more accurately reflects the degree of need in a given HPSA and enhances the sites' opportunity to qualify as an approved practice site for an NHSC Scholar, or to compete for a potential loan repayer. Sites in previously designated HPSAs may use the scores of these areas.

Does this affect any other programs?

The automatic HPSA designation allows eligibility for J1 Visa waiver physicians to practice in sites that may not have qualified previously. State Loan Repayment Programs will recognize these sites as HPSAs. Any other programs that use HPSA status as a factor are expected to recognize these sites as qualifying as a HPSA.

FINANCIAL STATEMENT PREPARATION FOR SNF'S

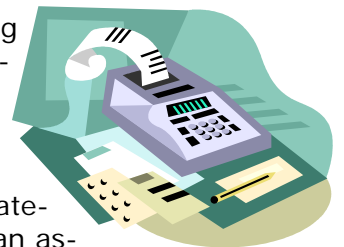
In adding to our compliment of financial services, **HFS** is now offering free-standing residential care facilities for the elderly ("RCFE's") and skilled nursing facilities the service of preparation of monthly financial statements.

Having trouble finding the time to run accurate, timely monthly statements? Let us assist you in your bookkeeping needs.

HFS can provide the advantage of professional experience in handling financial statements and cost reporting for healthcare facilities of all sizes and levels of care. We can assist your facility in the processing of timely financial statements which will accurately reflect your financial performance. If you are having reimbursement problems, **HFS** can also review, revise and improve your cost reporting.

Lisa Moon of our accounting staff is an authorized **QuickBooks** technician and can set up your entire accounting system for you, from Chart of Accounts to monthly P & L's.

For more information on our bookkeeping and cost report services, please contact **Lisa Moon** at ext: 233.



BUSINESS PLAN TEMPLATE

A GUIDE FOR DEVELOPING A PRODUCT OR SERVICE LINE

Today's business environment requires a disciplined approach when thinking about expanding (or contracting) your products or services. HFS has developed a Business Plan outline which can be molded into almost any healthcare scenario. This plan provides a step-by-step process for controlling the development of your next product or service line.

There are ten sections or phases in this template. Each phase is critical to the success of your business plan development. Each phase will prompt you to think about the validity of your product or service, and force you to consider consequences associated with your decisions. The phases are:

- **Project Description:** Ask yourself – what is the primary purpose of this product/service? It can be business growth, cost reduction, stakeholder satisfaction, or other reasons.
- **Strategic Rationale:** Start with the global view. How does the project support the mission and values of the parent organization? Consider the strategic fit of the product/service. Is it consistent with other services or plans? Consider the stakeholders and the impact upon them. Will this project meet a need or a mission? Will it improve patient outcomes? Improve quality? Will it positively impact caregivers or other employees?
- **Industry/Technology Trends:** Create an overview of the service or technology proposed. Is there a cost savings involved? Are you replacing a technology? With technology, remember “never to be first or last!”
- **Market and Competitive Analysis:** This process will help you understand your service area demographics. What area do you serve? Who are your customers? How should you model the current trends, market share, demand for products/services and projections for the future? Identify your competitors and understand what they are doing in your market area.
- **Integration of a Marketing Plan:** Ask yourself – how will we reach our customers? Develop a strategy to meet this important objective. How will you distribute your product/service, where will it be offered? The marketing plan should contain components for pricing and advertising.
- **Legal and Regulatory Analysis:** Consider whether there are licensing or accreditation issues pertaining to your product/service. If you are offering your service in partnership with another entity, investigate any legal issues for a joint venture.
- **Operational/HR/Clinical Considerations:** A major consideration here would be the impact of the service expansion upon staffing and labor.

Other considerations include facilities, equipment and supplies. Will there be an impact upon locations or availability?

- **Financial Performance:** Your business plan will review costs and expenses associated with product/service expansion. What are the estimated profits? How will you fund the project? You must create a model with stated assumptions and specific financial targets. Use hypothetical questions to explore alternative scenarios. What if? This section of the model will address these questions.



