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South Broward Hospital District d/b/a Memorial Healthcare System

Performance Review: Florida Statute Chapter 189.0695

January 9, 2025

Memorial Healthcare System

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TRANSMITTAL LETTER

January 9, 2025

South Broward Hospital District d/b/a Memorial Healthcare System
3501 Johnson Street
Hollywood, FL 33021

Pursuant to our executed statement of work signed September 9, 2024, with South Broward Hospital District d/b/a Memorial Healthcare System ("MHS," "the SBHD", "the Special District"), we hereby present our Performance Review to fulfill the requirements outlined in Florida Statute Chapter 189.0695. Our report is organized in the following sections:

Executive Summary	This provides a high-level overview and summary of the procedures and results obtained through this performance review.
Background	This provides an overview of the SBHD, as well as relevant background information.
Results / Performance	This section provides information related to each primary program, including financial data, goals and objectives, and recommendations resulting from our procedures.

We would like to thank the staff and all those involved in assisting our firm with this performance review.

Respectfully Submitted,

RSM US LLP

CC Auditor General
President of the Senate
Speaker of the House of Representatives

EXECUTIVE SUMMARY

Background

Since its founding in 1953, the SBHD has been at the forefront of delivering quality healthcare services to residents of South Florida. Committed to advancing health to address community needs, the SBHD ranks among the largest public healthcare systems in the nation and is highly esteemed for its outstanding patient- and family-centered care.

The SBHD monitors its performance through many different oversight mechanisms. The enterprise performance of the SBHD is monitored through a dashboard distributed and reviewed monthly to assess performance across the Seven (7) Pillars of Excellence; Safety, Quality, Service, People, Finance, Growth, and Community.

The SBHD offers many different services, each is aligned in some capacity with at least one of the strategic pillars. We understand the SBHD's current prioritizations include the following, which were the subject of this performance review:

- Cancer
- Cardiology - Adult
- Cardiology - Pediatric
- Labor and Delivery
- Neuroscience
- Rehabilitation

Memorial Healthcare System delivers comprehensive healthcare services through a diverse network of facilities, including Memorial Regional Hospital, Memorial Regional Hospital South, Joe DiMaggio Children's Hospital, Memorial Hospital West, Memorial Hospital Miramar, and Memorial Hospital Pembroke, as well as ambulatory facilities throughout the market.

Objectives and Scope

The primary objective of this engagement was to conduct an independent performance review of the SBHD in accordance with the requirements outlined in Florida Statute Chapter 189.0695. The SBHD has identified six (6) key priorities: Cancer, Adult Cardiology, Pediatric Cardiology, Labor and Delivery, Neuroscience, and Rehabilitation. These prioritizations, along with the goals, objectives and outcomes for each, as defined by the SBHD will constitute the basis of our scope for identifying and evaluating the metrics of the SBHD's major programs. The performance review scope period was May 2021 - April 2024, which was based on the SBHD's fiscal year end.

As part of this performance review, we performed research and analysis including the following procedures:

Evaluation of the Special District

- Conducted an evaluation of the purpose, goals, and objectives outlined in the charter of the Special District.
- Assessed the efficiency and effectiveness of programs and activities, examining their alignment with the Special District's goals, expected benefits, and the use of performance measures and standards.

Financial Analysis and Goal Achievement

- Examined the revenues and costs of programs and activities over the current year and the previous three fiscal years.
- Assessed the extent to which the Special District's goals and objectives have been achieved, assessing clarity, measurability, and alignment with statutory purposes.

Service Delivery Efficiency and Cost Analysis

- Evaluated the delivery of services by the Special District, exploring alternative methods to reduce costs and enhance performance.
- Compared similar services provided by the county and other municipal governments within the Special District's boundaries, considering costs, efficiencies, and potential service consolidations.

Assessment and Recommendations

- Assessed factors contributing to the failure to meet performance measures or standards, if applicable.
- Provided recommendations to enhance the Special District's program operations.

At the conclusion of our performance review, we summarized the results, key takeaways and results into this written report, and conducted exit conferences with management.

We would like to thank all team members who assisted us throughout this performance review.

EXECUTIVE SUMMARY (CONTINUED)

KEY TAKEAWAYS AND RECOMMENDATIONS

Based on our observations and analyses, we present the following recommendations. If not explicitly mentioned, no additional comments or recommendations were made.

The charter for the Special District provides that the Board of Commissioners is authorized and empowered to establish, construct, operate, and maintain such hospital or hospitals and other health facilities as in their opinion are necessary for the use of the people of the Special District, and to establish, construct, operate, and maintain such facilities for the care of such persons requiring limited medical care or treatment as in their opinion is necessary for the people of the Special District. The Mission and Vision of the Special District closely align with the charter, and the primary programs identified by the Special District are established to provide each of the services provided in the Special District's charter.

Through our inquiry of District Management and review of related documentation including financial statements, Board reporting packages, internal/management reporting packages, reporting dashboards, the Special District's charter, Florida Statutes, flyers and brochures, etc. we noted the following:

- The Special District has a robust process for continually evaluating performance and effectiveness of its programs.
- All six (6) defined programs have established goals and performance metrics by which success is measured.
- We observed historical tracking and reporting of performance metrics for all six (6) defined programs throughout our scope period which extended from May 2021 - April 2024.
- Performance metrics are actively tracked on a monthly and annual basis, utilizing data visualization dashboards.
- Metrics are communicated to various committees and the Board on a monthly and annual basis, as applicable.
- Performance metrics, while consistently reported during our scope period, are also evaluated and updated by Management to address emerging trends and areas of concern and interest.

The following sections of this report provide detail related to the six (6) defined programs, the established goals, performance metrics, results, and financial information of each. We recommend the Special District to continue its robust performance metrics tracking and reporting efforts.

Through review of the Special District's enabling legislation (Ch. 2004-397, 2016-258), and as excerpted below we understand the FL legislature declared the Special District as a public purpose and necessary for the preservation of the public health, for public use, and for the welfare of the district and inhabitants thereof; and therefore empowers the Special District's Board of Commissioners to establish, construct, operate, and maintain such hospital or hospitals and other health facilities as in their opinion are necessary for the use of the people of the Special District. Further, we confirmed that no county or municipal governments located wholly or partially within the boundaries of the Special District provide the same services as the Special District.

Ch. 2003-397, Section 4(2).

…"It is hereby found and declared to be a public purpose and necessity for the preservation of the public health and for public use and for the welfare of the district and the residents thereof that the board of commissioners of the district have the broadest possible power to provide and structure health facilities and services, and facilities and services incidental or related thereto, in order to meet all types of health needs, and pursuant thereto to have the broadest flexibility to involve public and private persons, for profit and not for profit, in the establishment, maintenance, and operation of such facilities and services so as to provide the board of commissioners with the greatest flexibility permitted by the State Constitution to establish, maintain, and operate, alone or in conjunction with other public or private persons, not for profit and for profit, such health facilities and services, and facilities and services related or incidental thereto, which in the sole judgment of the board of commissioners are responsive to the health needs of the district and are in the public interest."

BACKGROUND

Overview

The SBHD was established by the Florida Legislature in 1947, laying the foundation for what would become Memorial Healthcare System. Since the opening of Memorial Hospital in 1953, Memorial Healthcare System has been dedicated to delivering high-quality healthcare services to the region.

At the heart of Memorial Healthcare System is Memorial Regional Hospital, one of the largest hospitals in Florida. Renowned for its breadth and quality of care, Memorial Regional Hospital offers an extensive range of specialized services, including Memorial Cardiac and Vascular Institute, which features surgeons and state-of-the-art treatment options; Memorial Cancer Institute, a leading provider of cancer care in Broward County; and Memorial Neuroscience Institute, known for its innovative technology and medical expertise. This integrated healthcare system delivers specialized services designed to meet diverse patient needs, including comprehensive cancer care, adult and pediatric cardiology, labor and delivery, advanced neuroscience treatments, and rehabilitation services.

This unique health care system covers the entire county and consists of the following facilities:

- Memorial Regional Hospital
- Memorial Regional Hospital South
- Joe DiMaggio Children's Hospital
- Memorial Hospital West
- Memorial Hospital Miramar
- Memorial Hospital Pembroke
- 24/7 Care Center
- Memorial Manor Nursing Home

Other components of the SBHD include Memorial Physician Group; Memorial Outpatient Pharmacy Services; Memorial Neuroscience Institute; Memorial Rehabilitation Institute; Memorial Outpatient Behavioral Health; U-18 Sports Medicine programs with multiple locations; multiple primary care centers located throughout South Broward County; three Urgent Care Centers; Memorial Cancer Institute, including a partnership with Moffitt Cancer Center; Memorial Cardiac and Vascular Institute; a Graduate Medical Education program on the campus of Memorial Hospital West; Memorial Health Network; Broward Guardian; and Memorial Health Assurance.

Memorial Healthcare System

Mission

The mission of the SBHD is to heal the body, mind and spirit of those they touch.

Vision

The vision of the SBHD is to be a premier clinically integrated delivery system providing access to exceptional patient- and family-centered care, medical education, research and innovation for the benefit of the community we serve.

Prioritizations

The SBHD intends to accomplish their mission and vision through various programs and services, including:

- Cancer
- Cardiology - Adult
- Cardiology - Pediatric
- Labor and Delivery
- Neuroscience
- Rehabilitation

BACKGROUND (CONTINUED)

District Governance

The SBHD was created by Florida Legislature in 1947 and operates pursuant to its Charter, Chapter 2004-397, 2016-258 and Chapter 189 Florida Statues - Uniform Special District Accountability Act. The SBHD maintains a Charter, Chapter 2004-397, 2016-258 that establishes the framework, authority, and responsibilities of the SBHD within the State's legal and administrative structure.

The SBHD shall be governed by a seven-member Board of Commissioners who serve on a voluntary basis. All commissioners must be qualified electors residing in Broward County for more than one year and a qualified subdistrict for 90 days. All subdistricts require one commissioner each to reside within its borders. Each commissioner is appointed for a staggered four-year term with a $5,000.00 surety bond for the faithful performance of his/her duties. Each commissioner may serve until their successors are appointed. A quorum consists of 4 commissioners, with a vote of at least 3 being necessary to conduct business transactions.

According to the Special District Charter, "*the Board of Commissioners is hereby authorized and empowered to establish, construct, operate, and maintain such hospital or hospitals and other health facilities as in their opinion are necessary for the use of the people of the SBHD, and to establish, construct, operate, and maintain such facilities for the care of such persons requiring limited medical care or treatment as in their opinion is necessary for the people of the SBHD*."

In addition to the Board of Commissioners, the SBHD also maintains additional governance structures responsible for oversight of quality and compliance. The following table outlines some of the additional meetings utilized by the SBHD to achieve established goals and objectives.

Leadership Oversight	Composition of Attendees	Frequency
Monthly Operating Review (MOR)	Includes MHS Executive Leadership along with each hospital's Chief Medical and Chief Nursing Officers.	Monthly
Clinical Leadership	Includes Leadership Development Institute (LDI) and Leader Development for Managers (LDM) level clinical leadership at each hospital	Monthly
Department Leaders	Includes Leadership Development Institute (LDI) and Leader Development for Managers (LDM) level leadership at each hospital.	Monthly
CNO Divisional meeting	Includes Directors of Nursing, Quality/Safety, Pharmacy, Respiratory, Education	Monthly

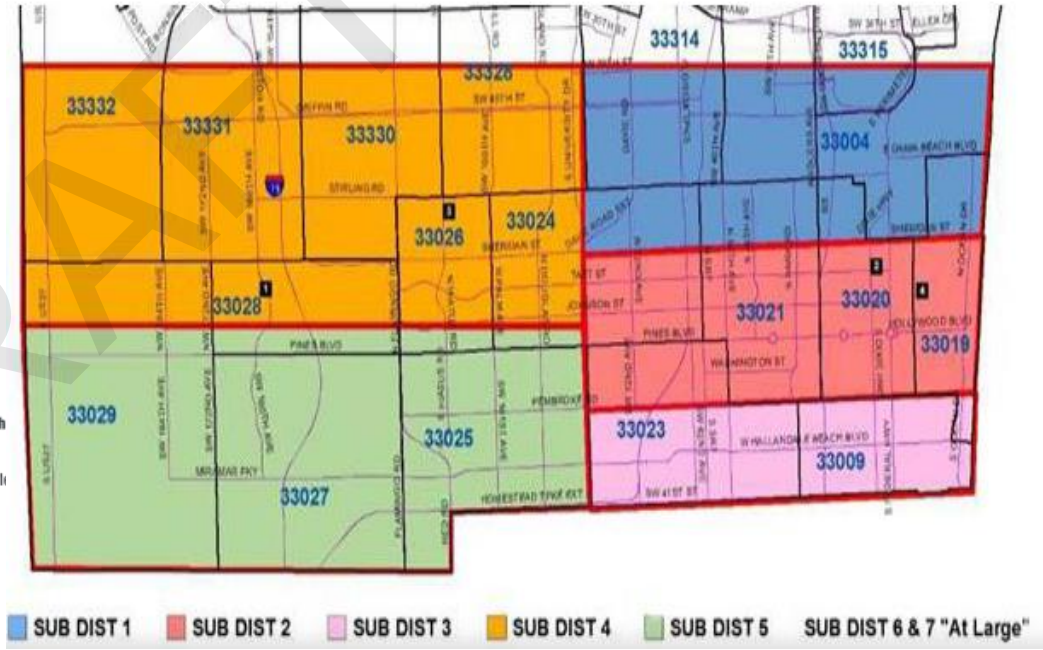
Memorial Healthcare System

BACKGROUND (CONTINUED)

District Governance (Continued)

The SBHD is dedicated to the health of the community and committed to providing high-quality healthcare services in a fiscally responsible manner, with Memorial's market share in South Broward County estimated at around 63%. The illustrations below provide a comprehensive overview of SBHD's service areas, including:

- Defined boundaries and primary service regions
- Geographic locations of key facilities within SBHD
- Population distribution across Memorial Healthcare System's primary and secondary service areas in Broward County



Geographical Area	Population	% of Population	Zip Codes
Broward County Population	1,947,026	100%	--
Broward by Zip Code	1,940,907	99.7%	--
MHS Primary Service Area	747,169	38.0%	17
MHS Secondary Service Area	480,716	25.0%	13
MHS Non-Service Area	713,022	37.0%	23

Source: American Community Surveys, 2022: ZCTA level averages. Density is based on the area of the zip code, which does not exclude water bodies.

BACKGROUND (CONTINUED)

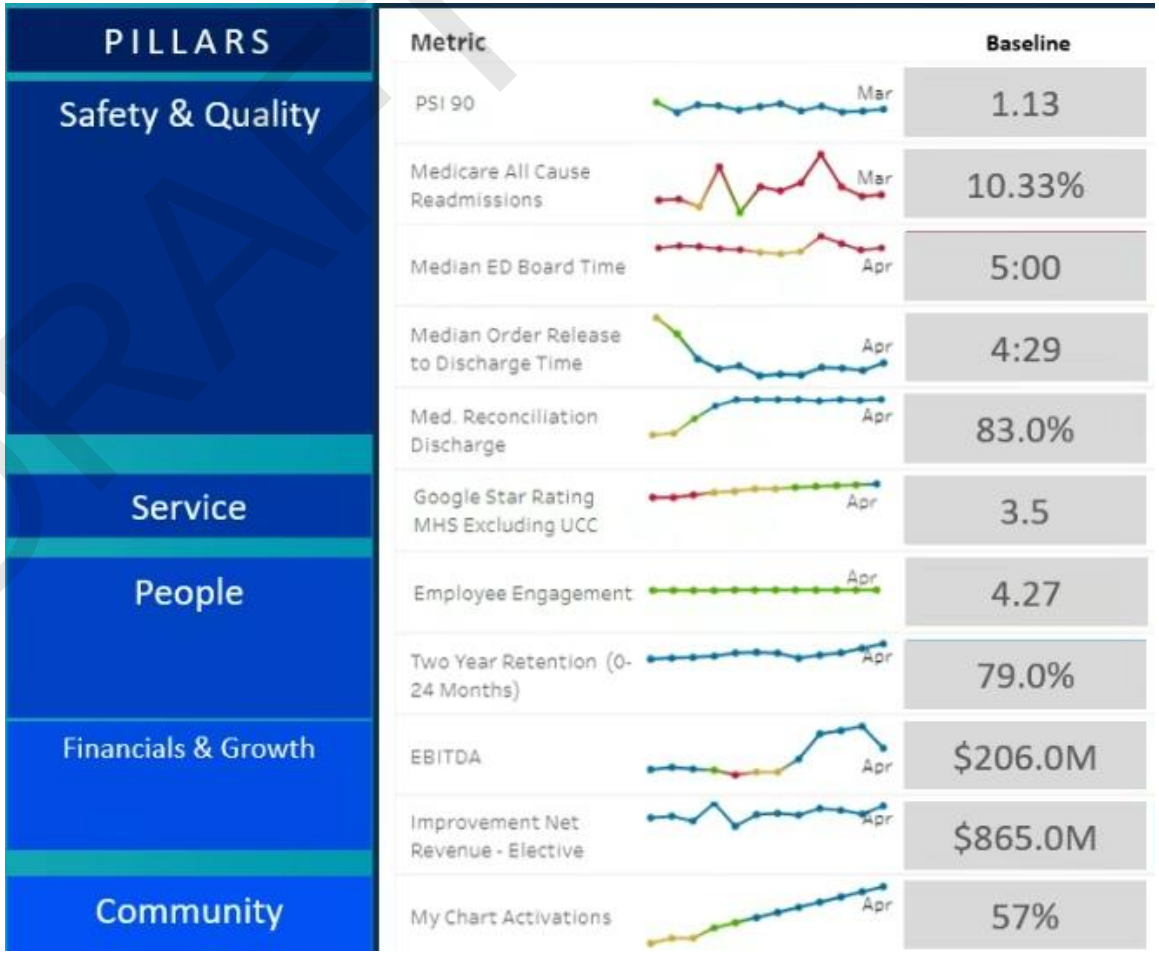
District Governance (Continued)

As part of the SBHD's ongoing monitoring efforts, management conducts a comprehensive review of key performance metrics across the entire healthcare system. This dashboard presents metrics related to Safety and Quality, Service, People, Finance & Growth, and Community, with each category rolling up through the primary programs included in this performance review. The dashboard is shared at the Monthly Operating Review (MOR) which includes attendees from leadership positions across the SBHD. Monthly, the group meets to review the results of these enterprise level goals and metrics. A designated stakeholder is assigned to each performance metric and is responsible for providing updates and insights on their respective metrics during the meeting.

Each metric is monitored against a benchmark provided by EPIC. When EPIC benchmarks are unavailable, the dashboard generates a benchmark based on historical performance. EPIC's data warehouse also enables benchmarking against other EPIC users. The SBHD recognizes the importance of bedside caregivers having access to data, empowering them to drive improvements. Additionally, doctors can compare their performance against EPIC benchmarks. New metrics are continuously identified and tracked, with insights used to actively engage underperforming units and foster improvement.

The illustration to the right provides an example of the dashboard reporting provided during the MOR to evaluate the performance of MHS during the fiscal year 2024. The primary purpose of this dashboard is to serve as a proactive tool for assessing enterprise-level performance, enabling data-driven, strategic decision making across the organization. It fosters a culture of continuous improvement and alignment with organizational objectives.

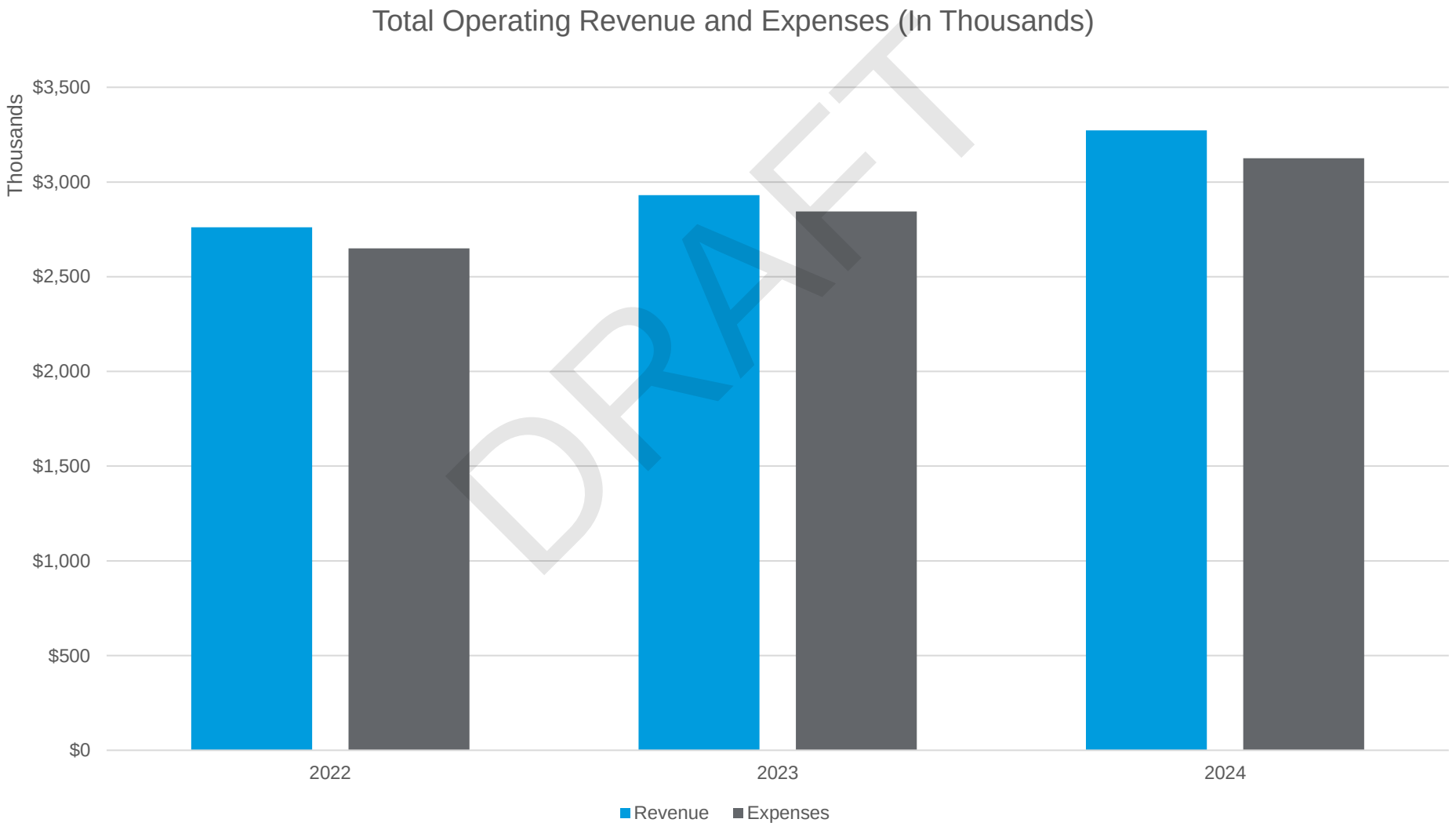
Each year, the SBHD's leadership team evaluates enterprise-level goals and metrics to assess their relevance and effectiveness. This process determines whether new metrics should be added to address emerging priorities or whether existing metrics should be removed from the dashboard due to diminished relevance or utility.



