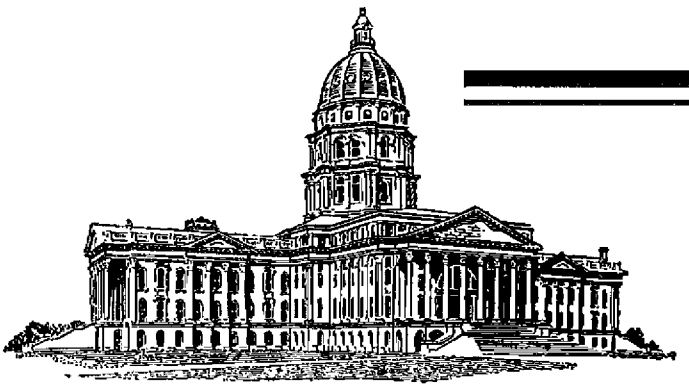

PERFORMANCE AUDIT REPORT

Reviewing Certain Financial Management Practices at The University of Kansas Medical Center

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
March 1995

95-46

Legislative Post Audit Committee

Legislative Division of Post Audit

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PERFORMANCE AUDIT REPORT

REVIEWING CERTAIN FINANCIAL MANAGEMENT PRACTICES AT THE UNIVERSITY OF KANSAS MEDICAL CENTER

OBTAINING AUDIT INFORMATION

This audit was conducted by Ellyn Sipp, Cindy Lash, and Trish Pfannenstiel. If you need any additional information about the audit's findings, please contact Ms. Sipp at the Division's office.

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Reviewing Certain Financial Management Practices at The University of Kansas Medical Center

The University of Kansas Medical Center is both a teaching facility and an operating hospital. The teaching facility is largely funded with State tax dollars, while the hospital is funded by patient revenues. In addition, the Center's doctors are both teachers and physicians with a private practice. This situation involves a great deal of sharing facilities and related costs.

Legislative concerns have been raised about several financial-management issues related to the Medical Center's sharing of facilities and costs, not only between the hospital and education operations, but also between the public and private aspects of the Center's operations. One concern deals with the Medical Center's allocation of general overhead costs between its hospital and education operations. Because these operations have different funding sources, an improper allocation of overhead costs would result in too much being paid from one source and not enough being paid from the other. Another concern deals with how the Medical Center used an appropriation to provide additional funding for primary care initiatives. A final concern deals with private enterprises established at the Medical Center, such as the Cancer Center, and the extent to which these organizations share costs equitably with the Medical Center.

To address these concerns, this audit answers the following questions:

1. **Have the Medical Center's allocations of overhead costs between hospital and education operations been appropriate?**

2. **Do the Medical Center's plans to use its fiscal year 1995 appropriation for initiatives in primary care appear to be appropriate?**

3. **Have the contracts with recently established Medical Center-related private enterprises been managed appropriately to ensure equitable sharing of costs?**

To answer these questions, we interviewed Medical Center officials, and reviewed the Medical Center's annual allocation study and related accounting records. We also reviewed statutes and legislative committee minutes. In addition, we reviewed contracts and agreements between the Medical Center and other enterprises. In conducting this audit, we followed all applicable government auditing standards as set forth by the U.S. General Accounting Office. We relied on the information contained in the Medical Center's cost accounting system, but did not independently test that system because such testwork was beyond the scope of this audit.

In general, we found that the process Medical Center officials used to identify overhead activities that benefited both the hospital and the university was reasonable. Their determination of how much these shared overhead activities cost in total was

not entirely accurate, but the monetary impact of the inaccuracies was not significant. Officials generally did a good job of determining each side's "share" of overhead costs, but we had some concerns about a few of the measures used to allocate those costs. However, for the last two years, the Governor and the Legislature have required the hospital to pay more than the allocation study indicates is the hospital's share of overhead costs.

We also found that the Medical Center has decided to use its $600,000 appropriation for hiring seven additional primary care faculty. This will not improve the financial viability of the primary care foundations in the short-run. However, in conjunction with other steps the Medical Center is taking, it should help them in the long-run. We also found that considerably less than half the appropriation actually has been obligated for primary care initiatives in fiscal year 1995; during the audit, Medical Center officials told us that what is not spent will be used to help the Medical Center meet its shrinkage requirements.

Regarding the third question, we found that the Salick Cancer Center has the exclusive right to provide outpatient cancer treatment services at the Medical Center during the 35 years of the contract. The Medical Center anticipated that this contractual arrangement would be financially advantageous, but the results have been far less than expected. Neither profits nor patient volumes have been as great as hoped-for. Also, the contract does not have provisions that would help ensure that the Medical Center receives its expected benefits.

Have the Medical Center's Allocations of Overhead Costs Between Hospital and Education Operations Been Appropriate?

We found that the process Medical Center officials used to identify overhead activities that the hospital and the university both benefited from was reasonable. Their determination of how much these shared overhead activities cost in total was not entirely accurate, but the monetary impact of the inaccuracies was not significant. Officials generally did a good job of determining each side's "share" of overhead costs, but we had some concerns about a few of the measures used to allocate those costs.

For the last two years, based on its annual allocation study, the Medical Center has provided the Governor and the Legislature with the amount of shared overhead costs that should be paid by the hospital with hospital revenues, rather than by the university with General Fund moneys. However, the amount the Governor recommended and the Legislature authorized required the hospital to pay more than its share of overhead costs. Finally, we found that the Medical Center does not adjust the amounts the hospital owes once actual cost figures are known. These and other findings are described in the sections that follow.

In General, the Medical Center Is Supposed to Pay Its Hospital Costs With Hospital Revenues, and Its Education Costs With State General Fund Appropriations

The University of Kansas Medical Center not only provides education through its Schools of Medicine, Nursing, and Allied Health, but it also operates a hospital on its Kansas City campus. The hospital provides general and specialized patient services, and also serves as a major teaching and research facility.

The Medical Center receives a State General Fund appropriation each year. That appropriation is intended to fund most of the educational operations of the Medical Center. The Medical Center also collects revenues from hospital patients and other parties responsible for care provided to patients, such as insurance companies and the federal Medicare program. Those revenues generally are dedicated to pay for the costs of operating the hospital.

Concerns About Whether the State's General Fund Was Subsidizing Hospital Operations Resulted in Separate Budgets for the Medical Center's Education And Hospital Operations, and a Plan To Allocate Overhead Costs Between the Two

As a State agency, the Medical Center participates in the State's budgeting and appropriations process, which begins with the Center's development of a budget

request. Until recently, the Medical Center's budget request was a single document that included both the education operations and the hospital operations.

According to Medical Center officials, the Legislature had been concerned about whether the Center's General Fund appropriation was subsidizing the operations of the hospital. When the budgetary information for education and hospital operations was combined, it was not possible to determine whether any subsidization was occurring.

To help ensure that General Fund moneys were not being used to fund hospital operations, the 1991 Legislature asked the Medical Center to submit separate budget documents for education and hospital operations. That request applied to the Medical Center's budget request for fiscal year 1993. Since then, the Medical Center has continued to submit separate budgets for hospital and education operations. The following table shows the two operations' expenditures for fiscal years 1993 and 1994, estimated expenditures for fiscal year 1995, and requested expenditures for fiscal year 1996.

University of Kansas Medical Center
Hospital and Education Expenditures
Fiscal Years 1993-1996

	Hospital (supported by hospital revenues)		Education (supported largely by State taxes)		
	Expenses (in millions)	% of Total	Expenses (in millions)	% of Total	Total
FY 1993 (actual)	$ 135.6	48.5%	$ 143.7	51.5%	$ 279.3
FY 1994 (actual)	150.9	48.9	157.8	51.1	308.7
FY 1995 (estimated)	151.6	48.7	159.5	51.3	311.1
FY 1996 (requested)	157.2	49.0	163.9	51.0	321.1

The preparation of separate budgets for the Medical Center's hospital and education operations called for allocating overhead costs that benefit both those operations. Costs for some activities—such as utilities, housekeeping, and business office operations—benefit both the hospital and university side of the Medical Center. However, each of those shared overhead costs is set up to be paid from a single budget that is dedicated to either the hospital or education—usually education. As a result, unless some adjustment is made, education funding (generally the State

General Fund appropriation) will pay for some shared overhead costs that should be paid for by hospital revenues.

The allocation of shared overhead costs is designed to address this problem, and to make sure that the State General Fund appropriation doesn't subsidize the hospital's operations. Allocation systems are designed to assign costs based on reasonable and consistent handling of data, but generally involve certain arbitrary decisions during the process.

The Medical Center's process for estimating the amount of shared overhead costs that should be paid by hospital funding and by education funding was based on actual costs and the extent to which those costs benefited hospital and education operations. The process comprised the following:

- Identifying overhead activities that benefit both hospital and education operations.
- Determining the total costs of each activity that is shared.
- Determining each side's "share" of these costs.

Because most shared overhead costs are set up to be paid from education funding sources, the Medical Center's determinations have always shown that an adjustment is needed to, in essence, "reimburse" the education funding sources for the hospital's portion of the shared overhead costs. The actual adjustment has been made by transferring hospital revenues into a special fund that is used to pay for educational costs.

Because of the timing constraints of the State's budget process, estimates of the amount that should be transferred must be made nearly two years in advance. Medical Center staff develop the transfer estimate based on the most recently completed fiscal year with an adjustment for anticipated inflation. For example, the Center's transfer request for fiscal year 1996, which is now under consideration, is based on figures for fiscal year 1994 with an upward adjustment for anticipated inflation between fiscal years 1994 and 1996.