- **Risks and Contingencies:** Create a list of possible outcomes. Again, use “what if” questions to explore possibilities. Can you determine any mitigating actions? What happens if the new product/service does not function as expected? Do you have a contingency plan? Will you have an exit strategy?
- **Performance Measures:** A new product/service remains an unknown success or failure without feedback and measurable results. What criteria will you measure? How will you gather information on results? Include benchmark targets for comparison. These could include clinical outcomes, return on investment, patient/employee satisfaction surveys, etc.

HFS offers experienced professionals who can assist you in creating, implementing and monitoring any product line development. We handle all sizes of healthcare facilities, from multi-state health systems down to your neighborhood community clinic. For more information on these services, please call **Randy Grossman** at ext: 310.

EMPLOYEE ADDITIONS & PROMOTIONS

HFS has been adding team members throughout 2005 to accommodate the increase in client engagements in a variety of business services. Among the team members we have added are:

Neville Jacks joins us as Manager to head up a new department in Physician Practice Management. Neville has over 25 years experience in directing specialty physician groups as Chief Operating Officer and Director of Operations for diagnostic imaging centers, occupational health centers and many multi-specialty physician groups and clinic settings.

Carla Santistevan joins the Accounting group as a Senior Consultant with 20 years experience as a Controller and CFO in acute care and clinic settings.

Nancy Arata joins the Accounting group as a Senior Consultant with over 20 years experience in acute care and LTC settings. Nancy has worked as a CFO, Controller and Director of Finance for hospitals, hospital districts and healthcare systems.

The Health Information Management group has added **Kathy McCaffrey** as a new Manager. Kathy is credentialed in coding work and has worked as a Finance Dept. Director for CA-OSHPD, been a Data

Project Manager for the California Association of Health Plans and was the Director of HIM for UCSF for over 10 years. Also added to HIM were **Pammi Sandhu** as a consultant and **Matthew Martinez** as a Technician.

Reimbursement has added **Myrna Stewart** as a Senior Consultant. Myrna comes to us from Kaiser Foundation Health Plan where she worked as a Senior Financial Analyst and will assist in Medicare and Medi-Cal cost reports.

Matthew Demchuk joins Management and Operations as an experienced Administrator/CEO of LTC facilities. Matthew brings many years experience in operations of free-standing SNFs and other LTC facilities.

Management and Operations also welcomes **Larry Blitz** as a new Manager who will assist in hospital operations and management. Larry has worked as a hospital CEO and performed a wide range of functions within acute care settings.

Luis Aguayo has joined the Admin team as receptionist.

HFS welcomes all our new employees!

Congratulations to the following individuals for their promotions:

Bill Deane, Pat Blaisdell and Tracy Addleman to Manager
Todd Anderson to Senior Consultant
Regina Simpkins to Consultant

PHYSICIAN PRACTICE MANAGEMENT SERVICES

HFS announces the addition of a new product line to benefit our clients. **Neville Jacks** brings extensive expertise in assisting physicians to develop strategic alliances with area hospitals/ancillary services. Services include:

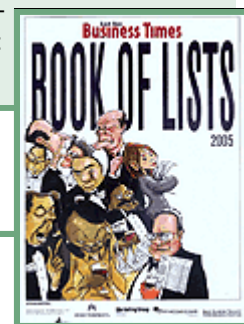
- Operational review
- Physician recruitment and retention
- Productivity analysis

- Development of needed ancillary services
- Development of marketing materials

Neville's extensive background includes COO and CEO work for primary care, numerous specialty groups and several ancillary service facilities. For additional information on these services, please contact **Neville** at ext: 356.

HFS CONSULTANTS in the Top 50 Fastest Growing Companies in the East Bay

Recently published in the *East Bay Business Times*, **HFS** is ranked as the 20th fastest growing privately held firm in the East Bay.