BACKGROUND (CONTINUED)

Financial Performance

The chart below shows MHS's financial performance over the past three fiscal years, highlighting growth in both expenses and revenues. The revenue depicted represents the total operating revenue for the SBHD, which includes net patient service revenue, disproportionate share distributions, and other operating revenues. The expenses are comprised of salaries and wages, employee benefits, professional fees, supplies, purchased services, facilities, depreciation and amortization, as well as other operating expenses.



RESULTS / PERFORMANCE (CONTINUED)

Cancer Institute

Overview

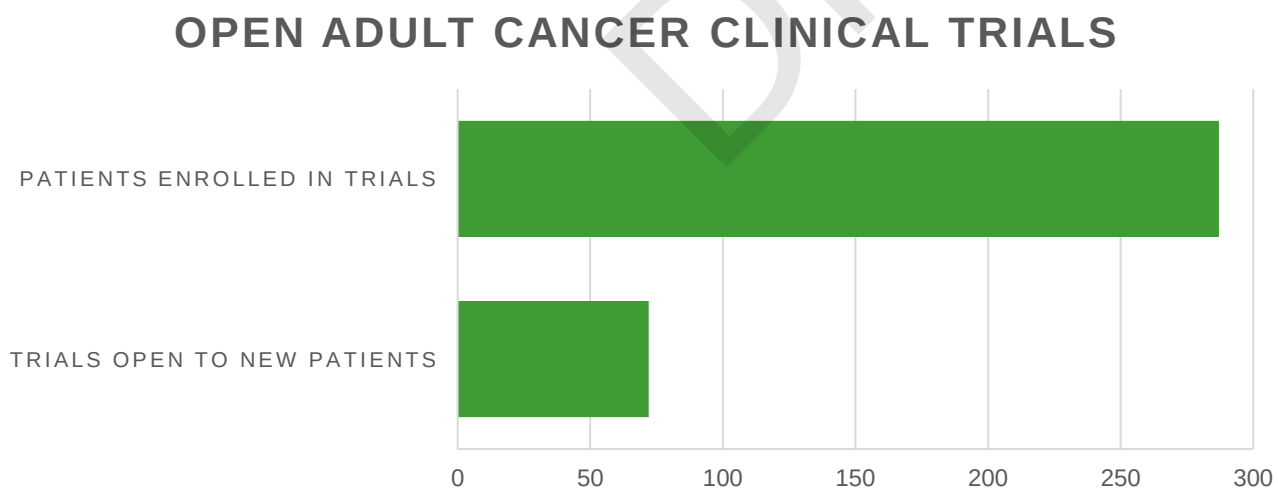
Memorial Cancer Institute is one of the largest cancer centers in Florida, treating nearly 5,000 newly diagnosed patients each year and pioneering advances in patient care. Through a research alliance with Florida Atlantic University, Memorial Cancer Institute is among a select group of Florida-designated "Cancer Centers of Excellence," offering diagnosis, integrated treatment, clinical trials/research, counseling, and support services customized for the patient and their family in a healing environment close to home.

Memorial Cancer Institute recently expanded with a 125,000 square foot center on the campus of Memorial Hospital West in Pembroke Pines that includes disease-specialized oncologists, chemotherapy infusions, a full array of radiation oncology treatments, a dedicated breast center, the Moffitt Malignant Hematology and Cellular Therapy program, the Benign Hematology program, Integrative Medicine and social work, nutrition, and navigation support services. MHS's partnership with Moffitt Cancer Center brings lifesaving expertise and excellence from one of the nation's most respected, world-class cancer centers to South Florida.

Memorial Healthcare System's Cancer Institute is available at the following locations:

- Memorial Cancer Institute at West
- Memorial Cancer Institute East Campus (Hollywood)
- Memorial Cancer Institute at Miramar
- Memorial Cancer Institute in Hallandale Beach

The chart below illustrates the number of open adult cancer clinical trials treated in the period from April 2023 - March 2024.



Memorial Cancer Institute
Conditions Treated

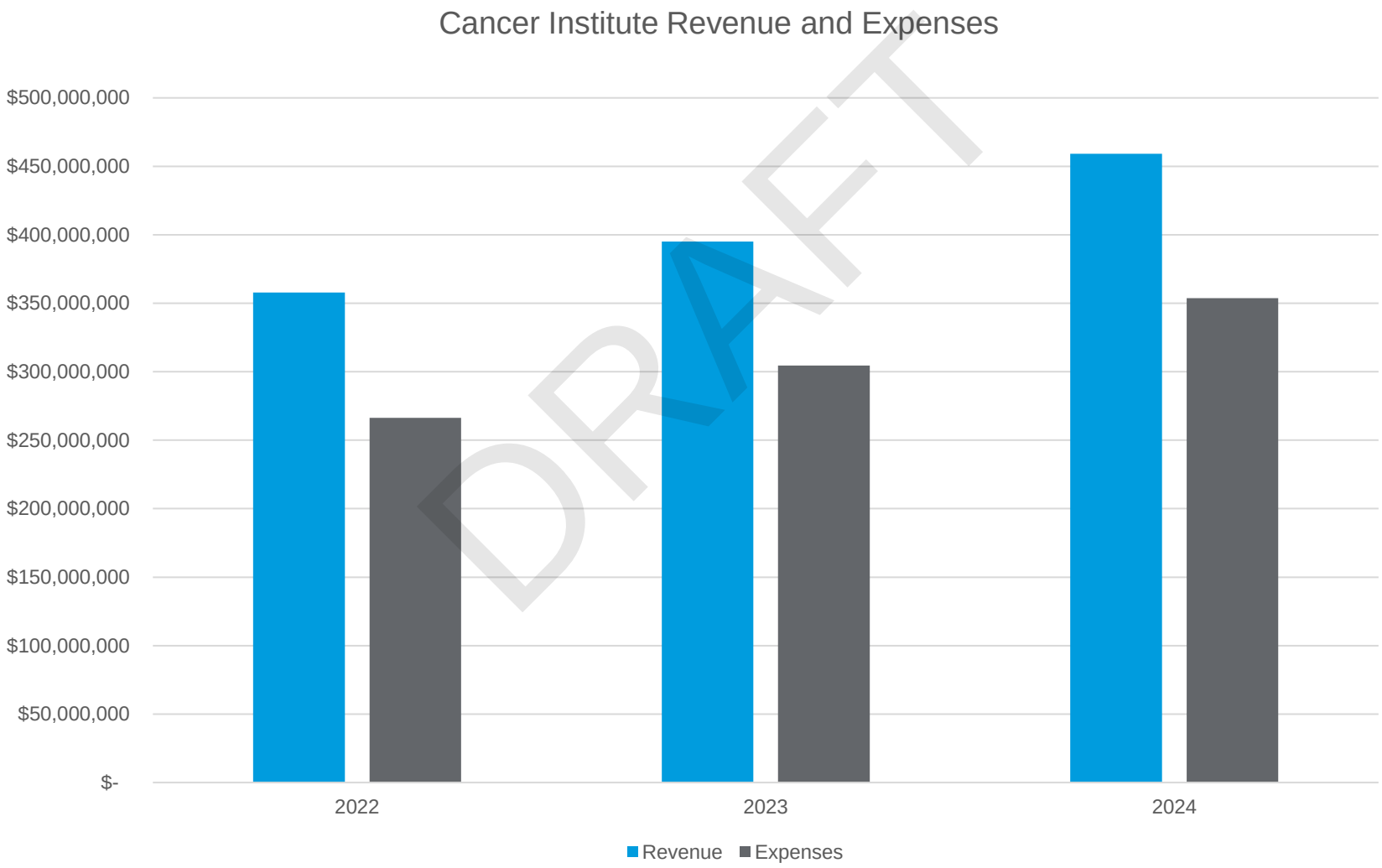
- Anal Cancer
- Appendix Cancer
- Bladder Cancer
- Breast Cancer
- Gallbladder and Bile Duct Cancer
- Colon Cancer
- Duodenal and Small Intestine Cancer
- Esophageal Cancer
- Gastrointestinal Cancer
- Gynecologic Cancer
- Head and Neck Cancer
- Kidney (Renal) Cancer
- Leukemia, Lymphoma and Multiple Myeloma
- Liver Cancer
- Liver Metastases
- Lung Cancer Treatment
- Melanoma
- Pancreatic Cancer
- Penile Cancer
- Peritoneal Surface Malignancy
- Prostate Cancer
- Rectal Cancer Treatment and Support
- Soft Tissue Sarcoma
- Stomach (Gastric) Cancer
- Testicular Cancer
- Thyroid Cancer
- Urologic Cancer

RESULTS / PERFORMANCE (CONTINUED)

Cancer Institute (Continued)

Financial Performance

The chart below illustrates the revenues and expenses for the Cancer Institute at Memorial Healthcare System over the past three fiscal years. According to MHS financial data, the program has seen an increase in overall size, with revenues increasing from over $357 million in 2022 to more than $459 million in 2024.



RESULTS / PERFORMANCE (CONTINUED)

Cancer Institute (Continued)

Established Goals and Objectives

We confirmed that the SBHD has established goals and objectives for this program, defining the expected benefits of the program, and the performance measures and standards used by the SBHD to determine if the program achieves the SBHD's goals and objectives. The following outlines the specific patient satisfaction goals tracked for this prioritization.

Patient Satisfaction

- *Goal 1: Rate Provider: The percentage of adult patients who said they would rate their doctor a 9 or 10 out of 10. This metric reflects patient satisfaction and the quality of care provided at Memorial Healthcare System.*
  - *Benchmark: Florida Average, Press Ganey Oncology Patient Survey Database.*
- *Goal 2: Physician Communication Quality: This goal embodies the percentage of patients who answered "always" to questions about how well the provider explained things clearly, listened attentively, showed respect, and spent enough time with the patient. This metric reflects the quality of patient-provider communication, essential for patient satisfaction, trust, and overall care outcomes.*
  - *Benchmark: Florida Average, Press Ganey Oncology Patient Survey Database.*
- *Goal 3: Office Staff Quality: The percentage of adult patients who answered "always" to questions about how often office staff were helpful and treated them with courtesy and respect. This metric reflects the quality of customer service and the overall patient experience, which are essential for building trust and satisfaction.*
  - *Benchmark: Florida Average, Press Ganey Oncology Patient Survey Database.*
- *Goal 4: Access to Care: The percentage of adult patients who answered "always" to questions about how often office staff were helpful and treated them with courtesy and respect. This metric reflects the quality of customer service and the overall patient experience.*
  - *Benchmark: Florida Average, Press Ganey Oncology Patient Survey Database.*
- *Goal 5: Care Coordination: The percentage of adult patients who answered "always" when asked if their provider followed up on test results, was aware of key details in their medical history, and discussed all prescribed medications. This metric reflects the providers effectiveness in communication and care coordination.*
  - *Benchmark: Florida Average, Press Ganey Oncology Patient Survey Database.*
- *Goal 6: Likelihood to Recommend: The percentage of adult patients who answered "Yes" when asked if they would recommend this provider's office. This metric reflects overall patient satisfaction and trust.*
  - *Benchmark: Florida Average, Press Ganey Oncology Patient Survey Database.*

RESULTS / PERFORMANCE (CONTINUED)

Cancer Institute (Continued)

Performance Measures

Patient Satisfaction

We assessed the achievement of the SBHD's goals and objectives, focusing on whether they are clearly defined, measurable, aligned with the statutory purpose of the Special District, and provide sufficient guidance for its programs and activities. Our evaluation confirmed that the SBHD systematically tracks and monitors patient satisfaction metrics specific to the Cancer Institute.

For transparency, the SBHD publishes detailed illustrations on its website that showcase progress toward established benchmarks for patient satisfaction metrics specific to the Cancer Institute performance. Using data from the review period, we verified that these goals are well-articulated, and performance is actively monitored. The six (6) patient satisfaction metrics are benchmarked against the Press Ganey Oncology Patient Survey Database over the period of January 2023 – March 2024, and are made available to the public to foster accountability and engagement. Any deviations from established benchmarks are reviewed and discussed as a leadership team during the MOR meeting, to further foster accountability and enhance performance.

Additionally, Cancer Institute goals are displayed on a monthly dashboard presented at the MOR meeting, which includes data for the current month, a rolling 3-month period, a rolling 12-month period, and a 13-month trend. The metrics are color-coded based on the percentile in which the data falls.

RESULTS / PERFORMANCE (CONTINUED)

Cardiology (Adult)

Overview

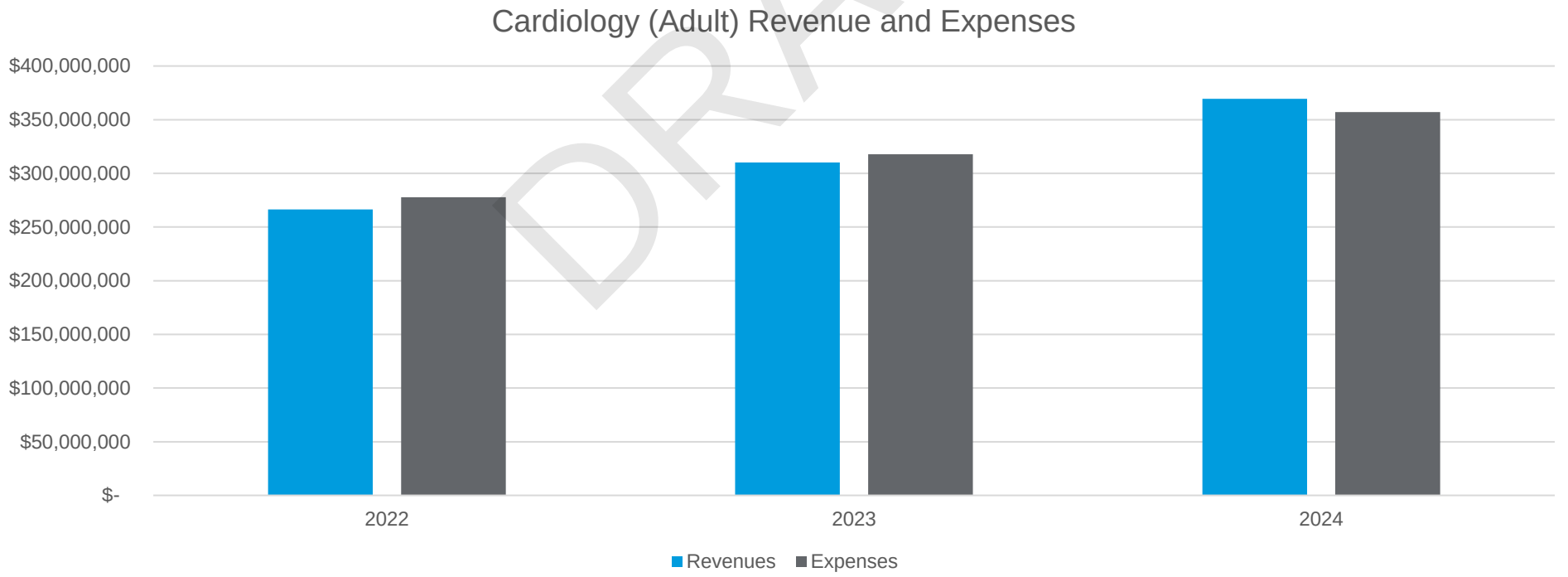
The SBHD offers comprehensive cardiological care for adult patients through the offices of physicians affiliated with the Memorial Cardiac & Vascular Institute. Memorial Healthcare System's Adult Cardiology Program operates from the Memorial Cardiac & Vascular Institute, where patients receive advanced treatment for a wide range of cardiac needs. Services provided include Diagnostic Cardiac Catheterization, Percutaneous Coronary Intervention, Coronary Artery Bypass Surgery, Trans-Catheter Aortic Valve Replacement (TAVR), combined Coronary Artery Bypass and Aortic Valve Replacement procedures, standalone Aortic Valve Replacement, Ventricular Assist Device (VAD) implantation, and Heart Transplantation procedures. These specialized treatments underscore the Institute's commitment to delivering high-quality, patient-centered cardiac care.

Memorial Healthcare System's Cardiology (Adult) program has the following locations:

- Memorial Cardiac & Vascular Institute (Memorial Regional Hospital and Memorial Hospital West)

Financial Performance

The chart below illustrates the revenues and expenses for the Memorial Cardiac & Vascular Institute (Adult) over the past three fiscal years. According to the financial data, the program has seen growth, with revenues increasing from over $266 million in 2022 to more than $369 million in 2024.



RESULTS / PERFORMANCE (CONTINUED)

Cardiology (Adult) (Continued)

Established Goals and Objectives

We confirmed that the SBHD has established goals and objectives for this program, defining the expected benefits of the program, and the performance measures and standards used by the SBHD to determine if the program achieves the SBHD's goals and objectives. The following outlines the specific patient satisfaction goals tracked for this prioritization.

Patient Satisfaction

- *Goal 1: Rate Provider The percentage of adult patients who said they would rate their doctor a 9 or 10 out of 10. This metric reflects patient satisfaction and the quality of care provided at Memorial Healthcare System.*
  - *Benchmark: Florida Average, Press Ganey Cardiology Patient Survey Database.*
- *Goal 2: Physician Communication Quality. This goal embodies the percentage of patients who answered "always" to questions about how well the provider explained things clearly, listened attentively, showed respect, and spent enough time with the patient. This metric reflects the quality of patient-provider communication, essential for patient satisfaction, trust, and overall care outcomes.*
  - *Benchmark: Florida Average, Press Ganey Cardiology Patient Survey Database.*
- *Goal 3: Office Staff Quality. The percentage of adult patients who answered "always" to questions about how often office staff were helpful and treated them with courtesy and respect. This metric reflects the quality of customer service and the overall patient experience, which are essential for building trust and satisfaction.*
  - *Benchmark: Florida Average, Press Ganey Cardiology Patient Survey Database.*
- *Goal 4: Access to Care. The percentage of adult patients who answered "always" to questions about how often office staff were helpful and treated them with courtesy and respect. This metric reflects the quality of customer service and the overall patient experience.*
  - *Benchmark: Florida Average, Press Ganey Cardiology Patient Survey Database.*
- *Goal 5: Care Coordination. The percentage of adult patients who answered "always" when asked if their provider followed up on test results, was aware of key details in their medical history, and discussed all prescribed medications. This metric reflects the providers effectiveness in communication and care coordination.*
  - *Benchmark: Florida Average, Press Ganey Cardiology Patient Survey Database.*
- *Goal 6: Likelihood to Recommend. The percentage of adult patients who answered "Yes" when asked if they would recommend this provider's office. This metric reflects overall patient satisfaction and trust.*
  - *Benchmark: Florida Average, Press Ganey Cardiology Patient Survey Database.*

RESULTS / PERFORMANCE (CONTINUED)

Cardiology (Adult) (Continued)

Established Goals and Objectives (Continued)

Quality and Safety

The following outlines the specific quality and safety goals tracked for this prioritization.

- *Goal 7: Coronary Artery Bypass Mortality: The percentage of patients, 18 years and older, whose death occurs within 30 days of the surgery. If the death occurs past the 30 days but the patient has not yet been discharged, it is counted as well.*
  - *Benchmark: Society for Thoracic Surgery Like Hospitals National Average.*
- *Goal 8: Aortic Valve Replacement Mortality: The percentage of patients, 18 years and older, whose death occurs within 30 days of the surgery. If the death occurs past the 30 days but the patient has not yet been discharged, it is counted as well.*
  - *Benchmark: Society for Thoracic Surgery Like Hospitals National Average.*
- *Goal 9: Coronary Artery Bypass Mortality/Aortic Valve Replacement Mortality: The percentage of patients, 18 years and older, whose death occurs within 30 days of the combined surgery. If the death occurs past the 30 days but the patient has not yet been discharged, it is counted as well.*
  - *Benchmark: Society for Thoracic Surgery Like Hospitals National Average.*
- *Goal 10: Door to Balloon Time: The percentage of patients with a particular type of heart attack (STEMI) whose blocked coronary artery is opened within 90 minutes of arriving in the Emergency Department. The procedure to open the artery is called a Percutaneous Coronary Intervention (PCI). The goal is to maximize the percentage of patients who have the procedure done in less than 90 minutes.*
  - *Benchmark: American College of Cardiology National Average.*
- *Goal 11: Infections in Association with Surgery: The percentage of patients 18 years and older undergoing a Heart Bypass (also known as a Coronary Artery Bypass Graft or CABG) who, within 30 days after surgery, develop a "deep sternal wound infection", which is an infection in association with the surgical wound that involves muscle, bone and/or the mediastinum (the cavity within the chest containing the heart, the heart vessels, the esophagus, the trachea, the cardiac nerve and the lymph nodes).*
  - *Benchmark: Society for Thoracic Surgery Like Hospitals National Average.*
- *Goal 12: Coronary Artery Bypass Surgery Patients Readmissions within 30 Days: The percentage of adult patients who have undergone Coronary Artery Bypass Surgery and are readmitted to the hospital, for any reason, within 30 days of discharge from the hospital.*
  - *Benchmark: Society for Thoracic Surgery Like Hospital National Average.*

RESULTS / PERFORMANCE (CONTINUED)

Cardiology (Adult) (Continued)

Performance Measures

Patient Satisfaction and Quality and Safety

We assessed the achievement of the SBHD's goals and objectives, focusing on whether they are clearly defined, measurable, aligned with the statutory purpose of the SBHD, and provide sufficient guidance for its programs and activities. Our evaluation confirmed that the SBHD systematically tracks and monitors both patient satisfaction and quality and safety metrics specific to Cardiology (Adult).

For transparency, the SBHD publishes detailed illustrations on its website that showcase progress toward established benchmarks for patient satisfaction and quality and safety metrics specific to the Cardiology (Adult) performance. Using data from the review period, we verified that these goals are well-articulated, and performance is actively monitored. The six (6) patient satisfaction metrics are benchmarked against the Press Ganey Cardiology Patient Survey Database over the period of January 2023 – March 2024, and are made available to the public to foster accountability and engagement. Additionally, the six (6) quality and safety metrics are benchmarked against the Society for Thoracic Surgery Like Hospitals and the American College of Cardiology. Any deviations from established benchmarks are reviewed and discussed as a leadership team during the MOR meeting, to further foster accountability.

Additionally, Cardiology (Adult) Institute goals are displayed on a monthly dashboard presented at the MOR meeting, which includes data for the current month, a rolling 3-month period, a rolling 12-month period, and a 13-month trend. The metrics are color-coded based on the percentile in which the data falls.