The Process the Medical Center Used To Identify Overhead Activities That Benefit Both Hospital and Education Operations Was Reasonable

To identify which university-funded activities might also benefit the hospital, Medical Center officials told us they began with a list of all the Medical Center's expenditure "accounts". Rather than review the nearly 1,800 accounts one-by-one, they immediately removed numerous groups of accounts from consideration. For example, all accounts associated with a hospital department, as well as the hospital's laun-

dry and purchasing accounts, were removed because they were funded from hospital revenues. Accounts identified as restricted fees, restricted use, previous-year encumbrances, and student grants and loans were removed because they were considered university-only accounts.

Medical Center officials told us the approximately 400 accounts remaining were reviewed by a group of hospital and university officials, and a determination was made for each account as to whether the hospital also benefited from the activities funded by that account.

We reviewed the Medical Center's categorization of accounts for fiscal year 1994, and determined that it was reasonable. We also verified that all of the Medical Center's expenditure accounts were considered during that process. For fiscal year 1994, 109 accounts totaling nearly $35 million were identified as shared overhead accounts. Appendix A shows the categories of accounts that were allocated and how the allocation process was applied to those categories.

The Hospital and the Education Operations May Have Shared Costs In Areas Other Than Overhead

The 1991 Legislature directed the Medical Center to develop separate budgets for its hospital and education operations to help ensure that State General Fund moneys were not being used to subsidize hospital operations.

The allocation study reviewed in this audit was intended to divide up the costs of overhead activities that benefited both the hospital and the education operations, but that were funded entirely from one or the other's now-separate budget.

During the audit, Medical Center officials told us that, in addition to overhead costs, there are some non-overhead costs funded from either the hospital or the education budget which benefit both entities to some limited degree. For example, hospital officials pointed out that members of their nursing staff spend time answering questions for medical students, but no portion of nursing costs is allocated to the university. Similarly, the hospital's physical therapists and respiratory therapists demonstrate techniques for students, but the hospital is not reimbursed for these activities.

Medical Center officials told us they had no plans at this time to allocate expenses for non-overhead categories.

The Medical Center's Determination of the Costs Of Shared Overhead Activities Was Not Entirely Accurate, But the Dollar Impact Was Not Significant

The Medical Center relied on expenditure information contained in its accounting system to determine the total cost of the overhead activities it had identified as benefiting both hospital and education operations.

In general, the Medical Center correctly determined the total costs in each expenditure category. However, our review showed that the Medical Center did not accurately account for encumbrances that were included in those expenditure figures. Encumbrances are obligations for future-year payments from a particular year's budget. To properly show the costs for a year, actual expenditures and encumbrances must both be included.

When Medical Center officials conducted the annual allocation study for fiscal year 1994, they did so at a time of year when their accounting records had been temporarily modified for other year-end reporting purposes. As a result of this modification, expenditure figures used in the study included nearly $22,000 of encumbrances that did not represent shared overhead activities.

For example, the Business Affairs Office's costs are reported in several accounts, only one of which included overhead costs benefiting both hospital and education operations. That one account had an encumbrance of $6,364. However, in determining costs of shared overhead activities, the Medical Center's modified accounting records combined encumbrances for all that Office's accounts into a single amount, and treated the entire amount, $25,442, as if it benefited both programs. As a result, $19,078 in encumbrances for Business Affairs was included that should not have been.

Because the Business Affairs office reported that 25% of its efforts were on behalf of the hospital, one-fourth of that $19,078, or $4,770, was erroneously allocated to the hospital.

We also found that Medical Center officials used the wrong expenditure figure for the Purchasing Department. Purchasing is one of only three areas with shared overhead costs that are funded by hospital revenues. At the end of the allocation process, manual adjustments were made to "reimburse" the hospital for the university's share of costs in these areas. During this process, the expenditure figure for purchasing was taken from a year-end report, rather than from the then-current data in the accounting system, and as a result, the hospital was underallocated $383 in purchasing expenses.

The Medical Center Generally Did a Good Job Of Determining Each Side's "Share" of Overhead Costs, But We Had Some Concerns About a Few of the Measures Used to Allocate Those Costs

In determining the amount of shared overhead costs that should be borne by the hospital, Medical Center officials first selected a basis for allocating that cost, and then determined what percentage should be applied to the hospital. The specific percentage then was applied to each category of expenditures to arrive at the hospital's share of these overhead costs. (Every year, Medical Center officials review the bases for allocating costs and update percentages as necessary.)

The table on the following page shows which accounts were allocated and on what basis, as well as the amount of shared expenditures allocated based on each measure. Appendix A shows this same information for each category.

Allocation Measures and the Operations Allocated Using Those Measures, Fiscal Year 1994

Types of Operations Allocated on this Basis	Measures	Amount Allocated Based on this Measure
Utilities, facilities operations, housekeeping, landscaping	Square footage	$ 18,728,154
Computing services	Effort and usage estimate	2,885,452
Executive vice-chancellor, safety administration, institutional research, legal, health care resources, chancellor, internal audit, controller, business affairs	Effort estimate (i.e., a percent of people's time spent on these activities)	2,852,834
Affirmative action, university relations, budget office, some accounting, payroll, employee transactions, human resources	Employee headcount	2,638,764
Library	Survey of other hospitals	2,485,049
Fitness center, medical center police	Employee and student headcount	1,752,858
Purchasing, accounts payable, travel audits, some accounting	No. of vouchers processed	1,137,071
Telecommunications, patient admission switchboard, gift shop phones	No. of telephones	879,896
Design and construction management	Construction costs	514,950
Employee health services, audio-visual	Services billed	392,070
Mailroom	Pieces of mail	175,731
Property accounting	No. of inventory items	62,374
Retirement disability	No. of recipients	36,552
Total		**$34,541,755**

Our review showed that the types of measures used to allocate costs generally were reasonable. For example, it makes sense to allocate costs for things like the budget office, payroll, and human resources based on headcount, because presumably every employee has equal access to, and benefit from, these offices. Likewise, allocating costs for utilities, facilities operations, housekeeping, and depreciation based on square footage makes sense because these expenditures should be directly related to the amount of space occupied. Similarly, it makes sense to allocate telecommunication costs based on the percent of telephones located in the hospital. (Telecommunication costs refer to things like line and equipment charges; expenses for long-distance calls are billed directly to the departments from which the calls were made.)

Because accurate records of such things as the way people spend their time are often not available, many expenditures are allocated based on subjective estimates. For example, allocation of computer costs was based on the estimated staff time spent on hospital projects and on the estimated computer usage for hospital activities. About eight percent of the shared costs were allocated on the basis of estimates of time spent by staff in those areas on hospital affairs. For instance, the hospital's share of expenditures for the Executive Vice Chancellor's office was set at 20% based on the Executive Vice Chancellor's estimate that he spends about one day a week on hospital business. In some cases, we found that more concrete items, like the total number of telephones, also were based on estimates rather than actual counts.

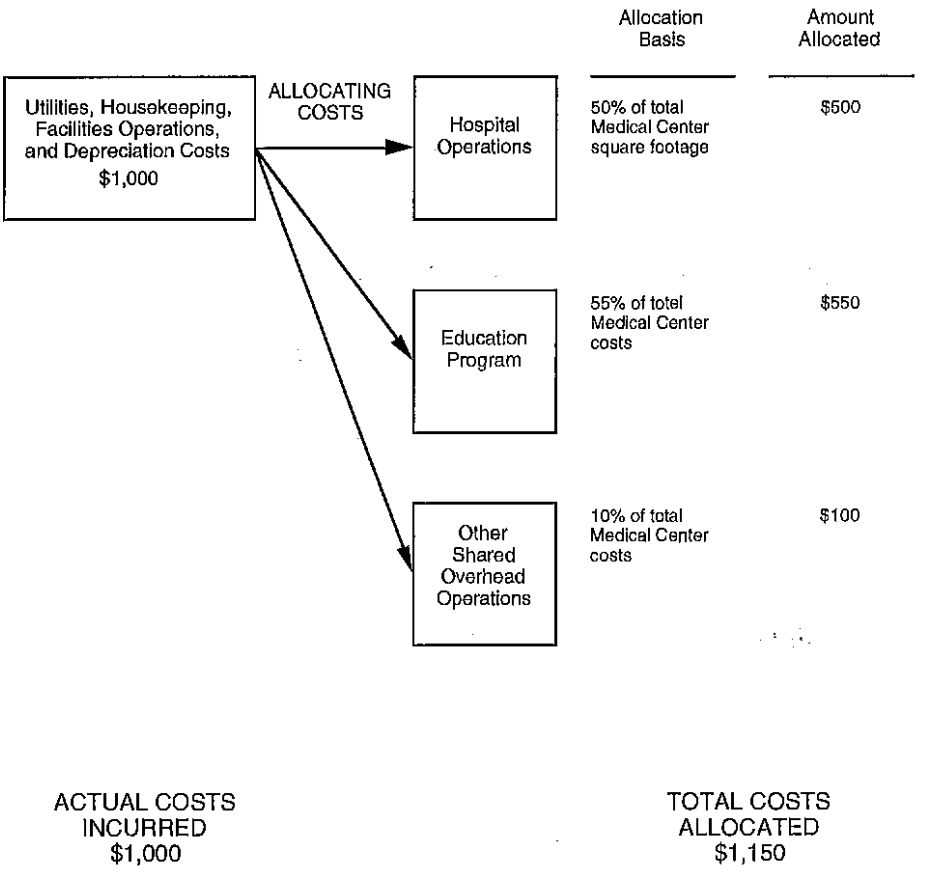
In two cases where actual data were provided, we questioned the way the hospital's share of costs was calculated. In one case, the Director of Safety Administration estimated the percent of time each of her staff members spent on hospital-related activities. She then indicated that 20-28% of her staff's work was for the hospital. Our review showed that, based on the percentages she provided for individuals, the hospital's share actually amounted to 27.6%. However, in the allocation study, the hospital's share of Safety Administration expenses was listed as 24%, the midpoint of the Director's estimated range. This error was compounded when, in calculating the hospital's share of Safety Administration expenditures, Medical Center officials used a figure of 16%, rather than 24%. (The 16% was for the previous fiscal year.)