HFS BUSINESS PARTNERS



- **Mayer, Hoffman & McCann**
– FHA/HUD 242 Loan applications
- **Armanino McKenna LLP**
– Certified Public Accountants
- **Hospital Council of Northern and Central California**
– Programs/Products for Hospitals
- **Association of California Healthcare Districts**

HFS RECENT ENGAGEMENTS

- HPSA application research and development for Primary Care HPSA in Modoc County.
- HPSA application research and development for Primary Care HPSA in Lake County.
- Licensure and certification of a new Acute Psychiatric care unit in Los Angeles.
- Preparation of application for licensure and certification for an RHC in Lindsey, CA.
- Preparation of a financial feasibility study associated with a HUD-242 insured financing for Methodist Hospital in Arcadia, CA.
- Development of a Rural Health Clinic in Fillmore, CA.
- Development of a business plan for clinic consolidation and reorganization for an Orange County healthcare system.
- Development and writing an application with co-applicants for an FQHC Look-alike in a southern California desert community.
- Three year management agreement for California Armenian Homes in Fresno, CA.
- Physician education for coding & billing for physicians at Santa Clara Valley Medical Center in San Jose, CA.
- Coding support services for Madera Community Hospital in Madera, CA.
- Assistance with expert testimony in legal proceedings involving a southern California acute care facility.
- Developing a discounted fee-for-service and self-pay program for a multi-specialty physician group in Foster City, CA.
- Revenue cycle management review and cost reports for S.F. Jewish Homes for the Aging.
- Hospital valuation and appraisal for Mee Memorial in King City, CA.
- Development of a Business plan for an Outpatient Neurosciences department for an acute care facility in the Bay Area.
- Assistance with a feasibility study for the development of a rehab hospital in Las Vegas, NV.
- Assistance with the development of an Inpatient rehab facility in San Francisco, CA.
- Assistance with case management reorganization and physician education for a Bay Area healthcare system.
- Third party review of a hospital audit for a Certified Public Accountant group.
- Evaluation of a proposed joint venture between physicians and hospital management for a Bay Area spine clinic.

HFS SPONSORS A HABITAT FOR HUMANITY PROJECT

The success of **HFS** as a company has placed us in a position to share our resources with the community in which we work. Our goal as part of our social responsibility is to assist our community with time or funds for the development of community projects and to assist those less fortunate. As part of that responsibility, **HFS** is committed to raising funds for the local **East Bay Habitat for Humanity** chapter and to provide labor for the construction of homes in West Oakland. If you would like to join us in working on this project, please contact **Heather Sansky** at ext: 239.

Other Activities that HFS employees are involved with:

- Walking the Avon Walk for Breast Cancer Cure – July 9-10
- Walking the AIDS Walk – San Francisco – July 17th
- Child mentoring at the Lafayette School Mentoring Project – Oakland
- Counselor at youth summer camp for underprivileged children
- Counselor for youth group outreach program on Blackfoot Reservation in Idaho
- Board of Directors for Partners in Care Foundation in Los Angeles
- Sponsorship of a child in the Friends of the Children Program – San Francisco

UPCOMING CONVENTION APPEARANCES

Look for our booth at the following events:

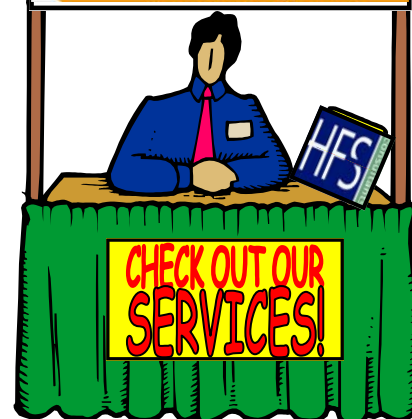
CPCA – September 29-30 Burbank, CA Silver Sponsors

ACHD – September 28-30 Incline Village, NV Rich Parsons will be a speaker

CHA – Hospital Council Summit September 14-16 Monterey, CA Silver Sponsors

CHA – Continuing Care San Diego, CA Silver Sponsor

AHIMA – October 15- 20 San Diego, CA Exhibit Booth #1247.





505 Fourteenth Street
Fifth Floor
Oakland, California 94612-1912



Recently, **HFS** was visited by children participating in the **Friends of the Children** mentor program. They were given a tour of our offices, got to work a copier, sit in the President's chair, attend a project meeting and have an ice cream social (which we have here *all* the time). For more information on FOTC, visit their website at friendsofthechildrensf.yvood.com.

- PROJECT HFS
- TASKS
 - Copying
 - Folding
 - Stapling
 - Mailing