RESULTS / PERFORMANCE (CONTINUED)

Cardiology (Pediatric)

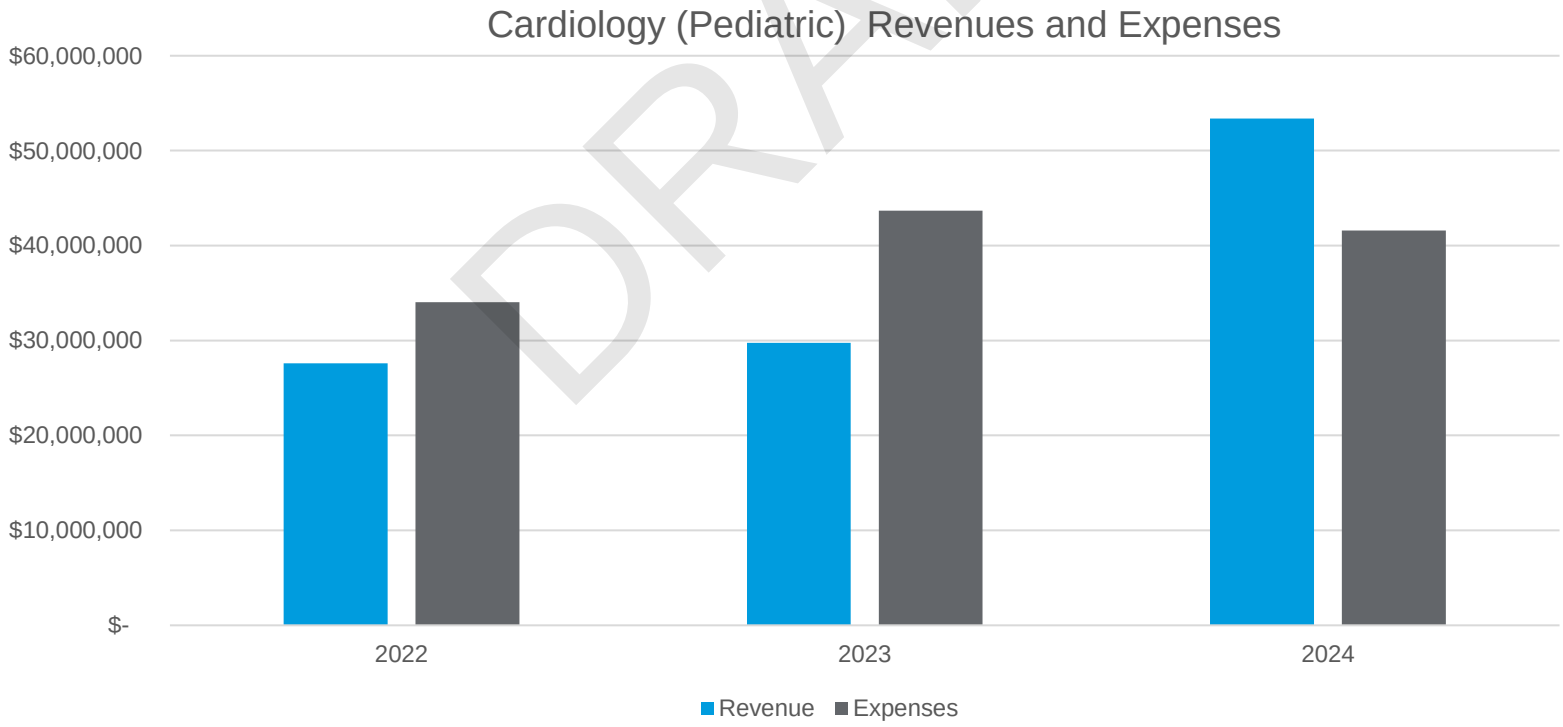
Overview

Memorial Healthcare System's Pediatric Cardiology Program is located within the Joe DiMaggio Children's Hospital Heart Institute, the dedicated pediatric unit of Joe DiMaggio Children's Hospital. The Heart Institute provides a comprehensive range of interventional cardiovascular care, specializing in the diagnosis and treatment of congenital heart conditions, including advanced procedures such as heart transplantation.

Pediatric cardiac services encompass general cardiology, congenital heart surgery, heart transplant, electrophysiology, pediatric heart imaging, management of heart failure in children, and treatment of congenital heart disease. The SBHD's multidisciplinary team comprises leading experts in congenital heart disease, cardiac surgery, heart failure, electrophysiology, cardiac catheterization, heart imaging, anesthesia, and intensive care, ensuring specialized and coordinated care for every patient.

Financial Performance

The chart below illustrates the revenues and expenses for the Memorial Cardiac & Vascular Institute (Pediatric) over the past three fiscal years. According to the financial data, the program has seen growth, with revenues increasing from over $27 million in 2022 to more than $53 million in 2024.



RESULTS / PERFORMANCE (CONTINUED)

Cardiology (Pediatric) (Continued)

Established Goals and Objectives

We confirmed that the SBHD has established goals and objectives for this program, defining the expected benefits of the program, and the performance measures and standards used by the SBHD to determine if the program achieves the SBHD's goals and objectives. The following outlines the specific patient satisfaction and quality and safety goals tracked for this prioritization.

Patient Satisfaction

- *Goal 1: Rate Provider The percentage of adult patients who said they would rate their doctor a 9 or 10 out of 10. This metric reflects patient satisfaction and the quality of care provided at Memorial Healthcare System.*
  - *Benchmark: Florida Average, Press Ganey Cardiology Patient Survey Database.*
- *Goal 2: Physician Communication Quality. This goal embodies the percentage of patients who answered "always" to questions about how well the provider explained things clearly, listened attentively, showed respect, and spent enough time with the patient. This metric reflects the quality of patient-provider communication, essential for patient satisfaction, trust, and overall care outcomes.*
  - *Benchmark: Florida Average, Press Ganey Cardiology Patient Survey Database.*
- *Goal 3: Office Staff Quality. The percentage of adult patients who answered "always" to questions about how often office staff were helpful and treated them with courtesy and respect. This metric reflects the quality of customer service and the overall patient experience, which are essential for building trust and satisfaction.*
  - *Benchmark: Florida Average, Press Ganey Cardiology Patient Survey Database.*
- *Goal 4: Access to Care. The percentage of adult patients who answered "always" to questions about how often office staff were helpful and treated them with courtesy and respect. This metric reflects the quality of customer service and the overall patient experience.*
  - *Benchmark: Florida Average, Press Ganey Cardiology Patient Survey Database.*
- *Goal 5: Care Coordination. The percentage of adult patients who answered "always" when asked if their provider followed up on test results, was aware of key details in their medical history, and discussed all prescribed medications. This metric reflects the providers effectiveness in communication and care coordination.*
  - *Benchmark: Florida Average, Press Ganey Cardiology Patient Survey Database.*
- *Goal 6: Likelihood to Recommend. The percentage of adult patients who answered "Yes" when asked if they would recommend this provider's office. This metric reflects overall patient satisfaction and trust.*
  - *Benchmark: Florida Average, Press Ganey Cardiology Patient Survey Database.*

Quality and Safety

- *Goal 7: Congenital Heart Surgery Mortalities: The percentage of pediatric patients undergoing congenital heart surgery whose death may be associated with the surgery. The measure includes deaths, regardless of cause, occurring within 30 days after surgery in or out of the hospital (including patients transferred to other healthcare facilities), and deaths occurring within 30 days after discharge from the hospital.*
  - *Benchmark: Society for Thoracic Surgery Participating Hospitals*

RESULTS / PERFORMANCE (CONTINUED)

Cardiology (Pediatric) (Continued)

Performance Measures

Patient Satisfaction and Quality and Safety

We assessed the achievement of the SBHD's goals and objectives, focusing on whether they are clearly defined, measurable, aligned with the statutory purpose of the SBHD, and provide sufficient guidance for its programs and activities. Our evaluation confirmed that the SBHD systematically tracks and monitors both patient satisfaction and quality and safety metrics specific to Cardiology (Pediatric).

For transparency, the SBHD publishes detailed illustrations on its website that showcase progress toward established benchmarks for patient satisfaction and quality and safety metrics specific to the Cardiology (Pediatric) performance. Using data from the review period, we verified that these goals are well-articulated, and performance is actively monitored. The six (6) patient satisfaction metrics are benchmarked against the Press Ganey Cardiology Patient Survey Database over the period of January 2023 – March 2024, and are made available to the public to foster accountability and engagement. Additionally, the one (1) quality and safety metric is benchmarked against the Society for Thoracic Surgery Like Hospitals. Any deviations from established benchmarks are reviewed and discussed as a leadership team during the MOR meeting, to further foster accountability.

Additionally, Cardiology (Pediatric) Institute goals are displayed on a monthly dashboard presented at the MOR meeting, which includes data for the current month, a rolling 3-month period, a rolling 12-month period, and a 13-month trend. The metrics are color-coded based on the percentile in which the data falls.

RESULTS / PERFORMANCE (CONTINUED)

Labor and Delivery (The Family Birthplace)

Overview

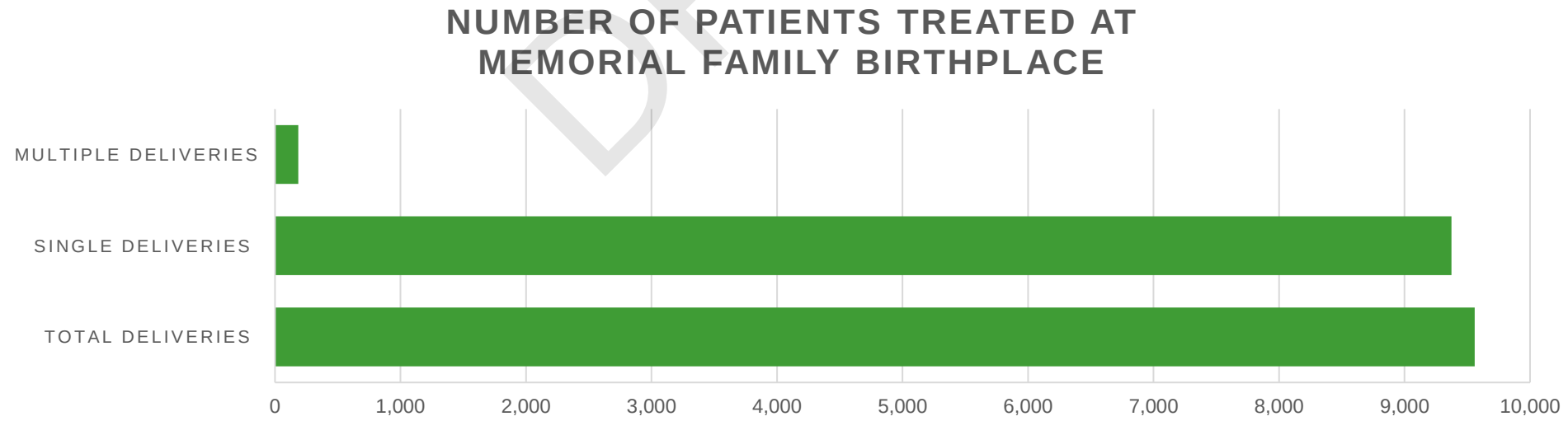
The Memorial Family Birthplace offers comprehensive care for expectant mothers, including labor and delivery services, online maternity classes, breastfeeding and lactation support, and high-quality maternity care. With three locations—Memorial Regional Hospital Family Birthplace, Memorial Hospital West Family Birthplace, and Memorial Hospital Miramar Family Birthplace—the Memorial Family Birthplace provides accessible, premier maternity services throughout the county. These facilities provide a full spectrum of childbirth education, labor and delivery care, and postpartum support to meet the diverse needs of families.

The Joe DiMaggio Children's Hospital offers three NICU locations; Wasie NICU at Joe DiMaggio Children's Hospital, Memorial Hospital Miramar NICU, and Memorial Hospital West NICU. The Wasie NICU is a nationally-recognized Level IV facility for critically ill newborns that require the highest level of complex medical and surgical care. This NICU is the largest in Broward County and one of eleven Regional Perinatal Intensive Care Centers (RPICC) in Florida. The team is committed to providing specialized care to high-risk pregnancies and 24/7 neonatal intensive care services to critically ill and low birth weight newborns. The Joe DiMaggio Children's Hospital at Memorial Hospital Miramar and Memorial Hospital West locations provide comprehensive Level III NICU services for babies who arrive prematurely or need extra medical attention following delivery and can seamlessly transfer babies to the main campus Level IV Wasie NICU if they require a higher level of care or subspeciality evaluation.

Memorial Healthcare System's Labor and Deliver is available at the following locations:

- Memorial Regional Hospital Family Birthplace
- Memorial Hospital West Family Birthplace
- Memorial Hospital Miramar Family Birthplace

The chart below illustrates the number of patients treated at Memorial Family Birthplace in the period from April 2023 - March 2024.

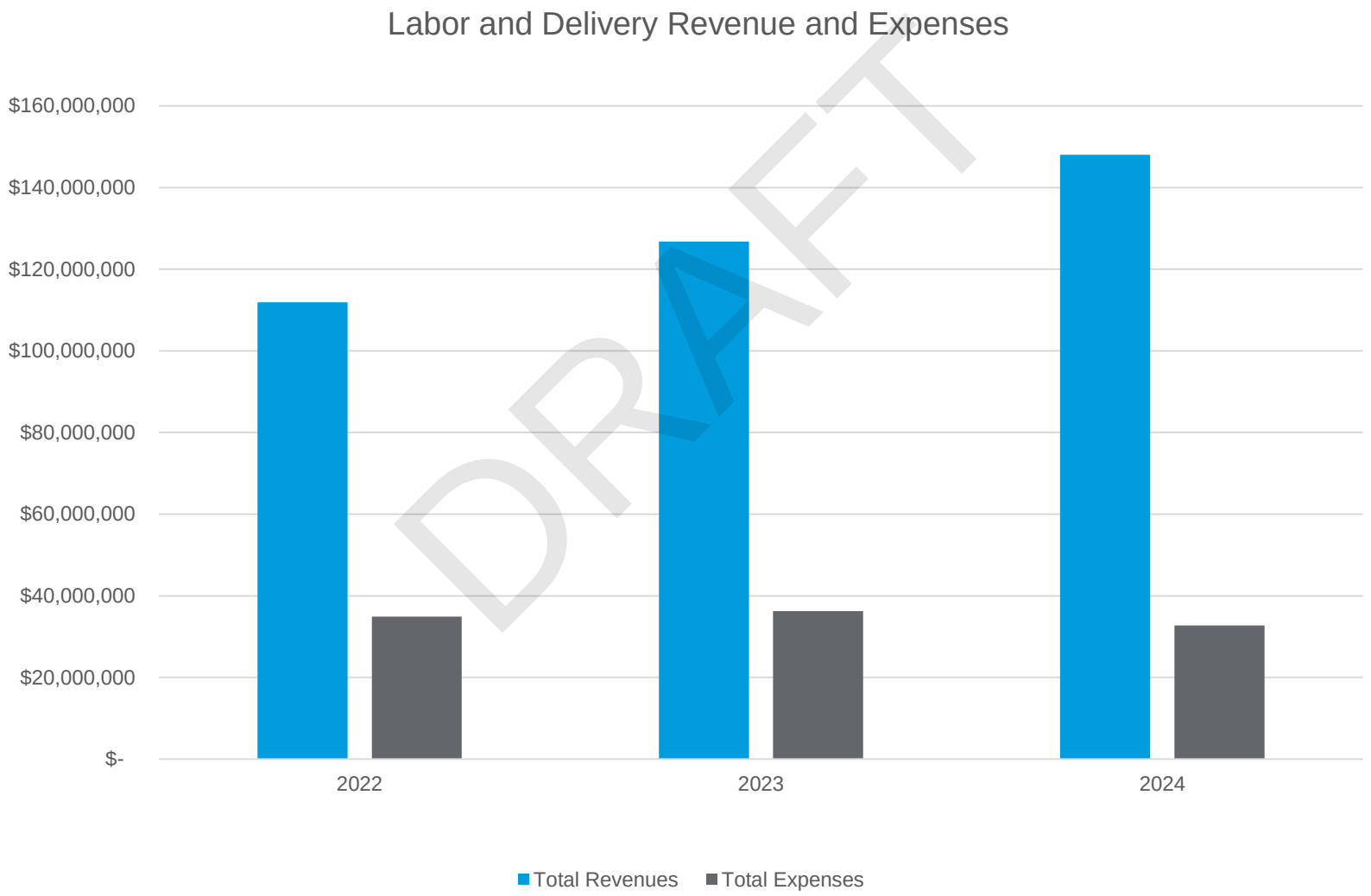


RESULTS / PERFORMANCE (CONTINUED)

Labor and Delivery (The Family Birthplace) (Continued)

Financial Performance

The chart below provides an overview of the combined revenues and expenses for Labor and Delivery services across three hospitals—Memorial Regional Hospital, Memorial Hospital West, and Memorial Hospital Miramar—over the past three fiscal years. According to the financial data, the program has seen growth, with revenues increasing from over $111 million in Fiscal Year 2022 to more than $148 million in Fiscal Year 2024.



RESULTS / PERFORMANCE (CONTINUED)

Labor and Delivery (The Family Birthplace) (Continued)

Established Goals and Objectives

We confirmed that the SBHD has established goals and objectives for this program, defining the expected benefits of the program, and the performance measures and standards used by the SBHD to determine if the program achieves the SBHD's goals and objectives. The following outlines the specific patient satisfaction goals tracked for this prioritization.

Patient Satisfaction

- *Goal 1: Rate Hospital: The percentage of patients who answered that they would rate the hospital a 9 or 10.*
  - *Benchmark: Hospital Compare*
- *Goal 2: Recommend Hospital: The percentage of patients who answered "Yes" when asked if they definitely would recommend the hospital.*
  - *Benchmark: Hospital Compare*
- *Goal 3: Communication with Nurses: The percentage of patients who answered "always" when asked if their nurses communicated well.*
  - *Benchmark: Hospital Compare*
- *Goal 4: Communication with Doctors: The percentage of patients who answered "always" when asked if their doctors communicated well.*
  - *Benchmark: Hospital Compare*
- *Goal 5: Quick Response from Hospital Staff: The percentage of patients who answered "always" when asked if they received help as soon as they wanted it.*
  - *Benchmark: Hospital Compare*
- *Goal 6: Communication Regarding Medication: The percentage of patients who answered "always" when asked if the staff explained about medicines before administering them to patients.*
  - *Benchmark: Hospital Compare*
- *Goal 7: Room/Bathroom Cleanliness: The percentage of patients who answered "always" when asked if their rooms and bathrooms were kept clean.*
  - *Benchmark: Hospital Compare*
- *Goal 8: Room Quiet at Night: The percentage of patients who answered "always" when asked if their areas were quiet at night.*
  - *Benchmark: Hospital Compare*
- *Goal 9: Information about Home Recovery: The percentage of patients who answered "yes" when asked if they received information about what to do during their recovery at home.*
  - *Benchmark: Hospital Compare*
- *Goal 10: Care Transitions: The percentage of patients who answered "strongly agree" when asked if they understood their care when they left the hospital.*
  - *Benchmark: Hospital Compare*

RESULTS / PERFORMANCE (CONTINUED)

Labor and Delivery (The Family Birthplace) (Continued)

Established Goals and Objectives (Continued)

Quality and Safety Data

The following outlines the specific quality and safety goals tracked for this prioritization.

- *Goal 11: Patients Who Breastfeed: The percentage of mothers feeding their baby exclusively with breast milk.*
  - *Benchmark: Joint Commission*
- *Goal 12: Patients with Primary Caesarean Sections (C-Sections): The percentage of primary (first-time) C-sections performed.*
  - *Benchmark: Florida Hospital Association*
- *Goal 13: Patients with Early Elective Deliveries: The percentage of elective deliveries performed.*
  - *Benchmark: Hospital Compare*
- *Goal 14: Patients with Episiotomy: The percentage of deliveries where an episiotomy is performed.*
  - *Benchmark: National Perinatal Information*

RESULTS / PERFORMANCE (CONTINUED)

Labor and Delivery (The Family Birthplace) (Continued)

Performance Measures

Patient Satisfaction and Quality and Safety

We assessed the achievement of the SBHD's goals and objectives, focusing on whether they are clearly defined, measurable, aligned with the statutory purpose of the SBHD, and provide sufficient guidance for its programs and activities. Our evaluation confirmed that the SBHD systematically tracks and monitors both patient satisfaction and quality and safety metrics specific to Labor and Delivery.

For transparency, the SBHD publishes detailed illustrations on its website that showcase progress toward established benchmarks for patient satisfaction and quality and safety metrics specific to the Labor and Delivery performance. Using data from the review period, we verified that these goals are well-articulated, and performance is actively monitored. The ten (10) patient satisfaction metrics are benchmarked against the Hospital Compare over the period of January 2023 - December 2023, and are made available to the public to foster accountability and engagement. Additionally, the four (4) Quality and Safety metrics are benchmarked against the Joint Commission, Florida Hospital Association, Hospital Compare, and National Perinatal Information Center. Any deviations from established benchmarks are reviewed and discussed as a leadership team during the MOR meeting, to further foster accountability.