In the other case, Medical Center officials had to reduce the amount they had determined the hospital should be reimbursed for employee labwork and immunizations from nearly $90,000 down to $5,600. They were unable to explain how they had arrived at the original figure.

The way the Medical Center handled utilities, housekeeping, facilities operations, and depreciation costs in its overhead allocation process resulted in the allocation of more of these costs than the Medical Center actually incurred. In allocating costs for utilities, housekeeping, facilities operations, and depreciation to hospital, education, and shared overhead activities, the Medical Center determined the hospital's portion of those costs based on the amount of the hospital's square footage as a percentage of the Medical Center's total square footage. That approach appears to be reasonable.

The Medical Center allocated the rest of those costs to education and to other shared overhead operations on a different basis—a percentage estimate of how big those costs were in relation to the Medical Center's total costs. By itself, that basis is reasonable as well. However, unless the Medical Center makes adjustment to ensure that the total costs allocated are equal to actual costs incurred, using these two different bases for allocating costs can result in allocating more or less costs than actually were incurred. The simplified illustration on the following page helps explain the reason why:

Illustration of How Certain Costs Were Overallocated



In this hypothetical example, total utilities and other costs were $1,000. Using the Medical Center's methodology, the hospital would be allocated $500 of these costs on the basis of square footage. The remaining costs would then be allocated to the education program and to other shared overhead operations based on their proportion of the Medical Center's total costs.

In this example, the education program represented 55% of the Medical Center's total costs. Therefore, it would be allocated 55% of the utilities and other costs (or $550). Other shared overhead operations would be allocated $100 on the same basis. In total, then, $1,150 costs would be allocated even though only $1,000 in costs actually were incurred.

In reviewing the Medical Center's allocation of shared overhead costs for fiscal year 1994, we found that the Medical Center allocated about $3.7 million more for utilities, housekeeping, facilities operations, and depreciation costs than it actually incurred. Although we could not determine the dollar impact of that problem on the overhead costs allocated to the hospital, it is likely that the amount allocated was too large.

Improved management controls over the allocation process likely would have prevented the type of errors we identified. Our review showed that Medical

Center officials generally had adequate management controls to assure themselves that the correct overhead activities were included in the allocation process. However, they had virtually no management oversight over the way expense information was handled.

For example, the Medical Center's way of handling utilities, housekeeping, facilities operations, and depreciation costs was developed by one person, with limited additional review. Similarly, one person was in charge of obtaining the hospital's share for each allocation measure, and also was responsible for performing all the calculations in the study. There was no detailed review of this work. A draft version of the allocation report was reviewed and discussed by several Medical Center officials, but this was a fairly high level of review, and was not likely to uncover the types of problems identified in the audit.

In addition, an adequate system of management controls would require that sufficient documentation be maintained to clearly show the amount of overhead allocated to the hospital and the university, and to ensure that money was not overallocated or underallocated.

Using Its Allocation Process, the Medical Center Has Developed an Estimate Each Year of How Much Should Be Transferred from the Hospital to the University To Pay for Shared Overhead Costs

As noted earlier, most overhead cost items are set up to be paid from education funding sources. Thus, the allocation process is designed to identify the amount the hospital should reimburse the university-side of the Medical Center for shared overhead costs. However, three cost categories—purchasing, Jaycare (employee day care center), and the Medical Center's cafeterias—are funded through the hospital's budget. As a result, certain adjustments must be made.

For example, the university's share of these three cost categories is calculated and subtracted from the amount the hospital owes. Likewise, the university's cost for labwork and other health tests performed by the hospital on all new employees is subtracted from the total. Such adjustments reduce the amount the hospital must reimburse the university.

The table on the following page shows the preliminary and updated amounts the Medical Center has recommended be transferred from the hospital to the university to pay the hospital's share of overhead costs. The table also shows the Governor's recommended transfer amount, and the legislative authorization. This final column is the amount that actually was or will be transferred from the hospital to the university.

The Hospital's Share of Overhead Costs
FY 1993 - FY 1996

Year	KUMC Preliminary Request (a)	KUMC Updated Request (b)	Governor's Recommendation	Legislative Authorization	% Over KUMC Updated Request
FY 1993	$ 14,429,705	$ 14,429,705	$ 14,429,705	$ 14,429,705	0.0
FY 1994	14,429,705	14,147,516	14,637,873	14,637,873	3.5
FY 1995	14,637,873	14,557,100	14,963,870	14,963,870	2.8
FY 1996	14,963,870	15,016,088	15,016,088 (c)	n/a	n/a

(a) Because the Medical Center's annual allocation study is not completed by the time budget requests must be submitted to the Governor, the Medical Center bases its preliminary estimates of the hospital's share of overhead costs on the previous year's legislative authorization.
(b) Once the Medical Center completes its allocation study, it revises its estimate of the hospital's share of overhead costs to reflect the updated figures.
(c) Because the Medical Center's fiscal year 1996 updated request was larger than the amount the Governor initially intended to recommend, the Governor's recommendation was adjusted to match the agency's updated request.

For fiscal years 1994 and 1995, the Governor and the Legislature did not use the figures generated by the Medical Center's allocation process in setting the hospital's share of overhead costs. In both years, the Governor recommended, and the Legislature approved, a higher reimbursement figure than the Medical Center calculated. This meant that the hospital bore somewhat more of the overhead costs than the allocation plan indicated it should have.

An official in the Department of Administration's Division of the Budget noted that the Governor's recommendation has been based on the notion that the hospital's reimbursement should constitute a reasonable proportion of the Medical Center's total education budget.

The Legislature has to-date always appropriated the amount recommended by the Governor, rather than the amount requested by the Medical Center based on the allocation study.

Requiring the Medical Center to develop, use, and maintain a cost allocation system that is not used during the appropriations process results in a significant amount of wasted time and effort. A more efficient approach may be to have the Medical Center update its cost allocation figures only periodically, and for the Governor and the Legislature to simply inflate those figures by a specified percentage in the interim years.

Whether the Medical Center's annual allocation of shared overhead costs is used in the appropriations process or not, it should be used to adjust each year's transfer to reflect actual expenditures. Because the amount of the transfer from the hospital to the university for any given fiscal year is an estimate based on

cost figures from two years before, it is important to make adjustments when actual figures become available. If this is not done, there is no assurance that the correct amount of shared overhead has been transferred from the hospital to the university.

During our reviews, we noted that the hospital's actual share of expenditures is never corrected for in the agency's subsequent requests. When fiscal year 1994 actual overhead expenditures became available, the Medical Center's allocation study showed that the hospital's share of overhead expenditures that year actually was $14,559,608. In fact, based on earlier estimates, the hospital had transferred $14,637,873 for its share of fiscal year 1994 expenditures, or about $78,000 more than it needed to.

Conclusion

The Medical Center has developed a reasonable process for allocating shared overhead costs, although we identified some problems with the way the process was carried out that need to be addressed. Rather than relying on the figures generated by the allocation study, however, in fiscal years 1994 and 1995 the Governor recommended that the hospital pay a higher amount than the allocation process showed it owed. The Legislature subsequently approved those higher amounts. These decisions reduced the amount of tax dollars needed to support the Medical Center's educational operations.

If the purpose of the allocation process is to avoid either side subsidizing the other side's operations, the Governor and the Legislature should be basing each year's transfer on the results of the allocation study. The Medical Center also should develop a plan to adjust future transfers up or down to reflect actual shared costs as final fiscal year figures become available.

On the other hand, if the allocation study results are intended to be used only as the starting point for determining how much the transfer should be, it might be just as useful to conduct a study every five years or so to ensure that the right accounts and the right hospital share has been identified. Then in the interim years, the transfer amount could be inflated by some percentage to arrive at the transfer amount.

Recommendations

1. To generate a more accurate hospital reimbursement figure, Medical Center officials should correct the problems this report identified in the allocation process. Specifically, Medical Center officials should:

a. conduct the allocation study either before its accounting records have been temporarily modified, or after the records have been restored to the original format, to ensure that they do not allocate non-shared encumbrances

b. improve management oversight of the process by instituting a detailed review of the costs, percentages, and calculations used in the allocation study

c. correct its method for allocating utilities, housekeeping, facilities operations, and depreciation costs to ensure that it does not overallocate these costs

d. develop a method to adjust its budget requests for the difference between the transfer amount the Legislature authorized based on estimated costs, and what the transfer should have been based on actual costs

2. To ensure that the Medical Center's efforts to determine the hospital's share of overhead costs are as efficient as possible, Medical Center officials should work with members of the Legislature and representative of the Governor's budget office to determine how the Center's recommended transfer amount is intended to be used. If it is intended to provide only a starting point, Medical Center officials should work with those same legislative and budgetary officials to consider ways to reduce the staff effort currently required to produce the allocation study, including the possibility of carrying our the study on a less-frequent basis.

Do the Medical Center's Plans to Use Its Fiscal Year 1995 Appropriation for Initiatives in Primary Care Appear To Be Appropriate?

The Medical Center decided to use the $600,000 appropriation it received in fiscal year 1995 for initiatives relating to primary care to hire seven additional primary care faculty. This expenditure will not address the financial viability of the primary care foundations in the short-term, but may help in the long-run as off-site clinics are developed and as the Medical Center obtains more managed-care contracts. Considerably less than half the appropriation actually has been obligated for primary care initiatives in fiscal year 1995; during the audit, Medical Center officials told us the remaining moneys would be used to fund part of the Medical Center's shrinkage requirements, which is not consistent with spending the money on primary care. These and other findings are discussed in the following sections of this audit.

The University of Kansas Medical Center Provides Patient Services at the University of Kansas Hospital and Through Private-Practice Foundations

The Medical Center is a research and teaching facility that includes a hospital. Physician faculty members are appointed to specific academic departments within the university and receive some State money for their teaching services. They also belong to one of the private-practice foundations that parallel the academic departments. Physician faculty members treat patients through these private-practice foundations, and receive compensation from their foundations as well.

On the Kansas City campus, these departments (foundations) include anesthesiology, cardiothoracic surgery, diagnostic radiology, family practice, general surgery, gynecology and obstetrics, internal medicine, neurology, ophthalmology, otorhinolaryngology, pathology, pediatrics, psychiatry, radiation oncology, and rehabilitation. On the Wichita campus, there is one professional corporation: the University of Kansas School of Medicine-Wichita Medical Practice Association, which includes family practice, internal medicine, pediatrics, and psychiatry. The department chair of each clinical department acts as the head of the corresponding foundation.

Each foundation has a contractual arrangement with the Medical Center for the provision of medical services, education, and research. This arrangement also involves payment by the foundations of a portion of physical faculty salaries. The foundations provide for the university's educational program and the clinical practice necessary for teaching. In exchange, the university allows the foundations to occupy space and facilities at the Medical Center and to use the University Hospital to provide patient care. The foundations pay the university a portion of their revenues as consideration for the space, facilities, equipment, and services furnished by the university. This totals three percent of gross income for the foundations for the period

September 1, 1994 through June 30, 1995 and four percent for the following twelve months. These funds are used for medical education, research, and development. In addition, the foundations may contribute a portion of net revenues for the benefit of the particular academic department with which they are affiliated. This amount is used for medical development, education, and research in the particular field of medicine for which the academic department is responsible.

The Legislature Gave the Medical Center $600,000 For Fiscal Year 1995 For Initiatives Related to Primary Care

The Legislature made this appropriation in response to the Medical Center's request for money to reimburse its primary care foundations for caring for indigent patients. During the appropriations process, the Legislature also reviewed a consultant's management study of the Medical Center.

Because of concerns about the financial viability of the primary care foundations, the Medical Center originally asked the 1994 Legislature for $1.2 million to reimburse these foundations for indigent care. In its fiscal year 1995 budget request, the Medical Center noted that its primary care foundations (pediatrics, internal medicine, and family medicine) were experiencing severe financial hardships. Several reasons were cited:

- an excessive number of Medicaid patients and an inadequate Medicaid reimbursement level for primary care physicians
- a large percentage of patients with no health care coverage, including a large number of indigent patients
- a small clinical faculty compared to the enrollment size of the School of Medicine, resulting in faculty spending a disproportionate amount of time teaching, leaving less time to generate income by treating patients
- a State fiscal policy requiring the hospital to be self-supporting, providing no State funding to offset the health-care costs for indigent patients treated by the foundations

We reviewed the financial statements for the primary care foundations and found they were, in fact, experiencing financial difficulties. For example, the Children's Center Foundation's (pediatrics) expenditures were about $11,000 higher than its revenues in fiscal year 1993. It also had debts that seemed to be large in relation to equity in both fiscal years 1992 and 1993. In the Family Medicine Foundation, revenues exceeded expenditures by only a very small amount in fiscal year 1993.

In the budget request, Medical Center officials noted that the issue of financial viability could only be addressed over several years because of the high cost associated with solving all the identified problems. They said the most critical issue relating to financial viability was the growing number of indigent patients treated by the primary care foundations.

To address this issue, the Medical Center asked that $1.2 million be given to the Executive Dean of the School of Medicine to reimburse the foundations as reimbursement for their care of indigent patients. The $1.2 million figure was derived by applying the Medicaid reimbursement rate (approximately 30% of charges) to the charges incurred by the foundations in treating indigent patients, estimated at more than $3.5 million a year.

The Medical Center's budget request noted that this appropriation would not fully address the problem. It noted that an additional concern—an inadequate number of primary care faculty—would be addressed in the next year's budget proposal.

During the 1994 legislative session, a consultant's study also made a number of recommendations to improve the competitiveness of the Medical Center and the hospital. This study, authorized by the Kansas Board of Regents and begun in September 1993, concluded that the Medical Center needed to move quickly to make the changes needed to survive in a managed-care environment. According to the consultants, the changes needed to be made within two years.

The types of changes the study recommended included the following:

- combining the 16 private-practice foundations into a single, multi-specialty group practice
- modifying the curriculum to further emphasize primary care, and to increase the number of students entering primary care to respond to the changing health care environment and growth in managed care
- developing a delivery network to provide an adequate supply of primary care and specialty patients by developing a central facility for the multi-specialty group practice, and developing several off-site primary care clinics
- enhancing the physician/hospital organization
- developing a public awareness and education program to inform citizens about the services provided by the Medical Center

The Legislature did not specify exactly how the Medical Center should spend the $600,000 appropriation. In her fiscal year 1995 budget recommendations, the Governor recommended that $300,000 be used to reimburse foundations with acute hardships. The Senate added $300,000 to this amount, specifying that the money was to be administered by the Dean of the School of Medicine, and would be targeted to primary care. In addition, the Senate added a proviso that stated the money would be released by the State Finance Council only upon the Medical Center's demonstration of a good-faith effort to consolidate the 16 separate practice foundations into a single practice. Ultimately, a conference committee recommended $600,000 for primary care initiatives, including the proviso. This appropriation was approved by the Legislature and the Governor. The $600,000 becomes part of the Medical Center's base budget, so will be available in subsequent years.

During this audit, Chairs of the Senate Ways and Means and House Appropriations Committees who were involved in making the appropriation told us the appro-

priation generally was not to be used to reimburse primary care physicians for their care of indigent patients, but was to be used in ways that would strengthen the primary care foundations and enable them to remain financially viable.

The appropriations subcommittee reports discussed the issue in conjunction with the issue of combining the private-practice foundations. During the same discussions, the subcommittee reports noted that consultants had recommended an increase in the number of primary care physicians, and that this issue should be addressed later.

The Medical Center Has Decided To Use the Appropriation To Help Pay For Seven Additional Primary Care Faculty

The State Finance Council released the money after the Medical Center demonstrated its ongoing efforts to combine the private-practice foundations.

In July 1994, the Dean sent letters to the chairs of the primary care departments indicating the $600,000 appropriation was going to be allocated to support additional primary care physicians. The following table shows the areas where the new faculty physicians were to be hired.

Number and Types of New Faculty Authorized to be Hired as a Result of the Fiscal Year 1995 Appropriation

Pediatrics	2
Family Medicine	2
Internal Medicine	2
Wichita Foundation	1

The money essentially would be used as seed money to ultimately allow the Medical Center to hire even more physicians. For the first year of the new physician's appointment, the appropriation would provide $85,000 in salary support, with the foundation picking up the rest of the salary. During the second year, State support would drop to $65,000 per physician. During the third year, State support would drop to $45,000. These reductions in State support for each physician each year would free up some of the $600,000 to be used for hiring more physicians. The foundations were expected to pick up the additional salary costs.

Spending Money for New Primary Care Faculty Will Not Address The Financial Viability of the Primary Care Foundations In the Short-Run, but When Coupled With Other Steps the Medical Center Is Taking, It Should Help in the Longer-Run

Hiring new primary care faculty will allow the Medical Center's primary care faculty to spend proportionately less time teaching and more time seeing patients. This could help these primary care foundations generate more income.

However, according to Medical Center officials, merely adding faculty whose salary and benefits would have to be supplemented by clinical foundations already in severe financial distress would not be a current solution. Even though the new physicians receive some State support, the foundations have to supplement their salaries. And if the foundations already have an inadequate patient base, with a high percentage of patients who can't pay for their health care, the foundations may not be able to support those additional physicians. Thus, in the short-run, hiring new primary care faculty may do little to ease those foundations' financial hardships, and may put some strain on some of them for the time-being. Unless some other actions are taken, adding new primary care faculty will not address these foundations' financial problems.

Additional steps the Medical Center is taking should eventually improve the financial health of the primary care foundations, and are consistent with the consultants' recommendations. Although these steps are more specifically designed to keep the Medical Center a viable health-care provider in the Kansas City metropolitan area, they should help the financial condition of the primary care foundations as well. The steps include the following:

- *Combining the private-practice foundations to reduce duplicate expenditures.* This step is under way. The combined foundations are now officially incorporated as a new entity, and a director of the combined group has been hired. Also, a contract has been awarded for a computer system to provide for centralized scheduling of patient visits, a common registration database, and a coordinated billing system. These "common" systems should reduce duplicate expenditures for such things as billing, scheduling, etc., which in turn should help improve the finances of all the private-practice foundations, including the primary care foundations.