RESULTS / PERFORMANCE (CONTINUED)

Neuroscience

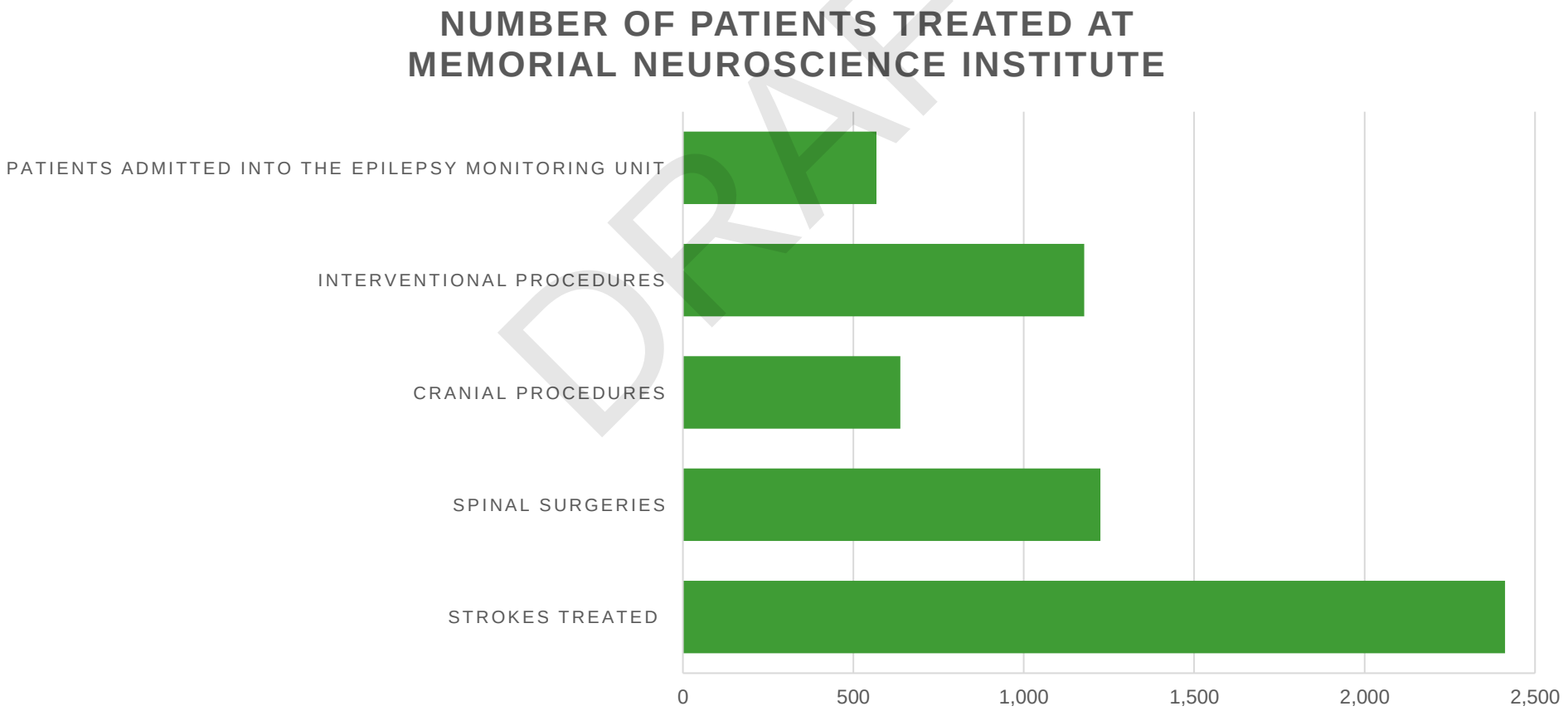
Overview

The SBHD provides advanced diagnostic capabilities, comprehensive treatments, and compassionate care for individuals with complex neurological conditions. Its Neuroscience Program offers specialized services in Neurology, Neurosurgery, Neurointerventional Surgery, Surgical Neuro-Oncology, and treatment for conditions such as Alzheimer's disease, dementia, memory loss, back and neck pain, brain aneurysms, headaches and migraines, epilepsy, multiple sclerosis (MS), and stroke.

Memorial Healthcare System's Neuroscience Program operates at multiple locations, ensuring accessible, expert care throughout the region:

- Neurology services are available at Memorial Regional Hospital, Memorial Hospital West, and throughout the community

These locations are equipped to deliver patient-centered care using the latest advancements in neuroscience to improve outcomes and enhance quality of life. The chart below illustrates the number of patients treated at Memorial Neuroscience Institute in the period from April 2023 - March 2024.

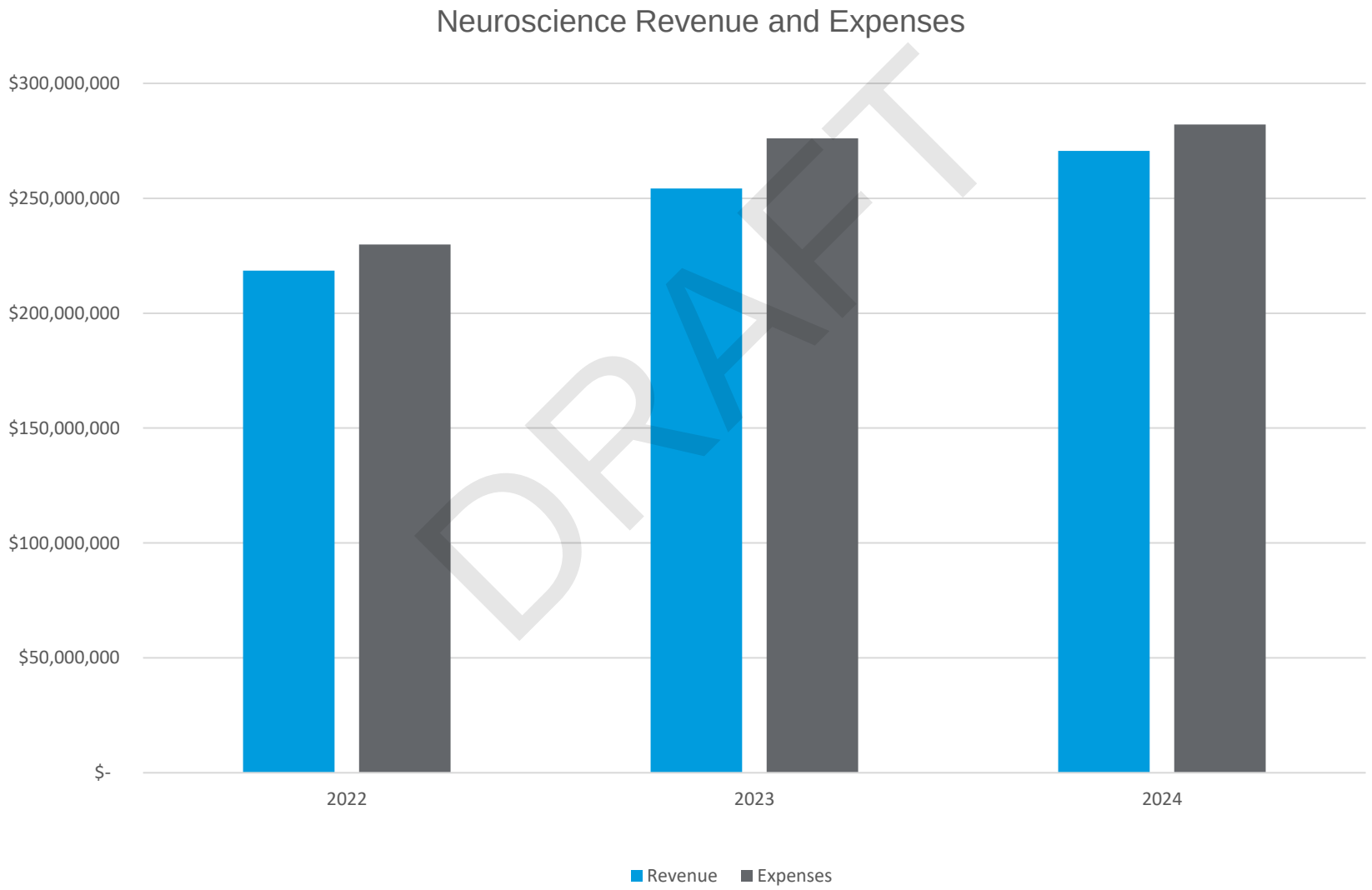


RESULTS / PERFORMANCE (CONTINUED)

Neuroscience (Continued)

Financial Performance

The chart below illustrates the revenues and expenses for Neuroscience over the past three fiscal years. According to the financial data, the program has seen growth, with revenues increasing from over $218 million in 2022 to more than $270 million in 2024.



RESULTS / PERFORMANCE (CONTINUED)

Neuroscience (Continued)

Established Goals and Objectives

We confirmed that the SBHD has established goals and objectives for this program, defining the expected benefits of the program, and the performance measures and standards used by the SBHD to determine if the program achieves the SBHD's goals and objectives. The following outlines the quality and safety goals tracked for this prioritization.

Quality and Safety

- *Goal 1: tPA within 45 Minutes: The percentage of adult patients experiencing certain types of strokes who are administered tPA (a drug that helps reduce blockage within a blood vessel) within 45 minutes of arrival at the emergency department. The goal is to maximize the percentage of patients receiving tPA within 45 minutes of arrival at the emergency department.*
  - *Benchmark: American Stroke Association, Get With The Guidelines, Florida*
- *Goal 2: Median Time (Minutes) to tPA: The median time (in minutes) of arrival at the emergency department to time tPA (a drug that helps reduce blockage within a blood vessel) is administered.*
  - *Benchmark: Florida Hospital Stroke Centers*
- *Goal 3: Stroke Mortality Rate: The percentage of stroke patients whose death occurs within 30 days of admission to the hospital. If the death occurs past the 30 days but the patient has not yet been discharged, it is counted as well.*
  - *Benchmark: Crimson Cohort Expected for Stroke Mortality*
- *Goal 4: Door to Reperfusion within 120 Minutes: The percentage of patients whose clot was removed and their blood flow was returned to the injured area of the brain.*
  - *Benchmark: Florida Hospital Stroke Centers*

RESULTS / PERFORMANCE (CONTINUED)

Neuroscience (Continued)

Performance Measures

Quality and Safety

We assessed the achievement of the SBHD's goals and objectives, focusing on whether they are clearly defined, measurable, aligned with the statutory purpose of the SBHD, and provide sufficient guidance for its programs and activities. Our evaluation confirmed that the SBHD systematically tracks and monitors quality and safety metrics specific to Neuroscience.

For transparency, the SBHD publishes detailed illustrations on its website that showcase progress toward established benchmarks for quality and safety metrics specific to the Neuroscience performance. Using data from the review period, we verified that these goals are well-articulated, and performance is actively monitored. The four (4) quality and safety metrics are benchmarked against the American Stroke Association, Get With The Guidelines, Florida, Florida Hospital Stroke Centers, Crimson Cohort Expected for Stroke Mortality, and Florida Hospital Stroke Centers over the period of April 2023 – March 2024, and are made available to the public to foster accountability and engagement. Any deviations from established benchmarks are reviewed and discussed as a leadership team during the MOR meeting.

Additionally, Neuroscience goals are displayed on a monthly dashboard presented at the MOR meeting, which includes data for the current month, a rolling 3-month period, a rolling 12-month period, and a 13-month trend. The metrics are color-coded based on the percentile in which the data falls.

RESULTS / PERFORMANCE (CONTINUED)

Rehabilitation

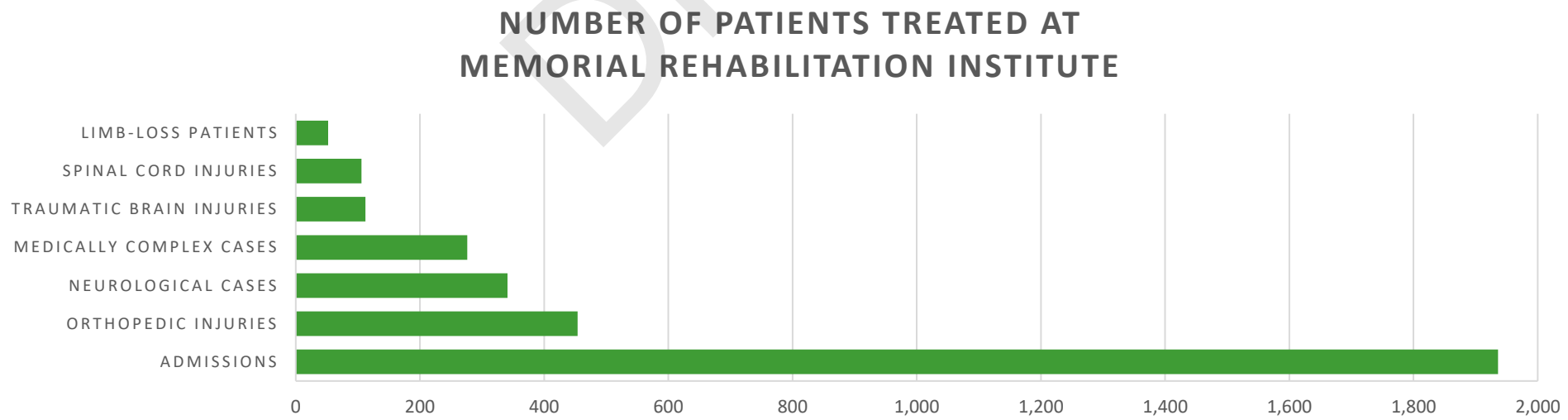
Overview

The rehabilitation program provides comprehensive care for a wide range of physical and neurological conditions, offering flexible treatment options that include inpatient, outpatient, and home health rehabilitation services. With a patient and family-centered approach, the program emphasizes personalized care and active family involvement. Advanced technology is utilized to enhance recovery, and short-term skilled nursing services are available at Memorial Manor for patients requiring transitional care. Additional services include driving assessments for safety and providing tailored recommendations, as well as specialized pediatric rehabilitation at Joe DiMaggio Children's Hospital. Notably, the Memorial Rehabilitation Institute at Memorial Regional Hospital South has been named among U.S. News & World Report's 2024–2025 Best Hospitals for Rehabilitation, a recognition that highlights its commitment to quality care, exceptional clinical outcomes, skilled nursing, and positive patient experiences.

Memorial Healthcare System's Rehabilitation program is available at the following locations:

- Inpatient Rehabilitation
  - Memorial Regional Hospital South
- Outpatient Rehabilitation
  - Memorial Regional Hospital South
  - Memorial Hospital West
  - Memorial Hospital Miramar
  - Memorial Orthopaedic Surgery and Sports Medicine Center
  - Joe DiMaggio Children's Hospital Rehabilitation Center
  - Joe DiMaggio Children's Health Specialty Center

The chart below illustrates the number of patients treated at Memorial Rehabilitation Institute in the period from April 2023 - March 2024.

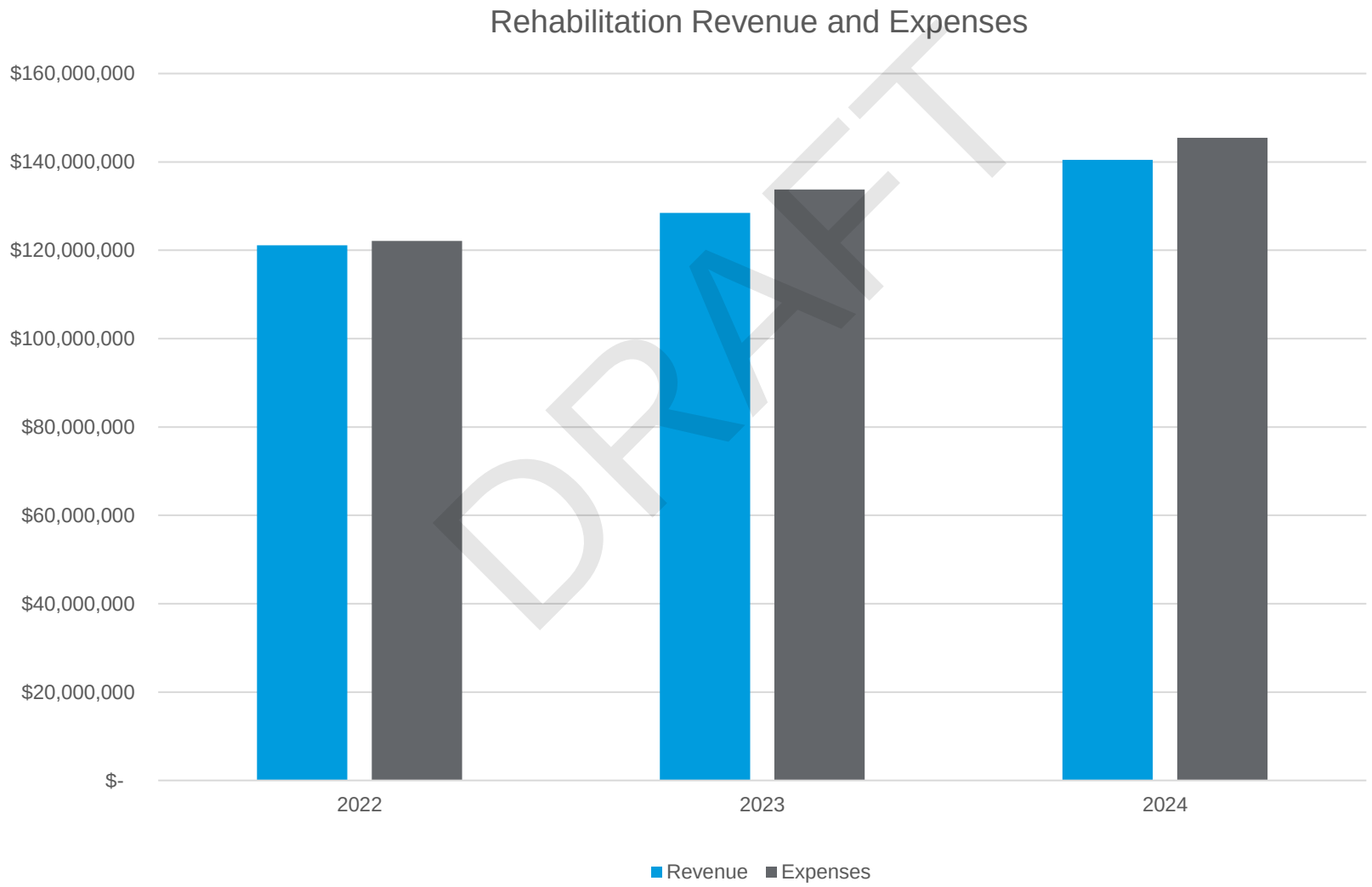


RESULTS / PERFORMANCE (CONTINUED)

Rehabilitation (Continued)

Financial Performance

The chart below illustrates the revenues and expenses for the Memorial Rehabilitation Institute over the past three fiscal years. According to the financial data, the program has seen growth, with revenues and expenses increasing from over $121 million in 2022 to more than $140 million in 2024.



RESULTS / PERFORMANCE (CONTINUED)

Rehabilitation (Continued)

Established Goals and Objectives

We confirmed that the SBHD has established goals and objectives for this program, defining the expected benefits of the program, and the performance measures and standards used by the SBHD to determine if the program achieves the SBHD's goals and objectives. The following outlines the patient satisfaction goals tracked for this prioritization.

Patient Satisfaction

- *Goal 1: Overall Care: On a scale of 0 to 100, the average score of all respondents when asked if they were satisfied with their overall inpatient care.*
  - *Benchmark: Press Ganey Survey Database*
- *Goal 2: Nursing Care: On a scale of 0 to 100, the average score of all respondents when asked if nurses were courteous and available, kept them well informed about their treatment and progress, and gave them clear and detailed instructions about their medications and home care.*
  - *Benchmark: Press Ganey Survey Database*
- *Goal 3: Physical Therapist Care: On a scale of 0 to 100, the average score of all respondents when asked if physical therapists were courteous, kept them well informed about their treatment and progress, encouraged them to participate in setting their physical therapy goals and helped them to achieve those goals.*
  - *Benchmark: Press Ganey Survey Database*
- *Goal 4: Occupational Therapist Care: On a scale of 0 to 100, the average score of all respondents when asked if occupational therapists were courteous, kept them well informed about their treatment and progress, encouraged them to participate in setting their occupational therapy goals and helped them to achieve those goals.*
  - *Benchmark: Press Ganey Survey Database*
- *Goal 5: Rehabilitation Doctor Care: On a scale of 0 to 100, the average score of all respondents when asked if doctors were courteous and available, kept them well informed about their treatment and progress, and gave them clear and detailed instructions about their medications and home care.*
  - *Benchmark: Press Ganey Survey Database*
- *Goal 6: Information about Home Recovery: On a scale of 0 to 100, the average score of all respondents when asked if staff explained home care plans, what to expect during their recovery at home, and provided assistance with arrangements after discharge.*
  - *Benchmark: Press Ganey Survey Database*
- *Goal 7: Care and Sensitivity to Emotional Concerns: On a scale of 0 to 100, the average score of all respondents when asked if staff explained what their stay would be like, provided accurate and complete information about their treatment program, expressed concern for their privacy, controlled their pain effectively, helped them to feel safe and secure, treated them with respect, minimized their inconvenience, expressed concern for their worries, answered their questions effectively, gave them encouragement, and responded promptly to their requests.*
  - *Benchmark: Press Ganey Survey Database*
- *Goal 8: Likelihood to Recommend: The percentage of adult patients who answered "Yes" when asked if they definitely would recommend this provider's office.*
  - *Benchmark: Press Ganey Survey Database*

RESULTS / PERFORMANCE (CONTINUED)

Rehabilitation (Continued)

Established Goals and Objectives (Continued)

Quality and Safety

The following outlines the quality and safety goals tracked for this prioritization.

- *Goal 9: Rehabilitation Patients Returning Home: The percentage of rehabilitation patients returning home after discharge during the time indicated.*
  - *Benchmark: USDPRO System*
- *Goal 10: Rehabilitation Patients Discharged to a Nursing Home: The percentage of patients who required continued therapy and nursing services following their stay at Memorial Rehabilitation Institute and were discharged to a nursing home.*
  - *Benchmark: USDPRO System*
- *Goal 11: Rehabilitation Patients Transferred to a Hospital: The percentage of rehabilitation patients whose medical condition required transfer to a hospital.*
  - *Benchmark: USDPRO System*

RESULTS / PERFORMANCE (CONTINUED)

Rehabilitation (Continued)

Performance Measures

Patient Satisfaction and Quality and Safety

We assessed the achievement of the SBHD's goals and objectives, focusing on whether they are clearly defined, measurable, aligned with the statutory purpose of the SBHD, and provide sufficient guidance for its programs and activities. Our evaluation confirmed that the SBHD systematically tracks and monitors both patient satisfaction and quality and safety metrics specific to Rehabilitation.

For transparency, the SBHD publishes detailed illustrations on its website that showcase progress toward established benchmarks for patient satisfaction and quality and safety metrics specific to the Rehabilitation performance. Using data from the review period, we verified that these goals are well-articulated, and performance is actively monitored. The eight (8) patient satisfaction metrics are benchmarked against the Press Ganey Survey Database over the period of April 2023 – March 2024, and are made available to the public to foster accountability and engagement. Additionally, the three (3) quality and safety metrics are benchmarked against the USDPRO System. Any deviations from established benchmarks are reviewed and discussed as a leadership team during the MOR meeting, to further foster accountability.

Additionally, Rehabilitation Institute goals are displayed on a monthly dashboard presented at the MOR meeting, which includes data for the current month, a rolling 3-month period, a rolling 12-month period, and a 13-month trend. The metrics are color-coded based on the percentile in which the data falls.

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Memorial Healthcare System

MEMORIAL REGIONAL HOSPITAL ● MEMORIAL REGIONAL HOSPITAL SOUTH ● JOE DIMAGGIO CHILDREN'S HOSPITAL
MEMORIAL HOSPITAL WEST ● MEMORIAL HOSPITAL MIRAMAR ● MEMORIAL HOSPITAL PEMBROKE

DATE: January 31, 2025

TO: Shane Strum, Interim President and Chief Executive Officer, MHS

SUBJECT: **AUDIT AND COMPLIANCE – THIRD QUARTERLY REPORT FISCAL YEAR 2025**

Attached is a copy of the third quarterly report of fiscal year 2025 summarizing the activities of the Internal Audit and Compliance Department from November 1, 2024, through January 31, 2025, for your records.

Please let me know if you have any questions regarding this report.