- *Developing an off-site primary care clinic that would attract new patients who can pay for their care, and who could be referred to the hospital for inpatient services.* The hospital is in the process of establishing an off-site family medicine clinic to serve residents of Johnson County. Jayhawk Primary Care, discussed more fully in question three of this audit, is being set up to serve residents of Johnson County and to refer patients to the Medical Center's hospital. It will be staffed, in part, by one of the newly hired family practice faculty. Eventually, the Medical Center hopes to establish more of these off-site clinics to increase its patient base and change its mix of patients, with the goal of attracting more patients who can pay for their health services. The Medical Center anticipates these off-site clinics will be staffed by the newly hired primary care faculty, once they are hired.

- *Entering into managed-care contracts.* The hospital is entering into numerous managed-care contracts through its Physician-Hospital Organization, University Affiliated Healthcare, Inc. One purpose of these contracts is to increase the hospital's patient base. Because the contracts generally require primary care physicians to act as "gatekeepers," increased use of such contracts should

increase the patient base of the primary care foundations. And, because the patients served have insurance, the Medical Center expects the mix of patients to change so that a higher percentage will be able to pay for their health care. The Physician-Hospital Organization is discussed more fully in question three of this audit as well.

Adding primary care faculty also will help the Medical Center address some of the consultant's other recommendations. For instance, the university is working to change its curriculum to increase the exposure of medical students to primary care. It also is trying to expand the number of residencies available to primary care physicians. Medical Center officials told us they eventually would like to have about a 50-50 ratio of primary care residencies to specialist residencies.

As of March 1, About $443,000 of the Appropriation Was Unspent And, According to Medical Center Officials, Would Be Used To Meet the Medical Center's Shrinkage Requirements

The $600,000 appropriation initially was given to the Dean of the School of Medicine. As faculty were hired, the money was transferred to the clinical departments to pay a portion of their salaries.

Medical Center officials told us it takes a long time to recruit new faculty. As of March 1, four new faculty members had been hired—three of these already had begun to work at the Medical Center and the fourth was scheduled to begin work April 3, 1995.

Two physicians were hired by the pediatrics department and two were hired by the family medicine department. According to Medical Center officials, recruiting for the other positions was ongoing. For example, the internal medicine foundation was in the process of completing its interviews. That foundation hoped to make offers to physicians in the near future, but it was unknown whether those physicians would begin work before the end of the fiscal year.

Moneys remaining from the fiscal year 1995 appropriation could be used to fund other university operations. At the time of the audit, we asked Medical Center officials how they planned to spend any of the money that was not used to hire new faculty. They did not indicate that they had any specific plans to spend the unobligated portion of the appropriation for primary care initiatives. Rather, Medical Center officials told us the unspent appropriation would be used to meet the Medical Center's shrinkage requirements this year. As a result, the university will not have to reduce expenditures elsewhere to meet its shrinkage requirements.

Conclusion

The Medical Center decided to use the $600,000 appropriation to hire seven additional primary care faculty. Although this decision probably will not improve the financial viability of the primary care foundations in the short-term, it could help ensure their long-term viability when coupled with the other steps the Medical Center is taking to make itself a competitive health-care provider in the Kansas City metropolitan area.

Only four of the seven positions had been filled as of March 1, 1995, and none of these new physicians was employed for the full fiscal year. As a result, most of the appropriation had not been obligated for primary care initiatives during that fiscal year. Medical Center officials told us the unspent appropriation will be used to help the Medical Center meet its shrinkage requirements for the year, which is not consistent with the purpose of the appropriation.

Recommendation

Given the Legislature's intent that the $600,000 appropriation the Medical Center received for fiscal year 1995 be spent for primary care initiatives, the Medical Center should reconsider its decision to use unspent moneys to help fund its shrinkage requirements this year. As part of that effort, the Medical Center should develop a plan for how those moneys could be used to strengthen the financial viability of the primary care foundations. That plan should be provided to the 1995 Legislature as part of the appropriations process. Alternatively, the Medical Center should explore ways to have the money reappropriated for fiscal year 1996.

Have the Contracts With Recently Established Medical Center-Related Private Enterprises Been Managed Appropriately to Ensure Equitable Sharing of Costs?

The Medical Center has one contract with a private enterprise—Comprehensive Cancer Centers, Inc., a wholly owned subsidiary of Salick Health Care, Inc.—to provide cancer-related outpatient services. (Throughout this report, we will refer to the private entity as Salick.) In entering into this contract, the Medical Center expected to receive certain benefits in exchange for giving Salick exclusive rights to provide outpatient cancer services for the 35-year contract period. These included eventually being designated a comprehensive cancer center by the National Cancer Institute (in part because of Salick's plan to build a new facility that would consolidate all outpatient cancer treatments in a single location), receiving a share in Salick's profits, and having more patients referred to the Medical Center by the Salick Center for various other outpatient and inpatient services.

We found that the Medical Center has not yet received many of the benefits it expected to receive from this contractual relationship. The new facility is currently on hold because bids were significantly higher than expected, profits have not materialized, and the number of patients has not increased as expected. In addition, the contract does not include provisions that would help ensure the Medical Center receives the expected benefits. These and other findings are described in the sections that follow.

In March 1992, the Medical Center Contracted With Salick To Provide Cancer-Related Outpatient Services

We interviewed officials at the Medical Center to identify what Medical Center-related private enterprises had been established within the past five years. The only such enterprise resulted from a 1992 contract between the Medical Center and Salick. Salick is a for-profit private enterprise that provides cancer-related outpatient services. It operates several similar centers across the country. (We also considered the Sutherland Institute for review. That institute was named for a private donor, but is not a private enterprise.)

The Medical Center had been providing outpatient cancer services itself, but decided to contract with Salick to take over the provision of these services for a number of reasons. For example, the Medical Center wanted to be designated as a comprehensive cancer center by the National Cancer Institute. One prerequisite for this designation was having a patient-centered outpatient facility. To achieve this, the Medical Center would have to move all its scattered outpatient cancer treatment facilities into one central location. Medical Center officials told us this would require considerable amounts of capital. In addition, the Medical Center wanted to increase

its patient base, and hoped it could benefit from the marketing efforts of the Salick organization.

By contract, Salick has the exclusive right to provide outpatient cancer-related services at the Medical Center for the 35-year life of the contract. The Cancer Center currently is housed in interim space in the hospital. In its interim location, Salick provides chemotherapy, radiation therapy, laboratory tests, and other related outpatient cancer services on an exclusive basis.

The contract specifies that Salick will build a permanent cancer center on the hospital grounds that will be in operation within 42 months after Salick first provides outpatient cancer-related services at the Medical Center (or by the end of October 1995). The contract also specifies that the new facility will be built with bonds secured by the Medical Center, although Salick will make all principal and interest payments on those bonds. At the end of the contract, the building will belong to the Medical Center.

Salick plans to build a permanent center on top of the existing Mid-American Radiation Center Building. This new facility will add about 38,000 net square feet on five additional floors, and will consolidate all outpatient cancer treatment services into one centralized location. When the new facility is constructed, Salick will be able to offer additional outpatient cancer-related services, including outpatient surgery and imaging, again on an exclusive basis.

The contract also provides that Salick will pay the Medical Center for existing radiation therapy equipment. When the Cancer Center moves into its permanent space, it will buy this equipment outright at no more than the depreciated book value as of January 1992 ($826,328). Salick also is responsible for purchasing any other equipment it needs. This equipment would be purchased by the Medical Center at the end of the 35-year contract.

Under the terms of the contract, all physicians practicing at the Cancer Center have to be members of the Medical Center's staff. They are employees of the Medical Center, not of Salick. In addition, the Cancer Center's Medical Director has to be an employee of the Medical Center. In undertaking the contract, Salick also hired all the support staff who had been performing outpatient cancer treatment-related tasks for the Medical Center.

In return for the exclusive right to provide outpatient cancer-related services, Salick agreed to pay the Medical Center an annual administrative fee, operating costs, and 15% of any net profits. Before entering into the contract, the Medical Center developed an estimate of the financial impact of contracting out its outpatient cancer-related services. That estimate considered the revenues the Medical Center would lose by not providing those services itself. The estimate also considered the costs the Medical Center would avoid (such as staffing, equipment, and utilities) by not providing those services. The following table, using figures developed in December 1991, displays these estimates.

Estimated Multiple-Year Impact of Contracting with Salick(a)

	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
Revenue Loss (in millions)	$(2.7)	$(2.8)	$(2.9)	$(2.7)	$(2.8)	$(2.8)
Reduction in Expenditures (in millions)	1.9	2.3	2.2	2.2	2.2	2.2
Net Loss in Medical Center Revenues (in millions)	$(0.8)	$(0.5)	$(0.7)	$(0.5)	$(0.6)	$(0.6)
Estimated Amounts Salick Center Would Pay to the Medical Center:						
Administrative Fee	$675,000	$675,000	$675,000	$675,000	$675,000	$675,000
Profit Sharing	-na-	100,000	100,000	100,000	100,000	100,000
Bond Interest Premium	80,000	80,000	80,000	80,000	80,000	80,000
Equipment Rental	66,000	66,000	66,000	826,328 (b)	-na-	-na-
Renovation of Interim Space	(18,250)	(18,250)	(18,250)	(75,000)	-na-	-na-
Cancer Center Participation in Charity Care	100,000	100,000	100,000	100,000	100,000	100,000
Total Estimated Payments from Salick Center	$902,750	$1,002,750	$1,002,750	$1,706,328	$955,000	$955,000
Total Financial Benefit	$106,670	$467,063	$332,096	$1,146,896	$336,192	$336,192

(a) These estimates do not factor in any increases in inpatient revenue or any increase in the number of outpatients.