Denise (Denny) DiCesare
Chief Compliance and Internal Audit Officer

cc: Dave Smith, Executive Vice President and Chief Financial Officer, MHS
Alan Whaley, Interim Chief Operating Officer

I. WRITTEN STANDARDS AND PROCEDURES

The following policies and procedures were reviewed and/or revised during the quarter:

Reviewed:

- None.

Revised:

- Patient Confidentiality, and
- Charity Care and Uninsured Discounts.

II. COMPLIANCE OFFICER

The Compliance Officer attended the following meetings during the quarter:

- Florida Compliance and Privacy Consortium: One Session, and
- Compliance Officer's Roundtable: One Session

III. TRAINING AND EDUCATION

The following compliance training was provided during the quarter:

- New Employee Orientation: Eleven Sessions
- Leadership Essentials: One Sessions
- Compliance Working Committee: One Session

IV. OPEN LINES OF COMMUNICATION

A. Hotline Calls

During the quarter, 94 calls, of which 32 were callbacks, were placed to the System's Compliance Hotline covering 63 new topics and one old topic. Eight topics were compliance allegations (eight calls, 18 callbacks). Three topics were HIPAA Privacy allegations (three calls). Two topics were Patient Safety allegations (two calls). Two topics were Quality of Care/Service allegation (two call). All of the calls were investigated and one of the compliance allegations was substantiated.

Finally, eight topics were informational (seven calls, three callbacks), four topics were incomplete calls (four calls), and 36 new topics and one old topic (36 calls, 11 callbacks) were employee-management relations issues. The employee-management relations issues have been forwarded to the Employee Relations and Human Resources Departments.

V. ENFORCEMENT & DISCIPLINE

A. Sanctions Checks

Sanction checks were conducted of employees, physicians, vendors, volunteers, and students. There were no sanctions during the quarter.

B. Conflicts of Interest

The Calendar Year (CY) 2025 Conflicts of Interest Questionnaire cumulative employee completion rate is 35%, in which 6,140 of the 17,495 employees completed their questionnaire. There were 104 reports of possible or potential conflict of interest that were researched.

Conflicts of Interest Calendar Year 2024 Survey Results

Background

The Memorial Healthcare System (MHS) "Standard Practice on Business Ethics and Conflicts of Interest" states, "No Memorial Healthcare System officer or management or physician employee

or any other employee who may be affected by a potential conflict of interest (as determined by Memorial Healthcare System shall have an ownership or financial interest in, or permit his spouse or minor children to have an ownership or financial interest, direct or indirect, in any outside concerns, unless an exception applies and he is willing and able to report the full facts concerning such relations to the Board immediately upon learning of such relations or upon request." A conflict of interest occurs when an individual's actions or activities on behalf of Memorial Healthcare System are influenced by the ability to obtain an improper gain or advantage or an adverse effect on the Healthcare System's interest. An accounting is requested by circulating a questionnaire to all employees, who are required to disclose potential or possible conflicts of interest. Each employee has the calendar year to complete the Conflicts of Interest (COI) questionnaire. New hires are given 30 days from their start date to complete the COI questionnaire. All active employees receive regular email notifications to complete their questionnaire. The COI questionnaire consists of eight questions for the employees to disclose all perceived or potential conflicts of interest. The current questionnaire has two completion statuses: "Completed" indicates all eight questions have been answered; and "Not Started" indicates that the employee has not answered any questions or started but did not complete the questionnaire. The Compliance Office reviews and researches all disclosures and those determined to be a conflict are prepared for submission to the COI Subcommittee. The COI Subcommittee evaluates each conflict, assigns a risk level, and recommends a mitigation plan. The MHS Chief Executive Officer (CEO) and President reviews all disclosures and makes the final determination.

Observations

MHS had 17,425 employees at the end of calendar year 2024, which includes new hires, retirees, employees on leave, and those off-boarding. There were 17,160 employees who completed their COI questionnaire for a completion rate of 98.5%. There were 292 employees who disclosed a potential or possible conflict of interest, 53 disclosures were previously made and cleared by the previous CEO; 21 disclosures were submitted by employees who have since terminated, two were reported conflicts that have since been eliminated, and five employees indicated a conflict in error. Twenty-one disclosures were submitted by employees to request additional access for their educational programs which is not considered a conflict. The remaining 190 new disclosures were reviewed and researched by the Compliance Office. Eight employed physicians disclosed conflicts that had not been reviewed by the Physician Outside Activities Committee (POAC) as required by their employment contracts. Ten disclosures were evaluated by the COI Subcommittee and received low to medium risk ratings and recommendations to manage the conflicts. Finally, there were 265 employees who did not complete their COI questionnaire, 28 of which were new hires and 15 were on Family Medical Leave (FMLA) or Leave of Absence (LOA), leaving 222 employees who did not complete the CY 2024 Conflicts of Interest Questionnaire. The CEO and President of Memorial Healthcare System reviewed the summarization of 264 disclosures and his final determination is pending.

Recommendations

Additional training and education will be developed to increase participation as well as decrease responses made in error to questions.

VI. RISK ASSESSMENT, MONITORING & AUDITING

VII. RESPONSE & PREVENTION

A. Internal Audit Recurring Quarterly Reports

South Broward Hospital District Construction Projects

Twenty-eight payment vouchers for eleven construction projects were audited during the quarter, as shown on Exhibit A. One exception was found during this audit.

South Broward Hospital District Requests for Proposal and Competitive Quotes

Nine Requests for Proposal and 30 Competitive Quotes were audited during the quarter, as shown on Exhibit B. No irregularities were found during these audits.

Board and Government Relations Expenses

Board Expenses were audited during the quarter. The list of expenses audited for the quarter will be presented and discussed during the meeting.

Government Relations Expenses were audited during the quarter. The list of expenses audited for the quarter will be presented and discussed during the meeting.

Employee Travel Reimbursement Expense

Employee Travel Expenses were audited during the quarter. A summary of total reimbursement per cost center and a list of expenses audited for the quarter will be presented and discussed during the meeting.

B. Internal Audits

Internal Audit of Requirements for Request for Proposals at Memorial Healthcare System

Background

Competitive bidding is used to ensure fairness and impartiality in the procurement process. Memorial Healthcare System (MHS) uses competitive bidding to procure goods and services by inviting vendors to send their bid for consideration for products and services based on MHS' requirements. The competitive bidding process includes Request for Proposals (RFP), Request for Qualifications (RFQ), or Request for Information (RFI). This audit focused on RFPs. An RFP is a project announcement that describes the project and solicits bids from vendors and contractors to complete it. The purpose of this audit was to review the RFP process for MHS to determine if controls are in place to ensure compliance with the MHS Standard Practice.

We reviewed the MHS "Request for Proposal" Standard Practice. In addition, we reviewed the MHS Board of Commissioners' (Board) May 24, 2023, meeting minutes where the motion passed for *Increasing the Threshold for When the RFP Policies are Applicable for any Expenditure Amount from $100,000 to $300,000*. We reviewed the procurement and contracting procedures for sales and service agreements that met the requirement for RFPs. We reviewed the process for managing repeat RFPs and rebidding contracts. We reviewed and assessed the process for contracts that were exempted from the RFP process through competitive bid waivers. We judgmentally selected a total sample of 28 contracts and assessed those contracts for conformance to the MHS RFP policy requirements.

Observations

The RFP Standard Practice was last revised in May 2021 and does not reflect the annual spend of $300,000. Two sole source contracts for nurse call system and physical therapy services lacked support to justify the sole source exemption. One contract for supply chain consulting services did not have documentation to support the MHS Executive approval to select the consultant. We observed six contracts where the vendor has been providing products or services for more than 10

years and the standard practice does not address a timeframe for how many times contracts can be renewed before rebidding.

Recommendations

We recommended Supply Chain Management (SCM) continue to work on revising the RFP Standard Practice. We recommended SCM establish standardized documentation of sole source vendors to include market research analysis and approval of the competitive bid exemption. We recommended that SCM maintain documentation to support the selection of all vendors and consultants for contracted services. We recommended SCM continue to review contracts near the end of term to determine the value and feasibility of rebidding the products of services.

Saul Kredi, Vice President Chief Supply Chain Officer, agreed with our findings and recommendations and has provided an action plan.

Internal Audit of Facilities Management at Memorial Healthcare System

Background

The Facilities Management Department (Facilities) at Memorial Healthcare System (MHS) oversees and manages a comprehensive range of functions critical to the operation and safety of the healthcare facilities. These include building infrastructure maintenance, encompassing both preventive and corrective maintenance, Heating, Ventilation, and Air Conditioning (HVAC), plumbing, electrical systems, and elevators. It also handles disaster preparedness, business continuity, emergency power systems, and patient/visitor comfort.

Facilities must comply with the Standard Practice of Construction Services (Standard Practice of Construction) which establishes the internal process and forms for projects costing less than the construction purchasing limits of $300,000 to construct or improve any building, or $75,000 for electrical work. The Facilities Management Requisition, Work Orders, Project Matrix (Facilities Matrix) which outlines the number of quotations (quotes) required for various dollar value levels of either supplies or parts to be installed by facilities and work orders, repairs, installations, and Facilities or Construction-managed projects, ensures that the procurement process is competitive. Finally, the Standard Practice of Requisition of Supplies and Services (revised September 2013) states, “Purchase Orders (POs) are the preferred method for obtaining goods and services for Memorial Healthcare System.”

Observations

We reviewed the purchasing processes for the Facilities departments at each hospital from January 1, 2024, through September 30, 2024, reviewed evidence that job bids and payments for work performed were properly authorized, and the invoices were correctly and accurately paid to the vendors in accordance with the Signature Authority Level matrix controls in the MHS Enterprise Resource Planning (ERP) Workday system. There was no evidence of inappropriate purchases or unauthorized payments for the sample transactions evaluated.

We were informed by the Facilities directors that they follow the most current 2024 version of the Facilities Matrix. However, the majority were unaware and did not follow the Standard Practice of Construction which outlines, in part, the role of the Facilities Department. We observed inconsistencies between the Facilities Matrix and the Construction Standard Practice which was last updated in 2019. These inconsistencies suggest that the Facilities Department is not fully adhering to the established governance and procedural guidelines. We also observed opportunities to improve documentation on vendor selection. The Standard Practice of Construction requires

vendor rotation for construction services below $2,000, however the Facilities Matrix does not specify that vendor rotation is needed or required. POs issued, where only one quote was required, could lead to the indefinite use of the same vendor, as there are no established time or dollar value limits on the work that can be awarded to a single vendor. Three of the eight invoices processed as non-POs had PO numbers that were not referenced on vendor invoices and were approved for payment as non-POs. The POs could also be submitted at a later date on a different invoice for payment which could lead to duplicate payments.

Recommendations

We recommended that the Facilities Directors work with the Construction Services department to update the Standard Practice of Construction to align with the Facilities Matrix and acceptable practices. We recommended that a policy and procedure is drafted specifically for Facilities Management department to address vendor selection, documentation of preferred vendors and vendors with exclusive products and services, Facilities Matrix, POs requirements and exceptions, vendor selection documentation in Workday, and vendor rotation. We recommended that the Facilities Management team collaborate with Supply Chain Management (SCM) and Accounts Payable (AP) to ensure that PO invoices are not paid as non-POs, to ensure that the open PO management control in place is effective.

David Smith, Executive Vice President and Chief Financial Officer, MHS agreed with the findings and recommendations of this audit and has provided an action plan.

Internal Audit of Artificial Intelligence Governance at Memorial Healthcare System

Background

Technological advancements have steadily increased the availability and scope of Artificial Intelligence (AI). AI is a wide-ranging tool that enables people to rethink how we integrate information, analyze data, and use the resulting insights to improve decision making. Clinical AI is an emerging field at the intersection of patient care and AI, and it is trying to harness the application of advanced algorithms and machine learning techniques with the aim of unveiling insights. Clinical AI aims to enhance medical decision-making, optimize treatment plans, and enable personalized medicine to empower clinicians to improve patient outcomes. AI utilities are becoming more and more ubiquitous in the regulated work community (in the form of defined and controlled applications) and ad-hoc work environment (any number of AI platforms available via the public internet, i.e., Chatbots, such as ChatGPT and Grammarly). The purpose of this audit was to evaluate the organization's AI application inventory, leadership’s risk tolerance for AI, and the influence of best practice and norms established by AI system owners, organizations, industries, legal or regulatory requirements.

Observations

The Cloud Access Security Broker (CASB) utility inventoried 3,680 web-based applications accessed by Memorial Healthcare System (MHS) users while logged into the MHS network. CASB assigns a risk rating between Level 2 (i.e., ChatGPT) and Level 7 (i.e., RapidTables), with Level 2 being the lowest risk and Level 7 being the highest risk. ChatGPT is free for personal use, but the premium version is intended for Teams and Enterprise use. ChatGPT Teams version is priced at $30 per user per month, which could potentially cost MHS $272,520 per year for the 757 MHS employees who were using the free personal version during our observation period. During our research of the Level 7 AI application, RapidTables, we were contacted by MHS Cyber Security telling us our PC was broadcasting malicious software across the MHS network. A scan was

conducted by MHS Cyber Security, and they immediately detected and removed the malware causing the issue. We found there were 48 known applications with AI components already installed on the MHS network and another 10 slated to be on-boarded at MHS, pending budget and legal approval. There were 15 AI applications installed that were requested by MHS staff for various use-cases (such as AI Retinal Screening, RadAI, TalkDesk, etc.); six modules in Epic that leverage AI (such as Note Summarization, Generative AI SlicerDicer Qx, Generated Dashboard Summary, etc.); nine instances of predictive modeling (such as ICU Readmission Risk, Risk of Readmission, ED likelihood to occupy bed, etc.); and 18 other instances of AI for other use-cases. We found no specific policies or procedures that provides AI Governance. The MHS *Enterprise Acceptable Use Policy* Standard Practice covers some aspects such as the user's responsibility for the data that they access, use and store, however, AI is not specifically discussed.

Recommendations

We recommended a policy that provides guidance for governing, mapping, measuring, and managing AI risks at MHS. We also recommended an AI best practices document be developed and established to provide guidance on AI acceptable uses within the healthcare system while a policy is being developed.

Jeffrey Sturman, Senior Vice President and Chief Digital Officer agreed with our findings and recommendations. An action plan to address these findings has been provided.

C. Compliance Audits

Compliance Audit of the 340B Program at Memorial Healthcare System - FY 2025 Third Quarter

Background

The 340B Program is administered and overseen by the Health Resources and Services Administration (HRSA). The 340B Drug Pricing Program requires drug manufacturers to provide outpatient drugs to eligible healthcare organizations/covered entities at significantly reduced prices. To participate, eligible organizations must register and be enrolled with the 340B Program and maintain an up-to-date 340B database, recertify eligibility yearly, and prevent duplicate discounts by having mechanisms in place to prevent receiving a 340B price and a Medicaid drug rebate for the same drug. Any covered entity that fails to comply with the program requirements may be liable to manufacturers for refunds of the discounts obtained. To be eligible for the 340B Program, patients must have an eligible medication order or prescription and receive health care services other than drugs from the covered entity, such as treatment in a hospital-based mixed-use area, a location serving patient type of both inpatient and outpatient and classified as an outpatient in the electronic health record (EHR) at the time of medication administration.

Memorial Healthcare System (MHS) participates in the 340B Program for Memorial Regional Hospital (MRH) which includes Memorial Regional Hospital South (MRHS) and Joe DiMaggio Children's Hospital (JDCH); Memorial Hospital Pembroke (MHP); Memorial Hospital West (MHW); and Memorial Hospital Miramar (MHM). In order to manage the 340B Program, MHS uses split-billing software from Verity Solutions Group (Verity) to determine what each pharmacy needs to purchase at the 340B price. Replenishment is accumulated each time a drug is administered as outpatient and meets all the program requirements. As the previous audits had findings related to the Automated Dispensing Cabinet (ADC), our medication dispensing system, overrides and eligibility of medication orders, this parameter was included in the 340B audits.

Observations

Of the 300 pharmacy claims reviewed, there were four claims with ADC medication overrides for which we were unable to find the provider's order in Epic. An ADC override occurs when a clinician pulls medication from the ADC without the pharmacy verifying the order or during emergent situations when the provider gave a verbal order. Pharmacy management monitors ADC overrides and links them with the provider order within 48 hours. All four claims were noted to have documentation that the drug was given in the medication administration record (MAR). The 340B management assisted to locate the order in Epic. Three of the four pharmacy claims had a telephone order written on the supplemental order form after the date of discharge. Two of the three were back dated to the date of service (DOS) and had physician signatures, and one used the current date with a note indicating it was a late order entry for a past date of service. All three claims deviated from the MHS Nursing/Pharmacy Policy "Provider Orders/Telephone/ Verbal/Fax/Transcription Implementation" that requires all phone and/or verbal orders be signed by the ordering provider within 30 days after discharge. We verified that one of the three claims included a controlled substance that documentation supported the drug's removal from the ADC and promptly administered to the patient. Hence, there was no diversion. The fourth pharmacy claim's medication order was not found in Epic. These made all four claims 340B ineligible. The error rate is 1.3%, resulting with an overpayment of $1,727. Subsequently, Accounts Receivable Management (ARM) reviewed the identified 340B ineligible claims, corrected and reversed the charges.

Recommendations

We recommended the 340B management continue to monitor and include the ADC overrides in the oversight for the 340B Program. We recommended pharmacy management from MRHS and MHW continue to monitor and ensure that ADC overrides are linked to a provider order in Epic. We recommended nursing leadership from MRHS and MHW reeducate the staff on verbal/telephone orders as per MHS policy. We recommended nursing leadership from MRHS and MHW to develop, implement, and monitor a process/workflow to ensure that the MHS "Medication Overrides" policy is followed.

Dorinda Segovia, Vice President & Chief Pharmacy Officer, MHS, Tina Hodges, Vice President, Reimbursement and Revenue Integrity, MHS, Joseph Stuczynski, Chief Executive Officer (CEO), MHW, Katherine Wong, Chief Financial Officer (CFO), MHW, Philoron Wright, CEO, MRHS and David Webb, CFO, MRHS agreed with the findings and recommendations and have provided action plans.

Compliance Audit of Documentation and Billing of Screening Colonoscopy at MRH

Background

Colorectal cancer (CRC) is a type of a disease that develops in the colon and/or the rectum in which abnormal cells divide uncontrollably, ultimately forming a malignant tumor. CRC screening test refers to any procedure including screening colonoscopy, furnished to an asymptomatic individual for the purpose of early detection of CRC.

Medicare pays for screening colonoscopy once every 24 months for individuals at high risk for CRC and for individuals that are non-high risk, once every 120 months or 48 months after a previous flexible sigmoidoscopy. Medicare has no minimum age limitation for screening colonoscopy for both the high-risk and non-risk CRC population. If a lesion or growth is detected during a screening colonoscopy that results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening colonoscopy but shall be made for the procedure

classified as a colonoscopy with biopsy or removal.

Medicare uses Healthcare Common Procedure Coding System (HCPCS) Code G0105 for Screening: colonoscopy on individuals at high-risk for CRC, and G0121 for Screening colonoscopy for non-high-risk individuals. For commercial payors and Medicaid, Current Procedural Terminology (CPT) code 45378, Colonoscopy, flexible; diagnostic, including collection of specimen(s) is used to report for screening colonoscopy or as based on the commercial payor guidelines. There are no deductible or coinsurance for CRC screening services. However, when biopsy or removal of the lesion/growth is done, Medicare beneficiaries are responsible for 15% of the cost, starting January 1, 2023, through December 31, 2026. The claim should report for the appropriate procedure based on the surgical technique and instrument used for the removal of the growth/lesion.

Memorial Healthcare System (MHS) Compliance and Internal Audit Department performed an audit of the Memorial Regional Hospital (MRH) Endoscopy Department in response to a hotline call allegation of improper billing at MRH for screening colonoscopy. The purpose of this audit was to determine if documentation supports medical necessity and determine the compliance and accuracy of coding, charging and billing screening colonoscopy procedures at MRH.

Observations

All 30 accounts reviewed have complete documentation supporting medical necessity and the procedure performed. All four Medicare accounts were coded, billed and paid appropriately. Out of the 26 commercial payor accounts, we noted four were initially not paid related to the commercial payors' preferred CPT code and modifier to report screening colonoscopy. Concurrent to the audit, Health Information Management (HIM) reviewed the claims and made the appropriate corrections as per the standard process. These accounts were paid appropriately. Based on the audit findings, the hotline allegation of improper billing for the screening colonoscopy was not substantiated. Medicare beneficiaries have a 15% co-insurance as per the Medicare guidelines, and as per the health plan policy for the commercial accounts when a lesion/growth is removed for biopsy during the screening procedure.

Recommendations

None.

Aurelio Fernandez, Interim Chief Executive Officer, MRH and Walter Bussell, Chief Financial Officer, MRH have been notified of the results of this audit. There were no findings or recommendations, therefore an action plan was not required.

Compliance Audit of Documentation and Billing of Medicare Severity Diagnosis Related Group (MS-DRG) 207 and MS-DRG 208 at MRH

Background

Mechanical ventilation (MV) is the use of a mechanical device such as a ventilator or respirator to take over the active breathing for a patient who is unable to breathe on their own. Through the inpatient prospective payment system (IPPS), the Centers for Medicare & Medicaid Services (CMS) pays for inpatient claims when Medicare beneficiaries receive MV. MS-DRG 207 Respiratory System Diagnosis with Ventilatory Support greater than 96 hours is assigned to Medicare beneficiaries who have received more than 96 consecutive hours of MV. MS-DRG 208 Respiratory System Diagnosis with Ventilatory Support less than or equal to 96 hours is assigned to Medicare beneficiaries who received less than or equal to 96 hours of MV. The use of procedure

code 5A1955Z indicates that an enrollee has received more than 96 consecutive hours of MV. If an enrollee did not receive more than 96 consecutive hours, procedure code 5A1945Z, Respiratory Ventilation between 24-96 consecutive hours or 5A1935Z Respiratory Ventilation, less than 24 consecutive hours is used. In a recent Office of Inspector General (OIG) audit on August 2024, OIG found that Medicare payments for inpatient hospital claims with MS-DRG 207 that required more than 96 consecutive hours of MV did not fully comply with Medicare requirements and resulted in overpayments. Memorial Healthcare System (MHS) Compliance and Internal Audit Department chose to perform an audit of the MS-DRG 207 and MS-DRG 208 at Memorial Regional Hospital (MRH) given the volume and acuity of inpatient discharges. The purpose of this audit was to determine if MS-DRG 207 Respiratory System Diagnosis with Ventilatory Support >96 hours or MS-DRG 208 Respiratory System Diagnosis with Ventilatory Support <=96 hours, complied with Medicare requirements and is supported by medical record documentation and determine the accuracy of coding, charging and billing at MRH.

Observations

All 30 accounts reviewed had provider orders and documentation which supported the principal diagnosis of respiratory failure or condition supporting medical necessity for the procedure of MV. All 30 accounts had the appropriate principal diagnosis codes that were supported by medical record documentation. Twenty-nine out of 30 accounts were assigned the appropriate MS-DRG. One account was incorrectly coded with MS-DRG 208 when it should have been MS-DRG 207 because the amount of time the patient was on MV was more than 96 hours. This account had the incorrect procedure code 5A1945Z instead of 5A1955Z which resulted in the incorrect MS-DRG reported. Subsequently, Health Information Management (HIM) corrected the coding error and Accounts Receivable Management (ARM) rebilled the account. The rest of the accounts were paid appropriately pending correction in reimbursement for the account with coding error. The error rate is 3.33% resulting in an approximate underpayment amount of $1,226.03.

Recommendations

We recommended that HIM continue to provide education to coding staff on respiratory failure and calculating MV hours by including MS-DRG 207 and 208 routinely in their regular audits for coding.

Aurelio Fernandez, Interim Chief Executive Officer, and Walter Bussell, Chief Financial Officer, agreed with the finding and recommendation of this audit and have provided an action plan.

Compliance Audit of Documentation and Billing of Controlled Substance in the Hematology Oncology Inpatient Department at MRH

Background

Controlled substances are medications that have the potential for abuse or dependence. Federal regulations require detailed documentation of the disposition of all controlled substances which includes the documentation of the persons' names who are administering to the patient, wasting and witnessing the wastage. Memorial Healthcare System (MHS) uses an automated dispensing cabinet (ADC), an advanced point-of-use system that automates the distribution, management, and control of medications, including controlled substances. All medications ordered by providers are available through ADC with a pharmacy link to each patient's medication profile after pharmacist review. All medications including controlled substances and multiple other medications are removed from the ADC, which keeps a record of the user, and the amount of each drug removed. According to the MHS "Controlled Substances Waste" policy, controlled substances should be

wasted in a timely fashion with a witness. It is preferred that wasting occurs prior to drug administration for safety purposes. However, if not feasible to waste immediately upon withdrawal and prior to administration, then waste shall occur immediately after administration. The personnel authorized to witness the waste shall visually verify and document the amount of drug wasted. The total amount of a controlled substance that is removed from ADC must equal the dose given to the patient and the amount wasted.

Patients admitted to the Hematology Oncology Department at Memorial Regional Hospital (MRH) often require the use of multiple controlled substances for pain management. There are designated ADC machines where Registered nurses (RN) withdraw controlled substances and record the unused portion as waste. There must be an appropriate physician order to accompany all administration of medications. Unreconciled controlled substances report is performed daily by the department management to ensure any controlled substance discrepancies such as undocumented waste are resolved appropriately. Also, a complete controlled substance inventory is completed by two RN's weekly. Waste discrepancies unable to be resolved by end of shift are, investigated according to "Controlled Substances – Discrepancies, Reporting and Resolution" policy. The purpose of this audit was to determine if documentation supports medical necessity and compliance with Federal Guidelines and MHS Policies and Procedures of Controlled Substances; and to determine the accuracy of charging in the Hematology Oncology Inpatient Department at MRH.

Observations

We selected 30 patient accounts with 331 ADC transactions of controlled substances were reviewed. There were appropriate provider orders for all controlled substances documented as administered. We noted two accounts with two discrepancies of documentation for medications administration and waste. In one account, documentation on the medication administration record (MAR) indicated the total dose removed from ADC was administered but the ADC transaction of waste was documented for same medication. Also, the pharmacy actions section of the MAR indicates medication was returned. For one account, medication was administered more than one hour after it was removed from ADC which deviated from the Nursing/Pharmacy Departmental Policies "Medication Administration - Policy Statement" and "Scheduling Medications Administration" resulting in less than 1% error rate. We noted two accounts with two transactions had an opportunity for improvement in supporting documentation for medications removed and wasted. One account had one ADC transaction with removal and waste of the total dose. However, there is no supporting documentation on the MAR for the reason the dose was not administered. One account had two separate ADC transaction of same medication within two hours of each other. The first total dose removed was appropriately wasted in ADC but there is no indication on the MAR why the dose was not administered. The second dose removed was documented as administered according to the physician order, with the remaining dose appropriately documented in ADC as wasted. The remaining 317 transactions were appropriately documented on the MAR as given and the returned, cancelled, or wasted transactions were noted on the ADC transactions. All medications including controlled substances are charged when ordered dose is scanned and administration is documented on MAR.

Recommendations

We recommended reeducating the Registered Nurses on the "Medication Administration - Policy Statement" and "Scheduling Medications Administration" and the "Medication Administration - Policy Statement". We recommend reeducating Registered Nurses to include supporting documentation on the MAR for the reason the total dose removed was wasted.

Aurelio Fernandez, Interim Chief Executive Officer, MRH and Walter Bussell, Chief Financial Officer, MRH agreed with the findings and recommendations of this audit and have provided an action plan.

Compliance Audit of Memorial Cancer Institute Hematology Oncology Procedures for Memorial Physician Group Professional Coding and Billing

Background

MCI offers world-class care in the community with a team of highly trained hematology and oncology (Hem/Onc) specialists who deliver diagnoses and integrated treatments. Centers for Medicare and Medicaid Services (CMS) requires reasonable documentation of medical and surgical services provided by the healthcare providers in all settings. The documentation validates medical necessity, place of service, and correct reporting of the services billed to the insurances for reimbursement. The physicians and the Advanced Practice Registered Nurses (APRNs) report health care services using code sets to identify medical procedures and professional services on the health care billing claims. The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10–CM) diagnosis codes are used to indicate the reason for care. The Current Procedural Terminology (CPT) codes are used to report services and procedures. Modifiers are appended to the CPT codes to report services that are altered under certain circumstances. CMS's Center for Program Integrity manages the Open Payments Program, a federally mandated program to increase the transparency of financial relationships between the drug and medical device companies and the healthcare providers. The Physician Payments Sunshine Act (Sunshine Act), part of the Affordable Care Act (ACA) of 2010, is a federally mandated disclosure program that requires manufacturers and distributors of medical devices and drugs to report payments to physicians, nurse practitioners, APRNs, and teaching hospitals. These payments are publicly accessible through the Open Payments Program.

Observations

We reviewed the MCI Hem/Onc screening and diagnosis documentation for laboratory (labs), and chemotherapy administration. Of the 15 labs for complete blood count (CBC) with differential (Diff), we noted there was a signed order for each CBC, with medical necessity reported with ICD10-CM codes, the frequency of lab tests, and an order expiry date. Seven accounts had expiration dates for greater than one year. This is an opportunity for improvement as Medicare Administrative Contractors (MACs) other than First Coast Service Options (FCSO), our MAC, require laboratory standing orders to be renewed on or about 12 months from the order date. Subsequently, we provided Oncology Administration the other MACs' requirements to renew orders at least annually. The documentation for all 15 accounts for the labs met the billing requirements. One account for chemotherapy administration was reported with the correct CPT code and required a place of service correction when billing for the services which was completed.

We collected and analyzed the CMS Open Payments data for each of the physicians and for the APRN in this audit and there were no significant findings.

Recommendations

None.

Patrick Brillantes, Senior Vice President of Service Lines, MHS and Esther Surujon, Chief Financial Officer, MPG agreed with the audit results and since there were no findings or recommendations in this audit, an action plan was not required.

Compliance Audit of Memorial Physician Group Urology Department Evaluation and

Management Services and Procedures Professional Coding and Billing

Background

The Memorial Physician Group (MPG) Urology Department consists of a team of providers who offers comprehensive treatments for complex Urology related conditions. Physician services are the professional services that include diagnosis, therapy, surgery, consultation, and care plan oversight. A medically reasonable and necessary evaluation and management (E/M) visit documents the patient's medical needs and medical decisions on the appropriate measures of care for specific clinical circumstances. Billing for an E/M service requires Current Procedural Terminology (CPT) codes that best represents a patient type, place of service, and level of E/M service performed. Place of service can be the physician's office or other outpatient facility, hospital inpatient, Emergency Department (ED) and telemedicine. Modifiers are appended on a claim for additional information. Advanced Practice Registered Nurses (APRNs) can report services independently, or under the incident-to guidelines, or shared/split visit guidelines. A visit provided by a teaching physician with a resident physician aiding in patient care is billed using an appropriate modifier. Physician and teaching physician E/M services can be provided through telehealth that are billed with codes that the telecommunications used was either audio-video or audio only and an appropriate modifier. The Physician Payments Sunshine Act (Sunshine Act), part of the Affordable Care Act (ACA) of 2010, is a federally mandated disclosure program that requires manufacturers and distributors of medical devices and drugs to report payments to physicians, nurse practitioners, APRNs, and teaching hospitals. These payments are publicly accessible through the Open Payments Program.

Observations

We reviewed 86 accounts: 10 E/M and 10 procedures for each of the four physicians and three E/M and three procedures for one APRN. Of the 43 E/M accounts reviewed, one telehealth service account did not meet the CMS telehealth coding and billing requirement for place of service due to copy and pasting. The account was overpaid by $59.25, and the MPG Business office will issue a refund. The error rate was 1%. Of the 43 procedures reviewed, we agreed with the documentation and coding of 42 accounts. One procedure was missing an additional CPT code that provided additional information and did not affect reimbursement. Modifiers were applied appropriately to 84 of 86 accounts and in the remaining accounts, reimbursement was not affected because the modifiers were informational. There were 76 accounts that the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes were appropriate for the documented medical necessity. In the remaining accounts, we noted that the medical diagnosis documentation supported additional or different ICD-10-CM codes, this did not affect reimbursement. One account was denied for a payer processing error. This account was appealed and is pending payment. We collected and analyzed the CMS Open Payments data for each of the physicians and for the APRN in this audit and there were no findings.

Recommendations

We recommended that MPG Business Office correct and rebill or refund accounts as appropriate. We recommended that Auditor of Coding and Compliance, and the Administrative Director of Urology conduct a reeducation session for the providers on documentation guidelines, requirements for telehealth documentation and coding, and the copy and paste policy.

Mario Salceda-Cruz, Chief Operating Officer, MPG and Esther Surujon, Chief Financial Officer, MPG agreed with the findings and recommendations and have provided a detailed action plan.

Compliance Audit of Orthopedic Surgery Evaluation and Management Services for MPG Professional Coding and Billing

Background

Memorial Healthcare System (MHS) has a highly trained team of orthopedic surgeons who offers treatments for bone, joint, and muscle care. Physician services include diagnosis, therapy, surgery, consultation, and care plan oversight. A medically reasonable and necessary evaluation and management (E/M) visit includes documentation of the patient's medical needs and medical decisions on the appropriate measures of care for specific clinical circumstances. Billing for an E/M service requires the selection of a Current Procedural Terminology (CPT) code that best represents a patient type, place of service, and level of E/M service performed. Place of service can be the physician's office or other outpatient facility, hospital inpatient, or telehealth. Billing also requires selection of the International Classification of Diseases Tenth Revision, Clinical Modification (ICD-10-CM) codes to report medical diagnoses. Advanced Practice Registered Nurses (APRNs) can report services independently or as a shared/split visit in an institutional setting when services are performed in part by a physician. A visit provided by a teaching physician with a resident physician aiding in patient care is billed using an appropriate modifier. Physician and teaching physician E/M services can be provided through telehealth. Telehealth billing codes indicate that either audio-video or audio only was used and appended using a modifier. The purpose of this audit was to determine whether documentation and coding complied with the Medicare requirements when billing for orthopedic surgery E/M services.

Observations

We reviewed 132 E/M services accounts of for 16 physicians and six APRNs. Some of the findings may overlap. Of the 132 accounts reviewed, we noted that for 119 accounts the CPT codes were appropriate for the E/M services documented. In the remaining thirteen accounts, three accounts were coded at two more E/M service levels higher than the supported documentation, seven accounts had documentation that supported a different CPT code, and three accounts had documentation that was insufficient to support billing for the services. This resulted in an 10% error rate for the E/M with an estimated overpayment amount of $645.72 and underpayment amount of $279.33. There were 33 accounts that appropriately reported the modifiers and reimbursement in the remaining 10 accounts was not affected since the modifiers were informational. There were 54 of the E/M accounts that had additional CPT codes reported for procedures, such as X-rays and other services. We noted four accounts did not have documentation to support reporting the CPT and one account had insufficient documentation to support reporting the CPT. Fifty-eight accounts had ICD-10-CM codes that were supported by documented medical necessity. In the remaining accounts, we noted that medical record documentation supported additional or different ICD-10-CM codes. However, reimbursement was not affected. Of the 132 accounts, five were denied payment due to payor guidelines, two of which were billed to a program payor. The accounts were appealed and expected to be paid.

Recommendations

We recommended that Memorial Physician Group (MPG) Business Office correct and rebill or refund accounts as appropriate. We recommended that the MPG Business Office reeducate providers on medical record documentation, coding, and billing to support medical necessity and services billed.

Mario Salceda-Cruz, Chief Operating Officer, MPG and Esther Surujon, Chief Financial Officer, MPG agreed with the findings and recommendations and have provided an action plan.

Follow Up Compliance Audit of Documentation and Billing of the Diabetes Self-Management Education and Support Services Program in the Diabetes and Nutrition Center at MRH

Background

The outpatient Diabetes Self-Management Training (DSMT) is a full range of educational and training services offered to people diagnosed with diabetes for the successful self-management of the chronic disease and related conditions. Medicare covers an initial 10 hours and a yearly follow-up of two hours of DSMT when provided by a Centers for Medicare and Medicaid Services accredited entity. Nine hours must be furnished in a group setting and one hour of individual DSMT to evaluate training needs. Individualized initial DSMT is covered only if there are no group sessions available within two months of the DSMT order or the referring provider documented the need for individual training on the order/referral and in the medical record. The initial and follow-up training must be furnished in increments of 30 minutes which is one unit. Rounding of time furnished is not allowed and any unused hours of the initial training or follow-up training that is not completed within the required time is not reimbursed. The order/referral must include the number of initial hours ordered; the topics to be covered; and a determination that the patient should receive individual or group training. The treating provider managing the patient's diabetic condition certifies that such services are needed and maintains a comprehensive plan of care. For the follow-up training, the provider must document on the referral and in the medical record that the beneficiary has been diagnosed with diabetes and the training to be addressed.

A compliance audit of the Diabetes Self-Management Education and Support (DSMES) Program at Memorial Regional Hospital (MRH) completed in August 2023 reviewed thirty accounts with 85 dates of service, of which twenty-eight accounts with 81 dates of service did not include all of the required order components and the documentation of education or training provided did not meet Medicare requirements resulting in a 95% error rate. The purpose of this follow-up audit was to determine if the action plan recommendations to review and reeducate staff on the Medicare requirements for providing, billing, and charging DSMT time, to review and update the order/referral template in Epic to include all Medicare's required components, to ensure orders/referrals from non-MHS providers include all Medicare required components, and to verify the effectiveness of the corrective actions.

Observations

The DSMES management reeducated staff on the Medicare requirements. The order/referral template in Epic was updated to meet Medicare requirements. There is a process to ensure that orders/referrals from non-MHS providers meet Medicare requirements. We reviewed 15 patient accounts with 30 dates of service and all had a provider orders/referral and met medical necessity. Ten of 15 orders/referrals had all components required by Medicare, 25 dates of service had the individual and/or group DSMT required documentation. Start and stop time were consistently documented in 30-minute increments on the visit summary note. Twenty-four of 25 dates of service were coded, charged and billed as per documentation and Medicare requirements. One date of service was coded accurately but charges were not posted by department staff. Accounts Receivable Management (ARM) billed this date of service. The remaining five dates of service were for patients admitted under observation status with orders for inpatient diabetes education consult, which met medical necessity but not for outpatient DSMT. Subsequent to this finding, corrective action was implemented by ARM and department management to add an edit in Epic to hold charges posted by the DSMES department to enable the ARM department to append modifier GZ to indicate the item is expected to be denied for observation status patients. ARM reviews and

appends the modifier. DSMES staff will continue to enter the charges to account for the time spent with patients. ARM rebilled or refunded the identified five dates of service, and all Medicare and Medicare Advantage observation accounts are currently being rebilled or refunded with corrected claims retrospectively to the previous audit calendar year as appropriate.

Recommendations

None.

Aurelio Fernandez, Interim Chief Executive Officer, MRH and Walter Bussell Chief Financial Officer, MRH, agreed with the audit findings. There were no recommendations, therefore an action plan was not required.

Follow Up Compliance Audit of the Important Message From Medicare (IM) Notice at MHP

Background

Hospitals and Critical Access Hospitals (CAHs) must deliver a written notice, the IM from Medicare to all Medicare and Medicare Advantage (MA) beneficiaries receiving inpatient hospital services, to inform them that they have a statutory right to appeal to a Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for an expedited review when a hospital, with physician concurrence, determines that inpatient care is no longer necessary. The initial IM must be delivered within two calendar days of the admission date or no more than seven days before the admission date if the patient is seen for a preadmission visit. A follow-up IM must be delivered within two days of the planned date of discharge and no later than four hours prior to discharge. If the initial IM is within two calendar days of the date of discharge, no follow-up notice is required.

The standardized written IM and verbal explanation must be provided to the beneficiary or the representative. The beneficiary or representative must sign and date the IM. However, beneficiaries are still entitled to an expedited determination if they refuse to sign the IM. The staff member who presented the IM must annotate the notice with the date of refusal. The IM must be delivered telephonically to a representative who is not physically present, and the "Additional Information" section must be annotated with the staff member's name who initiated the contact, the representative's name, date, time, and telephone number. A hard copy of the IM must be mailed to the representative on the day telephone contact is made and the original IM notice must be added to the patient's medical record. Failure to provide the IM to applicable beneficiaries is considered a violation of the conditions of participation (COPs) and could result in termination of the hospital's Medicare provider agreement.

Observations

At Memorial Hospital Pembroke (MHP), the Patient Financial Services (PFS) Department staff provides the initial IM, and the Case Management (CM) Department provides the follow-up IM to beneficiaries. From the previous IM audit completed in September 2023, 13 of 30 accounts reviewed did not comply with the Medicare requirements for providing the initial IM and 23 of 30 accounts did not comply with the Medicare requirements for providing the follow-up IM, resulting in error rates of 43% and 77% respectively. The purpose of this follow-up audit was to determine if MHP implemented the action plan recommendations to provide and complete the initial and follow-up IM notices, reeducate staff on delivering the initial and the follow-up IM notices in a timely manner, conduct prospective reviews to ensure compliance with Medicare requirements, and verify the effectiveness of the corrective actions.

All 15 accounts reviewed had inpatient orders documented by the provider and received inpatient

services exceeding 10 days. Two accounts did not have the initial IM in the medical records resulting in a 13% error rate. Additionally, one account delivered the IM after two calendar days from the admission date and the second account did not have the required "Additional Information" section annotated when patient refused to sign the notice. The remaining 11 accounts delivered the initial IM within the set guidelines. Twelve of 15 accounts had discharge orders documented, and three accounts had documentation that the patients expired prior to discharge. Three accounts of the 12 were provided the follow-up IM telephonically and documentation was kept in departmental records but not in the medical records resulting in a 25% error rate. Additionally, for two accounts the follow-up IMs were provided more than two days of the planned discharge date. The remaining seven accounts had the follow-up IM delivered within the set guidelines.

Recommendations

We recommended the PFS and CM management continue the ongoing staff reeducation on the Medicare requirements, timeframes, required documentation, and maintaining the IM notices in the patient's medical records. We recommended continuing regular prospective reviews to ensure compliance with the Medicare requirements.

Felicia Turnley, Chief Executive Officer, MHP and Patrick Connor, Chief Financial Officer, MHP agreed with the findings of this audit and have provided the attached action plan.

D. Services Provided by Protiviti

A list of Services Provided by Protiviti for the quarter will be discussed during the meeting.

E. Other Reports

Investor Log

The Investor Contact Log for the quarter is attached for your review. See Exhibit C.

Non-Audit Engagements

A list of RSM and Zomma Group Non-Audit Engagements for the quarter is attached for your review. See Exhibit D.

Compliance Environment

A discussion of Nationwide Audit and Investigation Activities for the quarter will be held during the meeting.