(b) This figure represents the purchase price of the equipment Salick would purchase from the Medical Center when it moves into the permanent facility.

As the table shows, the Medical Center estimated it would lose about $2.7 million in revenues during the first year as a result of Salick taking over its outpatient cancer-related activities. It also estimated it would save about $1.9 million in expenditures. The estimated net loss in revenues that first year was expected to be about $800,000. Losses also were projected for fiscal years 1994 through 1998.

Under the contract, Salick agreed to pay the Medical Center an annual administrative fee of $675,000, which included payment for the interim and permanent space the Cancer Center occupies and for the Medical Director's salary.

The table also shows that Salick was expected to pay an annual bond interest premium of $80,000. (It was anticipated that the Medical Center could secure tax-exempt revenue bonds to construct the permanent cancer center. For this reduced interest rate, Salick would pay the Medical Center this premium.) In addition, the table shows the payment Salick was required to make to the Medical Center for renting radiation therapy equipment.

The Medical Center also expected to be able to reduce its expenditures for indigent patients by $100,000, the amount of indigent care Salick is obligated by the contract to provide. Finally, Salick is required by contract to pay 15% of its pretax profits to the Medical Center within 120 days after August 31 each year. As the table shows, this profit-sharing payment was estimated to be $100,000 each year between fiscal years 1994 and 1998.

Overall, the table shows that the Medical Center expected it would be financially beneficial to enter into a contract with Salick.

The contract also requires Salick to pay its share of operating costs. Salick also pays for the costs associated with using its space. For instance, the contract requires it to pay the incremental costs associated with housekeeping, maintenance, and utilities. Incremental costs are defined to include the actual direct costs for support provided by the Medical Center to the Cancer Center, including the additional costs incurred by the Medical Center in providing the services, and the direct costs assigned to those services. The contract also states that the Medical Center will provide other services to Cancer Center at incremental costs, including printing, landscaping, snow removal, security, and the like.

In addition, the contract between the Medical Center and Salick provides that Salick will pay for its own medical supplies, medications, and forms. It is billed directly by the Medical Center for any pharmacy or laboratory services it uses. There are a number of other services that Salick provides on its own, including billing and collections, medical records supervision, infection control, and quality assurance.

The Medical Center Has Not Yet Realized the Advantages It Expected When It Entered Into the Contract With Salick

The table below shows how much the Medical Center has received from Salick in fiscal years 1993 and 1994, compared with what it expected to receive.

Payments From Salick to the Medical Center

	Fiscal Year 1993			Fiscal Year 1994		
	Original Estimate	Actual Receipts	Difference	Original Estimate	Actual Receipts	Difference
Administrative Fee	$675,000	$675,000	$0	$675,000	$675,000	$0
Profit Sharing	-na-	0	0	100,000	30,358	(69,642)
Bond Interest Premium	80,000	0	(80,000)	80,000	0	(80,000)
Equipment Rental	66,000	66,000	0	66,000	66,000	0
Renovation of Interim Space	(18,250)	(18,250)	0	(18,250)	(18,250)	0
Total Payments from Salick Center (estimated and actual)	$802,750	$722,750	$(80,000)	$902,750	$753,108	$(149,642)

Payments from Salick have been less than originally expected. As the table shows, Salick has paid the required annual administrative fee of $675,000 and equipment rental of $66,000. Salick also has paid the Medical Center $13,770 each month for its share of housekeeping, utilities, maintenance, and mailroom services. This figure was determined based on historical studies of such costs at the Medical Center in relation to the space occupied by the Cancer Center.

However, the table also shows that the hospital actually received $80,000 less from Salick in fiscal year 1993 and nearly $150,000 less in fiscal year 1994 than it estimated. We identified several reasons why.

- ***Cancer Center profits have not materialized.*** The original estimates projected that Salick would pay the Medical Center profit sharing of $100,000 after the first year of operation. In fiscal year 1994, the Medical Center received $30,358 in profit sharing, based on the Cancer Center's fiscal year 1993 profits. It will receive no profit-sharing distribution in fiscal year 1995 for fiscal year 1994, however, because the Cancer Center showed a pretax loss for 1994.

  The Medical Center's estimates consistently showed that it would have expected its own revenues to be greater than its expenses for providing outpatient cancer treatment services. Within the scope of this audit, we weren't able to determine why the Cancer Center had experienced a loss in fiscal year 1994. The Medical Center has had its internal auditor review the Cancer Center's unaudited financial statements for fiscal year 1994. The results of that internal audit are expected to be available in March 1995.

- ***The Medical Center will not receive a bond premium fee.*** The original estimate included an annual payment of $80,000 to the Medical Center as a bond premium fee. As it turned out, the bonds to finance the permanent cancer center will not be tax-exempt. As a result, Salick will not pay a bond premium fee as originally planned.

The new permanent cancer center facility has been put on hold until decisions are made about how to resolve financing problems. The Medical Center intended to use its authority to issue the bonds to construct the permanent facility. It developed a budget of $7.6 million for the construction of the permanent facility, which was approved by the Kansas Board of Regents.

In May 1994, bids were opened for the permanent facility. The low bid came in at $10.6 million, or $3 million more than the project's budget. As a result, no bonds were issued and the construction of the permanent facility has been delayed. Medical Center officials told us there are informal agreements between the two parties that extend the completion date for the permanent facility beyond the 42-month time-line specified in the contract. However, the longer it takes a permanent facility to be constructed, the longer it will be before the Medical Center is able to realize the advantages of having all outpatient cancer-related services centralized in one location.

The Medical Center and Salick are reviewing a number of options for completing the permanent facility, including reducing the scope of the project and identifying alternative sources of funding.

The goal of increasing the number of patients served by the Cancer Center has not been realized. One of the goals the Medical Center hoped to achieve by signing the contract with Salick was to increase the number of outpatient cancer patients served by the Cancer Center. Increasing the number of outpatients served would have a positive effect on the hospital in several ways:

- It would increase the profits of the Cancer Center, resulting in more profit-sharing revenues for the Medical Center.
- It would increase hospital revenues because these patients likely would need some outpatient services that the Cancer Center did not provide.
- It would increase the number of inpatient cancer patients, thereby increasing hospital revenue, because many outpatients need some inpatient services as well.

Hospital officials told us Salick officials had predicted that patient volumes for radiation therapy would grow by 5% each year, and that patient volumes for chemotherapy would grow by 10% per year. Hospital officials also told us that the projected growth in patient volumes was not occurring.

We reviewed information on monthly patient visits for radiation and chemotherapy treatments. As the following table shows, instead of increasing by 5%, the number of radiation therapy treatments actually dropped between fiscal year 1993 and 1994.

The table also shows that chemotherapy treatments increased at about the rate projected during the time period. However, during the first five months of fiscal year 1995, fewer chemotherapy treatments were performed than in the same period the previous year. These figures suggest the increase in chemotherapy treatments may not be sustained in 1995.

Number of Patient Treatments

	Radiation Therapy	Chemotherapy
Fiscal Year 1993	15,376	6,531
Fiscal Year 1994	14,395	7,177
Percentage Change	-6.4%	9.9%

If the patient volumes do not materialize as hoped-for, the Medical Center will receive fewer financial benefits from associating with Salick than it expected when it entered into the contract.

The Contract Does Not Have Provisions That Would Help Ensure That the Medical Center Benefits From the Cancer Center

We reviewed the contract between the Medical Center and Salick to see whether it contained sufficient controls to help ensure the Medical Center would achieve the benefits it hoped for through the association. We identified several areas of concern.

The contract does not contain any provisions for increasing the administrative fee over the 35-year life of the contract. According to the contract, Salick pays an administrative fee for the exclusive right to provide outpatient cancer-related services. The fee is supposed to pay for such things as the Cancer Center's space and Medical Director, and appears to have been set, at least in part, to offset the losses in revenues the hospital estimated it would incur. There are no contractual provisions to increase this fee during the life of the contract. As a result, the Medical Center has to rely on profit-sharing and increased patient volume to offset its revenue losses. And, as discussed above, neither of these has occurred as anticipated.

The contract does not include any mechanisms that would allow the Medical Center to question the costs and revenues that are used to calculate net profit. As noted earlier, the Medical Center assumed that the Cancer Center would be profitable. However, in fiscal year 1994 the Cancer Center operated at a loss. The Medical Center's internal auditor has reviewed the Cancer Center's unaudited income statements for that year. As noted earlier, the results of that audit will be available in March 1995. However, even if that audit should identify problems with certain costs included in those statements, there are no provisions in the contract for the Medical Center to challenge those costs.

The contract contains no financial incentives for increasing patient volume, although Medical officials told us that was a goal it hoped to achieve by entering into the contract. As noted earlier, Medical Center officials told us it was anticipated that the Cancer Center would have increases in patient volume of 5% to 10% each year. And, according to Medical Center officials, patient growth was one of the goals they hoped to achieve in signing the contract. However, the contract doesn't address patient volume. To help ensure this occurs, the contract might have included financial incentives that would have kicked in after patient volume got to a certain level, or financial sanctions that might have resulted if patient growth did not occur as expected. There are any number of possibilities for how this might have been treated in the contract.