SBHD Construction Projects
Period Ending 1/31/2025

Exhibit A

	PO#6007559 Interventional Radiology Turner Construction Co. #401622 MHS	PO#6007465 Urgent Care Center Miami Gardens Gerrits Construction Inc. #650322 MHS	PO#6007489 Central Sterile Processing Thornton Construction Co. Inc. #430122 MHW	PO#10049832 MOB II Third Floor Sports Medicine Thornton Construction Co. Inc. #PRJ00148 MHM	Family Birthplace PO#6007570 Turner Constuction Co., Inc. #400622 MRH
	Amount	Amount	Amount	Amount	Amount
Original Contract Sum	$ 1,826,577	$ 1,929,942	$ 1,620,971	$ 2,321,339	$ 43,850,159
Prior Change Orders					
Current Change Orders					
Prior Owner Purchase Orders	(401,108)	(179,731)	(261,732)		(7,196,957)
Current Owner Purchase Orders	205,923	2,027	83,952		
Current Contract Sum to Date	$ 1,631,392	$ 1,752,237	$ 1,443,191	$ 2,321,339	$ 36,653,202
Previous Payments	1,538,316	1,752,237	1,232,224	874,734	25,553,587
Total Payments			6 157,757	3 869,821	20 832,222
Balance			7 53,210		21 792,945
					22 1,165,342
Owner Purchased Materials					23 1,552,687
Retainage					
Payments	1,538,316	1,752,237	1,443,191	1,744,554	29,896,783
Work completed	$ 93,076	$ 0	$ 0	$ 576,785	$ 6,756,419
Status					
	20,034		31,524	72,173	1,724,483
	1,538,316	1,752,237	1,443,191	1,744,554	29,896,783
	$ 1,558,350	$ 1,752,237	$ 1,474,715	$ 1,816,727	$ 31,621,266
	Active	Active	Active	Active	Active

SBHD Construction Projects
Period Ending 1/31/2025

Exhibit A

	Command Center PO#6007669 LEE Construction Group, Inc. #PRJ-0012 MHS	MOB II Second Floor Pediatric Fit Out Thornton Construction Co. Inc. #800122 MHM	MOB Women Center PO#6006642 ANF Group, Inc. #450218 MHM	PO#6007171 Memorial Cancer Center Expansion DPR Construction #431019 MHW	PO#6007169 Hurricane Hardening Thornton Construction Co. #410121 MRHS
		Amount	Amount	Amount	Amount
Original Contract Sum	$ 1,021,046	$ 10,650,417	$ 35,067,236	$ 86,165,924	$ 13,613,113
Prior Change Orders			(5,101,409)	(15,571,906)	
Current Change Orders					
Prior Owner Purchase Orders		(2,482,914)	(750,000)	(494,336)	(1,891,946)
Current Owner Purchase Orders		(688,233)		101,973	
Current Contract Sum to Date	$ 1,021,046	$ 7,479,269	$ 29,215,826	$ 70,201,655	$ 11,721,167
Previous Payments		7,479,269	27,791,202	65,206,159	11,346,741
Total Payments	1 126,358	11 0		36 116,911	20 91,035
Balance					
Owner Purchased Materials					
Retainage					
Payments	126,358	7,479,269	27,791,202	65,323,070	11,437,776
Work completed	$ 894,687	$ 0	$ 1,424,624	$ 4,878,585	$ 283,391
Status					
	4,379			101,027	159,638
	126,358	7,479,269	27,791,202	65,323,070	11,437,776
	$ 130,737	$ 7,479,269	$ 27,791,202	$ 65,424,097	$ 11,597,414
	Active	Active	Active	Active	Active

SBHD Construction Projects
Period Ending 1/31/2025

Exhibit A

	PO#6007692 MOB II 3rd Floor Time Share Fit Out Thornton Construction Co. #830922 MHM	PO#6007446PS JDCH ER Room Finishes Engel Construction, Inc. New #460423 (Old#460120) JDCH	Memorial Cancer Institute ANF Group, Inc. #401820 MHS	PO#6007523 Emergency Department Trauma Center Turner Construction Company #400222/PRJ00030 MRH	PO#6006728 JDCH Vertical Expansion Robins & Morton Group #460117 JDCH
	Amount	Amount	Amount		Amount
Original Contract Sum	$ 2,148,948	$ 1,920,630	$ 3,318,036	$ 16,401,716	$ 108,993,259
Prior Change Orders			(396,184)		
Current Change Orders				-	(6,106,416)
Prior Owner Purchase Orders	(320,239)	(178,677)		(1,858,812)	(15,113,925)
Current Owner Purchase Orders		(9,805)	(113,525)		
Current Contract Sum to Date	$ 1,828,709	$ 1,732,147	$ 2,808,327	$ 14,542,904	$ 87,772,918
Previous Payments	1,530,857	742,894	2,808,328	8,159,636	87,772,918
		10 157,629			
		11 196,777			
		12 178,511			
		13 132,954			
		14 196,312			
Total Payments		15 33,791	22 -	20 513,369	29 0
Balance		16 50,687		21 146,152	
		17 80		22 337,350	
Owner Purchased Materials		18 30,399		23 414,117	
Retainage		19 12,113		24 309,170	
Payments	1,530,857	1,732,147	2,808,328	9,879,795	87,772,918
Work completed	$ 297,852	$ 0	$ (0)	$ 4,663,109	$ (0)
Status					
				362,636	
	1,530,857	1,720,034	2,808,328	9,879,795	87,772,918
	$ 1,530,857	$ 1,720,034	$ 2,808,328	$ 10,242,431	$ 87,772,918
	Active	Active	Active	Active	Active

Cell: AB34
Note: Morris, Valerie:
Turner Construction invoice#24 for $309,170.12. Amount paid was $328,101.15. Overpaid $18,931.03.

IA spoke with AP and an Internal Credit Memo was added to the vendor's account in the amount of $18,931.03 to be offset on the next invoice for this project.

Memorial Healthcare System
RFP and Competitive Quote Audits

	RFPs	Current Phase - 3rd Quarter FY 2025	Audited Last Quarter	Audited Current Quarter	Exceptions
1	Tissue Tracking and Point of Use Technology Solution	Ranking & Selection	New	Receipt	None
2	Janitorial Services RFP	Ranking & Selection	Analysis	Analysis	None
3	Rewards and Recognition RFP	On Hold	Design	Design	None
4	Contact Center Augmentation RFP	Ranking & Selection	Receipt	Analysis	None
5	Parking Management Service	Ranking & Selection	Design	Receipt	None
6	Joint Replacement RFP	Analysis	New	Receipt	None
7	Clinical Engineering Computerized Maintenance Management System	Selection	Oral Presentation	Oral Presentation	None
8	Pest Control RFP	Analysis	Advertising & Mailing	Receipt	None
9	EPIC On-Premise to Azure RFP	Selection	Receipt	Analysis	None

Memorial Healthcare System
RFP and Competitive Quote Audits

	Completed Competitive Quotes	Amount $	Exceptions
1	Biplane Vascular Equipment With Three Year Service Agreement for MRH Radiology	1,482,497	None
2	Four Year Service Agreement for Cyber Knife System at Memorial Cancer Institute	1,412,000	None
3	Three Year Service Agreement for Windows Servers License Renewal for MHS Data Centers	1,274,843	None
4	Three Year Stretcher Program Repairs and Maintenance at MHW	1,253,913	None
5	Five Year Stretcher Program Repairs and Maintenance at MRH	1,182,497	None
6	Six Year Repair and Maintenance Service Agreement for Operating Room Equipment at MHW	747,500	None
7	Five Year Laboratory Reagents Standing Order for MRH	685,246	None
8	Five Year Stretcher Program Repairs and Maintenance at MHM	672,238	None
9	Dragon Medical One Upgrade for Inpatient Admissions Licenses MHS	512,399	None
10	Five Year Subscription Agreement for Satellite Television for MHS	497,116	None
11	Five Year Preventative Maintenance Beds and Stretchers for MHP	460,300	None
12	Bi Plane Room Equipment for Cardiac Catheterization at MRH	447,821	None
13	Furniture for Telemetry at MHM	442,233	None
14	Furniture for Community Youth Services Taft Street	332,964	None
15	Five Year Maintenance Service Agreement for Beds and Stretchers at MRHS	316,708	None
16	DocuSign eSignature Agreement Years Two & Three for MHS	298,463	None
17	Change Order for Reclaimed Water Expansion Project at MHM	260,928	None
18	Cardiology Stents Bulk Purchase for Cardiac Catherization at MHW	245,000	None
19	Maintence Support Renewal for Medical Devices for MHS	222,318	None
20	Five Months Janitorial Services at Memorial Manor	203,659	None
21	Thirteen Months HVAC Equipment Rental and Installation Services at MHP	182,000	None
22	Sixty One Month Subscription for Satellite Television at MRHS	176,167	None
23	Data Storage Subscription for MHS	174,097	None
24	Annual Software Maintenance of OnBase Information Management System for MHS	166,000	None
25	Three Year Fluorescense Imaging System Lease for JDCH	161,631	None
26	Three Year Fluorescense Imaging System Lease for MHW	161,631	None
27	Annual Epic Claims Data Integration Services for MHS	153,096	None
28	Two Year Technical Support Services Agreement for Sterile Processing Microsystem at MHS	152,295	None
29	Infusion Pumps with Point of Care Software for MHW	147,205	None
30	Four Month Integration Development Services for Issue Resolution of Construction Services eBuilder Software and GHX.	115,200	None

Exhibit C

Memorial Healthcare System
Investor Contact Log
Fiscal Year 2025

Quarter: Ended	Contact:	Representing:	Discussion:
July 31,2024	Stephen Infranco	Standard & Poor's	Rating discusson
	Beth Wexler and Vanessa Chebli	Moody's	Rating discussion
October 31, 2024	Stephen Infranco	Standard & Poor's	Management change discussion.
	Beth Wexler	Moody's	Management change discussion.
January 31, 2025	None		
April 30, 2025			

Memorial Healthcare System
Non Audit Engagement Report
Q3 FY 2025

Quarter Ended	RSM US LLP Engagement:		
Q3 FY2025	For professional services rendered and expenses incurred in connection with the preparation of Form 990-T and quarterly estimates for the year ended April 30, 2024.	$	15,600
	For professional services rendered and expenses incurred in connection with advisory services related to 1099 mapping.	$	7,875
	Total	$	23,475
Q3 FY2024	Total spend, provided for comparative purpose	$	100,600

Quarter Ended	Zomma Group LLP Engagement:		
Q3 FY2025	For professional services rendered and expenses incurred in connection with Non Audit Engagements.	$	-
Q3 FY2024	Total spend, provided for comparative purpose	$	-

MEMORIAL HEALTHCARE SYSTEM
AUDIT AND COMPLIANCE WORK PLAN
FISCAL YEAR 2026

SUMMARY

		HOURS		
		FY 2026 Budget	FY 2025 Budget	Mar 1, 2024 thru Feb 29, 2025 Actual
I.	**INTERNAL AUDIT**			
	RECURRING ANNUAL AUDITS	750	1,150	3,022
	RECURRING QUARTERLY AUDITS	1,460	1,160	873
	INFORMATION SYSTEMS AUDITS	700	950	928
	OTHER INTERNAL AUDITS	3,350	1,450	1,561
	INTERNAL AUDIT TOTAL	6,260	4,710	6,383
II.	**COMPLIANCE**			
	FACILITY BILLING AUDITS	4,800	4,150	4,044
	PROFESSIONAL BILLING AUDITS	2,400	1,810	3,488
	FACILITY AND PROFESSIONAL BILLING AUDITS	400	600	631
	OTHER COMPLIANCE AUDITS	1,230	800	2,019
	COMPLIANCE AUDIT TOTAL	8,830	7,360	10,181
III.	**PRIVACY & SECURITY**			
	PRIVACY AUDITS	1,700	450	192
	INFORMATION TECHNOLOGY SECURITY AUDITS	2,600	910	128
	RISK MANAGEMENT	400		0
	PATIENT'S RIGHTS	750		0
	PRIVACY & SECURITY TOTAL	5,450	1,360	320
IV.	**CONFLICTS OF INTEREST**	1,810	1,400	2,022
V.	**HOTLINE AND OTHER INVESTIGATIONS**	3,000	1,400	1,100
VI.	**ADMINISTRATIVE & OTHER**	3,000	1,800	2,292
VII.	**PAID LEAVE**	2,860	1,890	1,804
	GRAND TOTAL	31,210	19,920	24,101

SUMMARY BY STAFFING

	INTERNAL AUDIT	COMPLIANCE	PRIVACY & SECURITY	CONFLICTS OF INTEREST	HOTLINE & INVESTIGATIONS	ADMIN & OTHER	PAID LEAVE	TOTAL
CHIEF COMPLIANCE & INTERNAL AUDIT OFFICER	624	964	135	258	385	265	113	2,743
DIRECTOR OF COMPLIANCE	5	1,135	0	22	346	301	279	2,088
COMPLIANCE AUDITORS	3	3,379	0	0	168	303	401	4,253
COMPLIANCE AUDITOR - MPG	0	3,721	0	0	8	101	333	4,163
DIRECTOR OF INTERNAL AUDIT	1,824	14	33	0	6	22	150	2,048
SR DIRECTOR OF INTERNAL AUDIT	366	7	0	9	1	51	0	433
SENIOR INTERNAL AUDITOR	1,523	24	0	2	3	351	185	2,088
INTERNAL AUDITOR	1,295	27	0	18	29	597	144	2,110
SENIOR IT & PRIVACY AUDITOR	743	610	152	41	151	265	128	2,088
CONFLICTS OF INTEREST MANAGER	0	301	0	1,673	5	37	72	2,088
SENIOR DIRECTOR OF PRIVACY								
PRIVACY MANAGER								
SENIOR PRIVACY SPECIALIST								
PRIVACY SPECIALIST								
SENIOR PRIVACY ANALYST								
PRIVACY ANALYST								
PRIVACY TECHNICIAN								
TOTALS	6,383	10,181	320	2,022	1,100	2,292	1,804	24,101

I. INTERNAL AUDIT		Hours
A.	**RECURRING ANNUAL AUDITS**	**750**
	Pension Plan Annual audit of pension plan activity for compliance with plan document. Audit of Contributions.	200
	RSM Annual Audit Assist RSM with annual financial audit.	550
B.	**RECURRING QUARTERLY AUDITS**	**1,460**
	Construction Audit of construction disbursements for all projects with an estimated cost of $1,000,000 or greater.	200
	RFPs and Competitive Quotes Audit to determine that all Requests for Proposal (RFPs) and Competitive Quotes are conducted according to System policies.	200
	Leases Audit to determine that all Leases are conducted according to System policies. Verify inventory, policies and procedures that include leasing policy, FMV policy, Rent Collection Policy, Space Measurement Policy, Real Estate Document policy, type of policy (from triple net to full service gross leases), base rate, rent table, competitive analysis report, documentation of the referral sources and the commercial reasonableness of the transactions.	200
	RSM Non Audit Engagements Identify and report to the Audit and Compliance Committee all RSM engagements that are not related to their main audit activities.	60
	Board and CEO Travel & Expenses Audit to determine that all travel and entertainment expenses incurred by Board members and President and CEO are consistent with System policies.	200
	Government Relations Department Expenses and Travel Reimbursement Audit to determine that the quarterly departmental expenses and travel reimbursements incurred by members of the Governmental Affairs Department are consistent with System policies.	200
	Employee Travel Expenses and Reimbursement Audit to determine that the quarterly travel and entertainment expenses incurred by all Memorial Healthcare System employees, including employed physicians, are consistent with System policies.	400
C.	**INFORMATION SYSTEMS AUDITS**	**700**
	Assistance Provided to Protiviti Coordinate and review services provided by Protiviti.	200
	Audit Workpaper Software Maintenance of the Audit Department management system, including the development of automated reports and management response process, development of risk assessments, updates to project program steps, and create and maintain audit summary dashboard.	300
	Pharmacy Concierge Follow up Determine whether the MHM PCS Program adheres to the Pharmacy Concierge Service policies and procedures, obtains patient choice to fill the Rx to maintain proper continuity of care, and takes necessary steps to collect the minimum amount of data while maintaining privacy and security.	200

I. INTERNAL AUDIT		Hours
D.	**OTHER INTERNAL AUDITS**	**3,350**
	Non-Monetary Compensation to Contracted Physicians Determine whether non-monetary compensation are provided to physicians for medical staff incidental benefits that can include meals, parking, and items or incidental services. Verify that an inventory of non-monetary compensation and benefits exists.	300
	Supply Chain Evaluate the supply chain governance, risk management and control processes appropriately reduce operations costs, increase competitive advantage, and inventory sole source providers, and verify supplier selection process ensures that they provide quality goods and services, timely delivery and follow up on delays, have strong cybersecurity controls, have service level audits, and are held to ethical standards.	400
	Employee Travel Expenses and Reimbursement Complete audit of travel expense and reimbursement for employees since fiscal year 2023 to current to verify employee travel and expenses were approved by their leader and reimbursement followed the travel policy's internal controls that include lodging, airfare, meals, and other expenses recorded on the appropriate expense forms and were submitted with supporting documentation, such as receipts and other proof of payment.	400
	District Labs Manage outside internal audit firm to assess the processes for supplies and availability, medication reconciliation, and capturing medication errors. Identify where in the process tests are charged, evaluate the timeliness and accuracy of the test and the need for retesting at all laboratory locations. Joint audit with the nurses for "medical necessity".	400
	Property Management (off-site facilities/non-hospitals and MOBs) Manage outside internal audit firm to assess the management of general maintenance and special requests for items such as painting, mold mitigation, social distancing set up, etc. Perform minor maintenance such as changing light bulbs and AC filters. Hospital facility departments will have the same level of risk. The hospital facility departments report through the hospitals.	200
	Drug Procurement Process Review the controls in the drug procurement process. Evaluate the adequacy of internal controls to manage the purchasing, receiving, approval and payments to MHS's pharmaceutical drug vendors. McKesson invoice approval within the "McKesson Connect" portal. No approval limits within that portal for MHS approvers. Invoices paid without approval, overpayments.	300
	Workday Approval Routing Procurement and Payments Evaluate the extent of the WD approval routing deviations from the MHS approval matrix for purchase orders and invoices. AP invoice routing issue identified during RSM interim testing. Purchase requisition routing issue identified during quarterly competitive bids review.	300
	Business Intelligence Review and validate the financial data that is being used for business decisions by Executives. Assess the role this function plays in decision making.	300
	Strategic Financial Support Evaluate strategic planning process for the requirements for accomplishing the vision and the steps to get there.	250
	AR Management Front end process at Manor, MPG, Urgent Care, and MPG and the back end process Corporate.	250
	Accounts Payable Review of MHS invoices with credit balances associated with purchase order line items. Determine if MHS is appropriately capturing credit balances to offset payment amounts. Issue was identified during quarterly review of construction payment applications.	250
	INTERNAL AUDIT TOTAL	**6,260**

II. COMPLIANCE

		Hours
A.	**FACILITY BILLING AUDITS**	**4,800**

DRG Coding — 300

Conduct coding audits of MS-DRGs that have been nationally identified as subject to manipulation. Determine whether the services provided were medically necessary. Audit the coding process to determine that the assignment of DRGs is appropriate and reasonable.

APCs & Outpatient Services — 300

Conduct coding audits that have been nationally identified as subject to manipulation. Determine whether the services provided were medically necessary. Audit to determine whether issues of medical necessity, diagnosis and procedure coding, and bundling and unbundling of services relating to the outpatient prospective payment system are properly handled.

Medicaid Services — 200

Determine whether the services are medically necessary. Determine whether the services are billed according to Medicaid guidelines.

340B Drug Pricing Program - Hospital — 400

Determine whether the patients are appropriate candidates. Determine if the provider is 340B eligible. Audit for potentially abusive practices, such as duplicate discounts. Audit to determine adequacy of documentation. Determine if the location is an eligible location.

340B Drug Pricing Program - Contract Pharmacies — 400

Determine whether the patients are appropriate candidates. Determine if the provider is 340B eligible. Audit for potentially abusive practices, such as duplicate discounts. Audit to determine adequacy of documentation. Determine if the location is an eligible location.

340B Drug Pricing Program - External Contract Pharmacies — 400

Determine whether the patients are appropriate candidates. Determine if the provider is 340B eligible. Audit for potentially abusive practices, such as duplicate discounts. Audit to determine adequacy of documentation. Determine if the location is an eligible location.

New Programs and Services — 800

Determine whether issues of medical necessity, diagnosis and procedure coding, and bundling and unbundling of services relating to new programs are properly handled. Includes Comprehensive Stroke Designation at MHW, RN Fellowship Program, LDL Pheresis at JDCH (see Plasmology under partnership), Manor Insourcing Pharmacy Services, Pharmacist Led Medication Management MRH, Laboratory downtime process, Hospital at Home at MHW & MRH and expected patient population - Medicare FFS and MEHP, MHW Operating Room LeanTAAS System documentation, coding and billing audit (IT audit if iQueue system under IT Security Audits) , MPC division is the City of Hollywood clinic, Transcranial Magnetic Stimulation (TMS) at Outpatient Behavioral Health (Started seeing patient July 2024), OBGYN has since added a new procedure and equipment (MPC), UCC seeing babies 6 months and older (as of November, 1, 2024), NICU Level 3 at MHM & MHW - JDCH was able to begin charging Level 4 and MHW/MHM (see Facility and Professional Billing Audits section) , and Sport Rehab clinic on Hollywood Blvd, JDCH (since August 2024) .

Total Heart Center and Adult Congenital Heart Disease Program — 200

Audit for potentially abusive practices such as upcoding; examine for adequacy of patient record documentation.

Clinical Trials — 200

Audit to assess program safeguards related to clinical trial claim processing requirements. Audit to assess that payment only includes items and services that Medicare would otherwise have covered if they were not provided in the context of a clinical trial.

Pain Management — 200

Audit to assess that the pain management program to ensure adherence to relevant regulations, ethical guidelines, and best practices, verify medical necessity is appropriately documented and coded, and accounts are properly documented, coded and billed according to Local Coverage Determination as well as Medicare and Medicaid requirements.

Partial Compliance Risk Assessment — 200

Evaluate consequences of leadership changes on identify areas internal control, evaluate potential compliance risks to possible outcomes, and prioritize legal and regulatory risks based on the severity of possible operational, legal, and financial damage associated with each.