Conclusion

In the longer-term, the Cancer Center may be able to provide the expected benefits to the Medical Center. In addition, Medical Center officials have indicated that patients are satisfied with the patient-friendly manner in which outpatient cancer treatment services are provided. But given some of the concerns we have identified—limited profits, lower patient growth than anticipated, and a permanent facility not yet under construction—it would be reasonable for the Medical Center to reassess its relationship with Salick and determine if any changes are needed to ensure the Medical Center receives the benefits it expects.

Recommendations

1. To ensure it is receiving the benefits it anticipated from its association with Salick Health Care, the Medical Center should review the contract with Salick in such areas as the administrative fee, profit sharing, and provisions for questioning costs, to determine if the contract is sufficient to meet the needs of the Medical Center. As part of this reassessment, the Medical Center should identify areas where the contract may not be sufficient to ensure it receives the expected benefits, such as in dealing with patient volumes, and should consider whether changes to the contract would help provide those assurances.

2. The Medical Center should report back to the Senate Ways and Means, House Appropriations, and Legislative Post Audit Committees, and any other appropriate legislative committees regarding its reassessment in these areas and any actions it proposes to take.

The Medical Center Also Is Beginning To Enter Into Arrangements That Will Position It As a Managed-Care Provider

In addition to an agreement with Comprehensive Cancer Centers, Inc. (Salick), the Medical Center is entering into a number of other contractual arrangements that provide benefits to the Medical Center.

Healthsource. Healthsource, Inc., is a for-profit organization that offers a health maintenance organization (HMO) product called Blue Advantage. In August 1993, the Medical Center invested just under $2.3 million in this organization. For this investment, the Medical Center received shares in the organization plus a surplus note with a face value of $1.57 million and a maturity date of May 2007.

Blue Cross and Blue Shield of Kansas and Blue Cross and Blue Shield of Kansas City hold 51% of the shares in Healthsource, and five Kansas City-area hospital groups, including the Medical Center, own the remaining 49% of the shares. (Each hospital group owns an equal number of shares.)

According to hospital officials, there are 35,000 subscribers to Blue Advantage. Subscribers can obtain services from any of the member hospitals, including the Medical Center. In addition, the Medical Center's Physician-Hospital Organization (described below) contracts with Healthsource to provide services to subscribers.

The purpose of the Medical Center's investment in Healthsource was to expand the Medical Center's patient base, and to put the hospital in a better position to participate in the emerging managed-care environment.

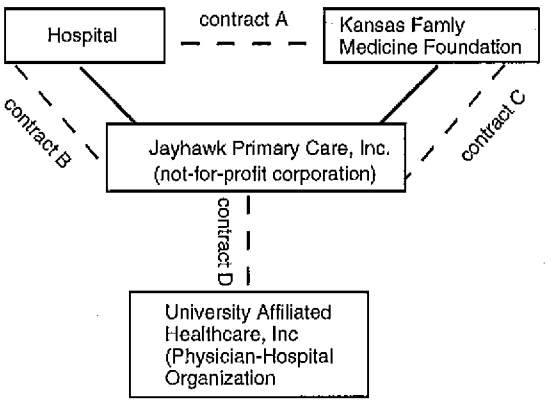
Physician-Hospital Organization. The physician-hospital organization, known as University Affiliated Healthcare, Inc., is a partnership between the hospital and the private-practice foundations that creates a single entity to negotiate with insurance companies and managed-care organizations to provide health care services on a fee-for-service basis or on a per-capita basis. A typical contract might provide that the physician-hospital organization provide services to people covered under an insurance company's policy at a discounted rate.

Before the creation of this not-for-profit organization, insurance companies had to contract separately with each of the private-practice foundations and the hospital. Not only were multiple contracts in place, but the contracts also weren't necessarily consistent among the private-practice foundations. According to Medical Center officials, the change to a single contracting entity has made the Medical Center more competitive. In addition, the hospital's involvement in the organization has helped increase its patient base and revenues. According to the organization's newsletter, the Physician-Hospital Organization had executed agreements with 18 managed-care organizations by the end of calendar year 1994.

The expenses of the Physician-Hospital Organization, which include marketing and providing for the processing of some patient claims, are paid for through assessments on the hospital and foundations. The hospital contributes two-thirds of the cost ($74,544 per quarter in fiscal year 1995), while the foundations contribute the other one-third.

Jayhawk Primary Care, Inc. is a joint venture between the Medical Center and the Kansas Family Medicine Foundation. It is a private, not-for-profit entity that will operate a family practice clinic in Lenexa, Kansas. The clinic is supposed to be open in April 1995. The following graphic shows the various contractual arrangements associated with this clinic.

Relationships Associated with Jayhawk Primary Care, Inc.



Contract A is the contract that establishes the partnership between the hospital and the Kansas Family Medicine Foundation. It sets forth such items as the structure of the board, the capitalization of the corporation, non-competition convenants, and the like.

Contract B is the contract between the hospital and the Jawhawk Primary Care, Inc., which specifies such things as patient relationships, and how services are provided by each entity.

Contract C is the contract between the Kansas Family Medicine Foundation and Jayhawk Primary Care, Inc. It is similar to contract B and adds additional provisions relating to the retention of family medicine physician services, and teaching and research responsibilities.

Contract D is the contract between Jayhawk Primary Care, Inc., and the physician-hospital organization (University Affiliated Healthcare, Inc.) that allows the physician-hospital organization to negotiate and administer managed care contracts that Jayhawk Primary Care, Inc. can participate in.

The clinic's location is designed be more accessible and convenient to patients. As a result, it is expected to increase the number of patients being served, to improve the ability of the Medical Center to train primary care physicians, to provide a new source of referrals to the hospital, and to improve the mix of patients.

The Medical Center has developed a pro forma for the new clinic. As the table below shows, the clinic is expected to have a loss at least through fiscal year 1998. However, that loss (which will be borne by the hospital) is expected to be more than made up by the number of inpatient referrals made by the clinic.

Estimated Impact on the Hospital of the Jayhawk Primary Care Clinic

	FY 95 (2 doctors)	FY 96 (5 doctors)	FY 97 (6 doctors)	FY 98 (6 doctors)
Jayhawk Primary Care, Inc. (loss)	($265,353)	($468,414)	($353,043)	($100,017)
Est. Inpatient Revenue	117,000	936,000	1,170,000	1,170,000
Impact on Hospital	($148,353)	$467,586	$816,957	$1,069,983

APPENDIX A

University of Kansas Medical Center
Fiscal Year 1994 Allocation of Shared Overhead Costs

This appendix shows the results of the Medical Center's fiscal year 1994 allocation of shared overhead costs. We have corrected inaccurate cost figures and calculations that were identified in the audit report.

UNIVERSITY OF KANSAS MEDICAL CENTER
FISCAL YEAR 1994 ALLOCATION OF SHARED OVERHEAD COSTS
(Used to project fiscal year 1996 transfer request)

Cost Center	Overhead Measure Used	FY 1994 Expenses and Encumbrances Without Capital Expenses	Overhead Add On 14.45%	FY 1994 Expenses and Encumbrances Without Capital With Overhead	Hospital Percent	Hospital Share of Expenses
Facilities Operations	Square Footage	7,786,887	800,492 (a)	8,587,379	37.2%	3,194,505
Utilities	Square Footage	5,716,320	N/A	5,716,320	37.2%	2,126,471
Housekeeping	Square Footage	4,813,886	587,294 (b)	5,401,180	37.2%	2,009,239
Computing Services	Effort and Usage Estimate	2,885,452	416,948	3,302,400	45.0%	1,486,080
Medical Center Police	Employee/Student Head Count	1,740,380	251,485	1,991,865	31.4%	625,446
Human Resources	Employee Head Count	1,076,305	155,526	1,231,831	42.8%	527,224
Telecommunications	Telephone Count	877,131	126,745	1,003,876	37.1%	372,739
Employee Health	Services Billed	391,836	56,620	448,456	67.0%	300,466
University Relations	Employee Head Count	495,581	71,611	567,193	42.8%	242,758
Executive Vice Chancellor	Effort Estimate	995,459	143,844	1,139,303	20.0%	227,861
Accounts Payable	No. of vouchers	440,950	63,717	504,667	43.1%	217,663
Landscaping	Square Footage	501,776	72,507	574,283	37.2%	213,633
Institutional Research	Effort Estimate	376,690	54,432	431,121	45.0%	194,005
Budget Office	Employee Head Count	359,998	52,020	412,017	42.8%	176,343
Legal	Effort Estimate	285,688	41,282	326,970	50.0%	163,485
Accounting and Payroll	Employee Head Count	318,780	46,064	364,844	42.8%	156,153
Affirmative Action	Employee Headcount	252,237	36,448	288,686	42.8%	123,557
Safety Administration	Effort Estimate	367,990	53,175	421,165	27.6%	116,241
Controller	Effort Estimate	225,917	32,645	258,562	40.0%	103,425
Accounting Control & Reporting	No. of vouchers	205,021	29,626	234,647	40.0%	93,859
Library	Survey of Other Hospitals	2,485,049	359,090	2,844,139	N/A	92,000
Design and Construction	Construction Costs	514,950	74,410	589,360	14.0%	82,510
Health Care Resource	Effort Estimate	185,660	26,828	212,488	30.0%	63,746
Employee Transaction	Employee Head Count	125,531	18,139	143,670	42.8%	61,491
Mailroom	Pieces of Mail	175,731	25,393	201,124	27.7%	55,711
Business Affairs	Effort Estimate	166,933	24,122	191,055	25.0%	47,764
Controller	Effort Estimate	88,181	12,742	100,923	30.0%	30,277
Property Accounting	No. of Inventory Items	62,374	9,013	71,387	27.6%	19,703
Chancellor	Effort Estimate	68,936	9,961	78,897	20.0%	15,779
Retirement Disability	No. Recipients	36,552	5,282	41,834	18.0%	7,530
Kirkayer Fitness Center	Employee/Student Head Count	12,477	1,803	14,280	31.4%	4,484
Gift Shop Telephones	Telephone Count	2,766	400	3,166	100.0%	3,166
Accounting Travel Audit	No. of travel vouchers	16,875	2,438	19,313	12.3%	2,377
Internal Audit	Effort Estimate	665	96	761	50.0%	381
Audio Video	Services Billed	234	34	268	8.1%	22
Less:						
Employee Health	Cost of non-hospital amount					-5,606
Cafeteria	Non-hospital employee/student % of cafeteria loss				-68.6%	-134,531
Jaycare	Non-hospital Employee Head Coun	10,332	1,493	11,825	-57.2%	-6,764
Purchasing	No. of non-hospital vouchers	474,563	68,574	543,137	-56.9%	-309,045
Subtotal		34,542,094	3,732,299	38,274,392		12,702,148
Plus:						
FY 1994 Medicare direct medical education amount (as filed)						2,009,555
This item is a revenue transfer, rather than an allocation of overhead. Each year, Medicare reimburses the hospital for a portion of expenses associated with medical students serving as residents. However, these students are funded from the education budget. The Medical Center uses the overhead transfer as a mechanism for shifting this money from the hospital budget to the education budget.						
Total hospital overhead with FY 1994 direct medical education amount						**14,711,703**

(a) Overhead add-on = 10.28%
(b) Overhead add-on = 12.20%

APPENDIX B

Agency Response

On March 6 we provided copies of the draft audit report to the University of Kansas Medical Center. Their response is included as this appendix.

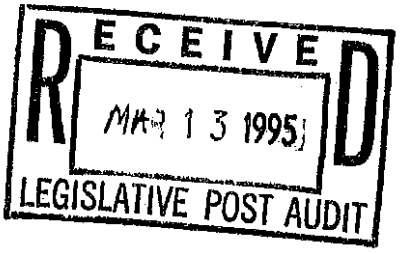
On March 9, we met with officials of the Medical Center to discuss the report. As a result of the meeting, we made some minor clarifications to the report. None of these clarifications resulted in changes to the audit conclusions or recommendations.

The University of Kansas

Office of the Chancellor

March 10, 1995

Ms. Barbara Hinton
Legislative Post Auditor
Legislative Division of Post Audit
800 Southwest Jackson Street-Suite 1200
Topeka, Ks. 66612



Dear Ms. Hinton:

The following is our formal response to the draft audit report on the University of Kansas Medical Center. I will generally comment only on Post Audit's conclusions and recommendations on each of the three issues. We will address some of the other comments and observations raised in the report during our oral presentation to the Committee.

Allocation of Overhead Costs Between the Hospital and the Education Program

We are pleased with the auditor's conclusion that the methodology used for allocating overhead costs between the hospital and the education program is a reasonable process. We share some of the same uncertainties as were expressed in the report as to the specific legislative intent in initiating this process. Whether the Legislature utilizes the specific amounts in the appropriations process or not is certainly their prerogative. Were the Legislature to follow a policy of adopting the calculated amount in their funding of the Medical Center budget, your recommendation that retroactive adjustments be made based on actual expenditures would certainly seem appropriate.

With regard to the other audit recommendations, the University is in general agreement. The recommendation that we alter our methodology for allocating utilities, housekeeping, facilities operations, and depreciation to the support units themselves will be reviewed and we will consider using a single apportionment step-down method in the future. We do believe the methodology we have employed is appropriate, even though it may result in a slight overstatement of the amounts allocated to the Hospital.

Use of the FY96 Appropriation for Enhancing Primary Care

The 1994 Legislature appropriated $600,000 for enhancing primary care programs. Our long-term commitment is to use those funds for additional primary care faculty. Recruitment of physician faculty is a time-consuming task. Four of the seven positions

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have been filled; we expect appointments will be made to the remaining positions by July 1. Based on current appointments, we agree with the auditors that only $157,000 will be expended on these salaries in FY95. Obviously, if other persons can be recruited and brought on board before the close of the fiscal year, the actual expenditures could be slightly higher.

The audit findings clearly confirm that our planned use of the monies is in keeping with legislative intent. The audit recommendation that the "Medical Center reconsider its decision to use unspent moneys to help fund its shrinkage requirements" suggests that perhaps we did not adequately communicate to the audit staff as to our intent. We plan to use monies not required in the current year for faculty for other meaningful one-time purposes. As was pointed out in the audit, Pediatrics is a major continuing problem. Several months ago we appointed an administrative team to review the Department and to suggest actions that should be taken to improve that situation. One recommendation already accepted was to make a one-time allocation of $110,000 to upgrade the department's computer network. There are other actions still under consideration.

We are currently considering a one-time commitment of funding to Family Practice to support a project for testing the reliability and acceptability to patients of various telemedicine technologies to enhance delivery of medical care to rural Kansas. We are also currently reviewing equipment needs of the Department for supporting Family Practice residency programs in communities across the state. As of this writing, no dollar amount has been committed to either of these proposals.

I regret that we may have failed to communicate clearly our intent. I would expect that by the close of the fiscal year most of the funds will be committed. Given the audit recommendation that we devise a plan to use the funds for other appropriate purposes, I believe our strategy indicates our concurrence with this recommendation.

Management of Related Private Enterprises

The audit focused totally on the experience to date with the contract entered into in 1992 between the Medical Center and Comprehensive Cancer Centers, Inc., (CCC) for operation of the University of Kansas Cancer Center. We concur with the audit recommendations that, 1) the Medical Center should reassess the contract with CCC, Inc. to ensure that the relationship is a positive one for the institution; and 2) that we should report back to the Senate Ways and Means, House Appropriations and Legislative Post Audit Committees regarding our reassessment as well as any contract modifications we propose to seek.

Of the three issues addressed in the audit, this is certainly the most complex. The institution had several motivations for pursuing this contractual relationship, including those enumerated in the audit report. The University has long been recognized as the preeminent cancer care facility in the metropolitan area. It was the desire to build upon this base of excellence that prompted the institution to explore a contractual relationship with Salick. Our desire to seek ultimate designation as a comprehensive cancer center by the National Cancer Institute was certainly one consideration. Access to the expertise of Salick Health Care, Inc., as well as its marketing and financial resources, was an additional consideration. We also believed that we could enhance the quality of cancer treatment and the satisfaction of the patients by overcoming some of the inherent organizational and physical problems which then plagued our cancer program.

After negotiations in the last half of 1991, the contract was signed and the University of Kansas Cancer Center began operation in an interim space in the spring of 1992, where it continues to function today. Given two years of experience in the interim space and operating under the existing contract, the University concluded, as did the auditors, that it would be appropriate that a comprehensive review should be made to ensure that the existing relationship remained a mutually beneficial one. Perhaps the major factor that caused us to re-evaluate the relationship is the dramatic changes that have occurred in the health care delivery and reimbursement system since the contract was negotiated. These changes, which could not be foreseen in 1991, have dramatically changed the patient-provider-payer relationship. They certainly impact upon the contractual relationship that the institution has with CCC, Inc.

When construction bids for the permanent center were received in the spring of 1994, they significantly exceeded the original project budget. Salick was very willing to make the additional financial commitment to complete that project. The institution, however, felt that in order to expand the project it would again have to provide assurances to the Board of Regents and the Kansas Legislature that the contractual relationship remained a financially positive one for the institution. We advised officials of Salick Health Care, Inc. that we would have to undertake a reassessment of the relationship before we could provide such assurances and seek an expansion of the project.

As part of the reassessment, the University directed its own internal audit staff to initiate a comprehensive audit of the first two years of this contractual relationship. The results of that audit will be available within the next several weeks. Further, we advised Salick Health Care, Inc. that changes that have taken place in the marketplace may necessitate a revision of the current agreement.

The above comments should not be construed as evidence that the institution is negative with respect to this undertaking, but merely reflect our objective appraisal of the current situation. An assessment of the program must acknowledge the fact that the Center remains in a physically limited space that certainly constrains the level of program that can be offered. Patients have been very complimentary about the quality of services that have been provided. We have realized an increase in inpatient days for oncological patients during a period in which overall census trends are downward. We also believe that the Center has, to some extent, enhanced the image of the institution within the metropolitan area and has had some positive effect on the willingness of other patients to seek medical care at the institution.

Our agreement with your recommendations is evidenced by the course of action that we, as an institution, have already undertaken. If a change of course is deemed appropriate, we would certainly advise and confer with not only the appropriate legislative committees, but also the Board of Regents and the Governor's staff.

I want to compliment the audit staff for the thorough and professional manner in which the study was conducted.

Sincerely,

Delbert M. Shankel

Delbert M. Shankel
Acting Chancellor
Professor of Microbiology

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