II. COMPLIANCE	Hours
Memorial/Moffitt Cancer Program Audit to ensure all policies, care plans, and other documentation are in order, medication adherence rates are monitored; examine for adequacy of patient record documentation. Audit for potentially abusive practices such as upcoding; examine for adequacy of patient record documentation.	200
Florida Parental Consent Law CMO of JDCH reported needed education for a general consent signed a foster parent who has no authority. Verify new Florida Parental Consent Law process is documented and procedures to follow to avoid misdemeanor of the first degree for physicians and other health care providers to provide medical services to a minor without first obtaining written parental consent. See Florida HB 241 at https://www.flsenate.gov/Committees/BillSummaries/2021/html/2475	200
Regulatory Audits Conduct audits that determine whether we are following the rules which allow us to be Medicare and Medicaid providers, such as, the Medicare Outpatient Observation Notice, the Important Message from Medicare, the Detailed Notice of Discharge, signage, Pregnancy Termination after 15 weeks, and the new Medicare Change of Status Notice (MCSN) effective 2/14/25, etc.	200
Medicare Administrative Contractor Comparative Billing Reports Conduct audits to review First Coast Service Options, Inc. letters of utilization units and dollars paid, average number of units and dollars paid as compared to our peer group to identify opportunities to refine Medicare billing and utilization.	200
Partnerships and Outside Services Programs Conduct audits that determine whether we are following the rules which allow us to be Medicare and Medicaid providers with our partnerships and outside services, including HOPCo, Janus Health, Inc, Plasmology4, Inc. ICHOR Vascular, Inc, CaringWays, Inc ScriptDrop, Inc. and ProRank, Inc.	200
New CARF Standards Review to ensure the corporate compliance CARF policies have been adopted by leadership, policies and procedures address exclusions, compliance officer monitors, conducts risk assessments implements an annual work plan, reports on matters pertaining to the compliance program, trains personnel on compliance, and conduct internal audits.	200
B. PROFESSIONAL BILLING AUDITS	**2,400**
Coding and Billing Practices of Employed Physicians Audit for potentially abusive practices such as upcoding; examine for adequacy of patient record documentation, include telehealth reviews and teach physician services for Hospitalists, Pediatric GI Program, Pulmonary, Pediatric Cardiac, Gastroenterology, Infectious Disease, Otolaryngology, Thoracic Surery, and Vascular Surgery.	2,400
C. FACILITY AND PROFESSIONAL BILLING AUDITS	**400**
Medical Necessity, Coding and Billing Audits for Hospital and MPG Audit for compliance with Medicare and Medicaid requirements for medical record documentation of medical necessity, diagnosis and procedure coding, and medication adherence for both technical component and professional components in programs such as Bariatric/Weight-Loss Program, Chronic Care Pediatrics, and NICU III at MHM.	400
D. OTHER COMPLIANCE AUDITS	**1,230**
Evaluation of Corporate Compliance Program Self Assessment Determine that the Compliance Program effectively articulates and demonstrates the organization's commitment to the compliance process and ethical business practices, a culture that promotes prevention, detection and resolution of conduct that does not conform to Federal and State laws.	300
CCP Network Perform the function of compliance committee member at the Community Care Plan.	30
Excluded Party Searches Perform annual searches of all employees, physicians, non staff physicians, non physician practitioners, traveling nurses, students, volunteers, vendors and vendor principles to ensure that none have been excluded from participation in federal programs.	200

II. COMPLIANCE	Hours
Compliance Policies and Procedures Update standard practices, systemwide policies and procedures, and departmental policies and procedures. Audit to determine whether the Compliance Program and Privacy Program policies and procedures are being followed.	1,000
COMPLIANCE AUDIT TOTAL	**8,830**

III. PRIVACY & SECURITY	Hours
A. PRIVACY AUDITS	1,700
Privacy Technical Issues Participation in the management of Privacy Technical issues including log management and development, remote and system access, software application privacy compliance, investigation tools, and privacy monitoring.	100
Population Health Services Assess the current policies and procedures for this program to determine whether it meets the objectives and is consistent with the privacy and security standards. Audit approach would be validating any key indicators, reportable statistics on productivity, efficiency, and resource allocation, etc. Source - www.CDC.gov/POPhealthtraining/what is Population Health	150
General Data Protection Regulation Review patients and employees for residence in the European Union and evaluate privacy requirements are met to ensure data protections at rest and transit, use and disclosure, and data retention meet the requirements of GDPR.	150
Break the Glass Evaluate a sample of the break the glass report for escalated access to ePHI for appropriateness.	150
HIPAA ROI to Law Enforcement Determine whether appropriate use or disclosure to law enforcement complies with the requirements under HIPAA and verify disclosures were limited to the relevant circumstances under which law enforcement may access patient health information.	200
Health Information Management Assess the vendor compliance of contracted entity for the records release function to ensure the vendor follows Memorial policies and procedures for release of information, is compliant with contractual obligation, and adheres to all privacy requirements including HIPAA privacy and security requirements of protected health information. Verify appropriate legal medical record	200
Business Associate Contracts Verify that MHS has an active contract and Business Associate Agreement (BAA) with vendors or contracted entities that will have a BAA where there is a risk that contracted entity will access to PHI, PII, or sensitive information or where there is reasonably cause to believe that PHI, PII, or sensitive information will be incidentally or otherwise disclosure to them.	150
Privacy Rule Requirements for Group Health Plans Assess compliance with 164.504(f) Uses and Disclosures Standard for Group Health Plans self-insured maintain a separation that ensures only those employees with a plan-related need access to PHI for plan administrative functions are permitted access to the plans PHI, including payment and health care operations activities performed by employees of the employer.	200
Right of Access Obtain and review access requests that were granted and denied to ensure process followed policies and procedures, access was fulfilled in the form and format requested if able to produce in the requested format, that response was in a timely manner (30 days), fee charged met reasonable requirements of 164.524(c)(4) and denied PHI was excluded per §164.524(d)(1)	200
HIPAA Walk Throughs Walk through selected departments at each facility to ensure employees adhere to privacy requirements and provide education to workforce.	200
B. INFORMATION TECHNOLOGY SECURITY AUDITS	2,600
Ransomware Readiness Evaluate effectiveness of controls to mitigate ransomware attacks at the Memorial Healthcare System network perimeter.	150
IQueue OR Scheduling Access Review Verify required security guardrails have been implemented with a community accessible Operating Room Scheduling application.	150
Identity and Access Management Evaluate access controls as employees and vendors change roles within Memorial Healthcare System.	150
Transmission Security Review electronic transmission of ePHI, verify a mechanism to encrypt the ePHI was implemented appropriately, to include email, texting, application sessions, FTP, remote backups, remote access and support sessions (VPN) and web conferencing.	250

Epic Slicer/Dicer Level 2 Monitoring Review Epic Slicer/Dicer default Level 2 access to all MHS users, which is unmonitored, does not present an elevated risk.	150
Privacy and Security of Voice Recognition Drives Available in Patient Rooms Review Opt In/Opt Out procedures of voice recognition devices available in patient rooms along with the data retention/activation of conversations held within range of such devices.	150
Risk Management Framework Review the standards and guidelines for assessing and managing risks, which include setting objectives, establishing principles for corrective actions, identifying threats and vulnerabilities, analyzing the impact that PHI, PII and sensitive information losses may have and developing criteria for accepting risk levels.	200
Emergency Preparedness Assess emergency response procedures to mitigate environmental emergency situations related to geographic areas, care-related emergencies, equipment and power failures, communications interruptions, loss of all or a portion of the facility, loss of all or a portion of supplies. Evaluate management controls, business impact analysis, emergency plan for continued operations, and recovery plan. https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-emergency-preparedness/core-ep-rule-elements	400
Florida Off-Shore Storage of eHealth Records Review compliance of new Florida law requiring all patient data storage is physically held within the United States.	200
Smart Patient Rooms MRHS is piloting a smart room solution allowing patients to use voice technology to request medical or physical assistance. Review controls to ensure that patient information remains secured at rest and in transit, is properly disposed of, personal and unintended patient conversations are not to be stored, and meet the ADA requirements.	400
Governance Policies, Processes, and Procedures Evaluate whether the MHS formalized and published System Development Life Cycle (SDLC) policy requires and uses a well-documented system(s) development life cycle framework, has been reviewed and received approval from MHS security and privacy teams in all application development and enhancement projects.	200
Data Processing Policies, Processes, and Procedures Review the process of developing policies and procedures to ensure that the data review transfer, sharing or disclosure, alternation, and deletion of non-PHI and sensitive data stored and processed by the organization, including plans for access and management of website analytics, data, data lifecycle policy or guidelines, cookies management policy and procedures allow individuals to control their privacy preferences when browsing MHS websites. Review to verify the current Risk Management and Risk Analysis policy includes non-PHI personal data collected, used for analytics, and processed in routine reviews for privacy risk, particularly marketing data from MHS Websites, verify risk tolerance levels have been established to align with the organization's objectives and privacy requirements, and have developed procedures to review population subsets against model outcomes and through common bias assessment solutions.	200
C. RISK MANAGEMENT	400
Risk Management Framework Review the standards and guidelines for assessing and managing risks, which include setting objectives, establishing principles for corrective actions, identifying threats and vulnerabilities, analyzing the impact that PHI, PII and sensitive information losses may have and developing criteria for accepting risk levels.	200
Inventory and Mapping Manage the update process for the MHS Application Inventory of PCI, PII, PHI data classifications to include an additional classification of who the data belongs to e.g., patients, employees or prospective employees, contractors. Ensure criticality tiers are defined across inventory maintenance standards and related program documentation to ensure consistency and accuracy of the information available in the Application Inventory to better prioritization mechanisms and inform business process owners and stakeholders of risk management decisions.	200
D. PATIENT'S RIGHTS	750
Right of Access to Medical Records Investigate allegations of patient's denied right of access to their medical records within a timely manner, and provide written notification to patients.	150
Request Corrections to Records	150

Process patient requests for amendments to their medical records, present potential denials to the Privacy Subcommittee for approval, and provide written notification to patients.	
Request for Restrictions Process patient requests to restrict their medical records, present potential denials to the Privacy Subcommittee for approval, and provide written notification to patients.	100
Accounting of Disclosures Process patient requests for an accounting of disclosures of their medical records, present potential denials to the Privacy Subcommittee for approval, and provide the accounting of disclosure or denial notification in writing to patients.	150
Notice of Privacy Practices Prepare, update, and ensure the Notice of Privacy Practices is up to date and complies with the HIPAA requirements to inform the patient how MHS uses and disclosures patient protected health information, how MHS secures their protected information and maintains their privacy, and informs patient of their rights to complain to Health and Human Services and to MHS if they believe the privacy rights have been violated.	50
Notice of Breach of PHI Notify patient of any breach of their unsecured medical records when there is reason to believe the PHI has been accessed, acquired, used, or disclosed without authorization. Furthermore, notify the Secretary of small breaches of unsecured protected health information by March 1 of the following calendar year and breach of 500 or more individuals within 60 days and notify the State of Florida Department of Legal Affairs within 30 days.	150
PRIVACY & SECURITY TOTAL	5,450

IV. CONFLICTS OF INTEREST	Hours
C. CONFLICTS MANAGEMENT	1,810
Distribution and Analysis mitigated. Determine that the risks of purchase schemes, kickbacks, bid rigging, etc. are mitigated.	900
Training Program Provide training throughout the organization about conflicts, how and when to disclose potential conflicts, and make available on the MHS LMS Aspire.	200
Policies Adherence Verify policy compliance policies for identification, evaluations and mitigation of potential and possible conflicts of interest.	200
Conflicts Management Application Development Work with Information Technology Application Development to drive the enhancements of the current Conflicts of Interest System to send, receive, and store workforce communications, to allow the user to use their prior year's disclosure when there has been no change to the disclosed conflict from year to year, to include a new template for the Physician Outside Activities Form with the same capabilities as the Conflicts of Interest system, and to have the COI Subcommittee documentations in the application.	200
Subcommittee with Conflicts Evaluation and Risk Instrument Process Conflict decision-tree flowchart, verify members of the COI Subcommittee have been training and complete the risk evaluations for each conflict of interest disclosed. Provide training on applicable laws and regulations related to the disclosed conflict, standardize tools and processes to mitigate conflicts, fielding questions and requests for additional information, coordination of Subcommittee votes and mitigation requirements. Implement updated and new software, including contracting, roll-out, training, and maintenance.	310
CONFLICTS OF INTEREST TOTAL	**1,810**

V. HOTLINE AND OTHER INVESTIGATIONS	
Hotline Investigate and respond to compliance hotline calls.	700
Privacy Investigate and respond to Privacy Reports of inappropriate access, Fairwarning co-worker snooping, VIP, break or bump the glass and other reports, Data Loss Prevention reports, HIE monitoring reports, and other reports	700
Internal Reports Investigate and respond to Internal Reports of suspected noncompliance.	700
Document Requests Document requests, audit, review, and response to HHS OIG, OCR, CMS, FCSO, RAC, TPE, UPIC SMRC, CERT, and any other scheduled or ad hoc audits.	600
Contract and License Reviews Evaluate contracts and license agreements to ensure compliance with CMS, Florida Statute on conflicts of interest, HIPAA and FIPA privacy and data security requirements.	300
INVESTIGATIONS TOTAL	**3,000**

VI. ADMINISTRATIVE & OTHER	
Compliance, Internal Audit, Conflicts of Interest, Privacy Training and Development Includes New Employee Orientation, Leadership Essentials, Management Updates, Compliance Working Committee, Physician Compliance Training, HIPAA training, and Inservice sessions as needed.	2,200
Administrative and Other Includes special projects, meetings, etc. Includes Credit Union	800
TRAINING, STAFF DEVELOPMENT & OTHER TOTAL	**3,000**

VII. WORK PERFORMED BY OUTSIDE AUDIT FIRMS

A.	ANNUAL IT SECURITY AUDITS	Firm
	External Penetration Testing Conduct an annual scan to identify and evaluate the security posture and risk exposures of external MHS environments (Internet perimeter) and to identify information security system issues. Conduct scans of new, outward facing features such as ePrescribing and Patient Medical Records.	Protiviti
	Internal Penetration Test Internal Penetration Test, with a focus on Ransomware attack vectors, would be performed to evaluate the risk the organization faces if an attacker, malicious code, or internal employee were to attempt to perpetrate an attack on the network from the inside, otherwise bypassing external network controls that would prevent an external attacker.	Protiviti
	Internal Vulnerability Assessment Conduct an annual scan to identify and evaluate the security posture and risk exposures of internal MHS environments and to identify information security system issues.	Protiviti

B.	NEW IT SECURITY AUDITS	Firm
	Vendor Risk Delegation Protiviti will perform evaluation of rules and policies adopted to manage the risks of delegating responsibility to vendors and related entities of first tier, downstreatm, and related entities.	Protiviti
	Data Governance This review will include follow up on control of the effective data management and governance with an increased focus on data commercialization and interoperability.	Protiviti
	Application Review (i.e. Population Health, Telehealth) Protiviti will assist MHS to evaluate the system and security controls of Population Health and telehealth solutions, including an evaluation of the databases, servers, and infrastructure that support the applications, access management, and data governance.	Protiviti
	Incident Response Program Assessment Assess Information Technology Incident Response Program against industry best practices and standards to identify potential risks and vulnerabilities, measure maturity, forensic capabilities, and lessons learned process.	Protiviti
	NIST's Artifical Intelligence Framework Assess the business processes, policies and technologies that facilitates AI and consier the development of organizational AI management frameworks to suppport appropriate risk coverage.	Protiviti
	Life Sciences Measure against current transparency and explainability in artificial intelligence in the interpretable models and detailed documentaiton that are vital for regulatory compliance.	Protiviti
	International Privacy Evaluate the process to ensure privacy program is compliant with the GDPR and EU AI act that has influenced global data protection strategies. In addition, evaluate the readiness of the organization's privacy program as it relates to the American Privacy Rights Act of 2024 and read for any future changes.	Protiviti

C.	INTERNAL & COMPLIANCE AUDITS	Firm
	District Labs Assess the processes for supplies and availabilty, medication reconciliation, and capturing medication errors. Identify where in the process tests are charged, evaluate the timeliness and accuracy of the test and the need for retesting at all laboratory locations. Maybe a joint audit with the nurses for "medically necessary". In Hallandale and is the same as the individual labs in regards to risk.	TBD
	Property Management (off-site facilities/non-hospitals and MOBs) Managing general maintenance and special requests for items such as painting, mold mitigation, social distancing set up, etc. Perform minor maintenance such as changing light bulbs and AC filters. Hospital facility departments will have the same level of risk. The hospital facility departments report through the hospitals.	TBD

VII. WORK PERFORMED BY OUTSIDE AUDIT FIRMS

Cancer Institute Risk Assessment — TBD

Identify and assess the likelihood and potential impact of operational risks to the organization and evaluate how adequate controls are in reduing risk to ensure that residual risk is at a manageable level.

Pharmacy — PPP

Regular quarterly audits to determine medication adherence

Physician Agreements — Nelson Mullins Broad & Cassel

Determine whether Physician Agreements, including lease agreements, are in compliance with federal regulations. Verify that the work being performed and the payments being made are in accordance with an executed and current contract.

Evaluation of Corporate Compliance Programs — RFP Process

Determine that the Compliance Program effectively articulates and demonstrates the organization's commitment to the compliance process and ethical business practices, a culture that promotes prevention, detection and resolution of conduct that does not conform to Federal and State laws.

Memorial Manor — PYA

Assess the Memorial Manor to ensure appropriate processes are in place to ensure that infection prevention, meeting the regulatory requirements for quality, life safety, and emergency preparedness, and meet accreditation and the CMS and State skilled nursing facility requirements.

Transplant Program — TBD

Determine transplant program policies and procedures align with regulatory requirements and data reporting, and coding and billing are appropriate.

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To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: December 12, 2024

From: David Smith, Executive Vice President and Chief Financial Officer, MHS
Saul Kredi, Vice President, Chief Supply Chain Officer, MHS

Subject: **Action Plan: INTERNAL AUDIT OF REQUIREMENTS FOR REQUEST FOR PROPOSALS (RFP) AT MEMORIAL HEALTHCARE SYSTEM**

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend Supply Chain Management (SCM) continue to work on revising the RFP Standard Practice.	We are going to work with Legal on creating a comprehensive Procurement Guideline and in conjunction with that, we will also revise the RFP Standard Practice.	8/1/2025
We recommend SCM establish standardized documentation of sole source vendors to include market research analysis and approval of the competitive bid exemption.	We will draft a policy to document this process.	8/1/2025
We recommend SCM maintain documentation to support the selection of all vendors and consultants for contracted services.	Training new staff on documentation of selection of all vendors is in process in conjunction with the sole source vendor policy. We will also be providing on-going education to the organization on sourcing products, services, and equipment as a refresher.	8/1/2025
We recommend SCM continue to review contracts near the end	Supply Chain will continue this practice. In addition, we will	8/1/2025

of term to determine the value and feasibility of rebidding the products or services.	obtain Executive Approval for any agreements that require extension.	

cc: Shane Strum, Interim Chief Executive Officer, MHS

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To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: December 10, 2024

From: Dave Smith, Executive Vice President and Chief Financial Officer, MHS

Subject: **Action Plan: INTERNAL AUDIT OF FACILITIES MANAGEMENT AT MHS**

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend that the Facilities Management Directors work with the Construction Services Department to update the Standard Practice of Construction Services to align with the Facilities Matrix and acceptable practices.	Construction Services will update the Construction Services Standard Practice in collaboration with MHS Facilities Directors, Supply Chain Management and MHS CFO, ensuring alignment with Facilities Matrix and current practices.	June 1, 2025
We recommend that a policy and procedure is drafted specifically for Facilities Management department to address vendor selection, documentation of preferred vendors and vendors with exclusive products and services, Facilities Matrix, Purchase Order (PO) requirements and exceptions, vendor selection documentation in Workday, and vendor rotation.	MHS Facilities Directors, Construction Services and Supply Chain Management will develop a policy and procedure that address the Facilities Matrix requirements, including all necessary references to approvals, vendor selection, sole sourcing of vendors, ordering, verification and documentation requirements. MHS CFO will evaluate the need for vendor rotation requirements to include in said policy, if any.	June 1, 2025

We recommend that the Facilities Management team collaborate with Supply Chain Management and Accounts Payable to ensure that PO invoices are not paid as non-POs, to ensure that the open PO management control in place is effective.	Supply Chain Management & Accounts Payable department will develop a process to improve invoice and PO line item matching prior to invoice approvals at the entity level, and a reporting process for open PO line items that enables monitoring at the individual entity level. Requirement to utilize POs and confirm non-PO invoices will be addressed in Facilities Matrix policy and procedure being developed.	June 1, 2025

cc: Shane Strum, Interim Chief Executive Officer, MHS

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To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: January 6, 2025

From: Jeffrey Sturman, Senior Vice President and Chief Digital Officer DS

Subject: **Action Plan: INTERNAL AUDIT OF ARTIFICIAL INTELLIGENCE GOVERNANCE AT MEMORIAL HEALTHCARE SYSTEM**

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend that AI best practices be developed and established to provide guidance on AI acceptable uses within the healthcare system.	Draft guidance document is complete. We are in the process of getting feedback from stakeholders and will have it published in policyStat.	3/31/2025
We recommend a policy that provides guidance for governing, mapping, measuring, and managing AI risks at MHS.	IT is working on developing governance group. Which will be part of data and analytics governance group. We should have a charter and measures to mitigate AI risks at MHS	9/30/2025

cc: Shane Strum, Interim Chief Executive Officer, MHS

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To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: February 25, 2025

From: Joseph Stuczynski, Chief Executive Officer, MHW
Katherine Wong, Chief Financial Officer, MHW 3/17/2025

Subject: **Action Plan: COMPLIANCE AUDIT OF THE 340B PROGRAM AT MEMORIAL HEALTHCARE SYSTEM (MHS) - FY 2025 THIRD QUARTER**

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend nursing leadership to reeducate the staff on verbal/telephone orders as per MHS policies.	Tips and Educations for Nursing leaders has been shared with MHW Nursing leadership on 2-26-2025. Nursing Managers have been huddling to their respective teams.	4/1/2025
We recommend nursing leadership to develop, implement, and monitor a process/workflow to ensure that the MHS policy on "Medication Overrides" is followed.	Epic Workbench report was created for MHW Nursing Leadership, and the Pharmacy Operations Manager is currently validating to ensure data is capturing the information correctly. Pharmacy Operations Manager is working with Director of Nursing, Lotta Tall to review and identify opportunities for reducing non-emergent overrides. The Clinical Pharmacists at MHW are now running the report 3-4 times daily to capture in real time and have the nurse	Overall estimated completion date: 4/1/2025 for the new report with the other action items already completed and implemented.

	enter the corresponding telephone/verbal order.	

cc: Shane Strum, Interim Chief Executive Officer, MHS

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To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: February 25, 2025

From: Philoron Wright, Chief Executive Officer, MRHS
David Webb, Chief Financial Officer, MRHS

Subject: **Action Plan: COMPLIANCE AUDIT OF THE 340B PROGRAM AT MEMORIAL HEALTHCARE SYSTEM (MHS)- FY 2025 THIRD QUARTER**

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend nursing leadership to reeducate the staff on verbal/telephone orders as per MHS policies.	Nursing education regarding verbal/telephone orders starting April 1st	4/30/25
We recommend nursing leadership to develop, implement, and monitor a process/workflow to ensure that the MHS policy on "Medication Overrides" is followed.	Nursing and Pharmacy to develop an audit process for Medication overrides. Ongoing auditing for 3 months starting 5/1/25	7/1/2025

cc: Shane Strum, Interim Chief Executive Officer, MHS

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To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: March 3, 2025

From: Aurelio Fernandez, Interim Chief Executive Officer, MRH
Walter Bussell, Chief Financial Officer, MRH

Subject: **Action Plan: COMPLIANCE AUDIT OF THE DOCUMENTATION AND BILLING OF THE MEDICARE-SEVERITY DIAGNOSIS RELATED GROUP (MS-DRG) 207 and MS-DRG 208 AT MEMORIAL REGIONAL HOSPITAL**

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend that Health Information Management continue to provide education to coding staff on respiratory failure and calculating mechanical ventilation hours by including MS-DRG 207 and 208 routinely in their regular audits for coding.	HIM will monitor respiratory failure and mechanical ventilation hours by including DRGs 207 & 208 in routine coding audits. Education for coding respiratory failure and calculating ventilation hours is available for staff to review and refresher will be provided for coding staff. Additionally, HIM has collaborated with Respiratory Therapy to ensure hours for mechanical ventilation is appropriately documented in EPIC.	Routine auditing will be ongoing and refresher education will be completed by 5/31/2025.

cc: Shane Strum, Interim Chief Executive Officer, MHS

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To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: March 13,2025

From: Aurelio Fernandez, Interim Chief Executive Officer, MRH
Walter Bussell, Chief Financial Officer, MRH

Subject: **Action Plan COMPLIANCE AUDIT OF DOCUMENTATION OF CONTROLLED SUBSTANCES IN THE HEMATOLOGY ONCOLOGY INPATIENT DEPARTMENT AT MEMORIAL REGIONAL HOSPITAL**

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend reeducating the Registered Nurses (RN) on the "Medication Administration - Policy Statement" and "Scheduling Medications Administration".	• Leadership will conduct a thorough review during huddle and staff meeting of the "Medication Administration- Policy Statement" and "Scheduling Medication Administration" to ensure all key points and updates are clearly identifying timely removal and administration of medication from automated dispensing cabinet (ADC). • Unit leadership will utilize the audit provided by pharmacy to inspect compliance and follow up with staff accordingly. Pharmacy audit tool includes undocumented waste and narcotic discrepancies. • Policy review and sign in sheet will be returned to Corporate Compliance to validate completion of action plan on or by April 18, 2025	April 18, 2025
We recommend reeducating RNs to include supporting documentation on the Medication Administration Record for the	• Leadership will conduct a thorough review during huddle and staff meeting of the "Medication Administration- Policy Statement" and	April 18, 2025

reason the total dose removed was wasted.	"Scheduling Medication Administration" focusing on the proper procedure for documenting medication waste, including the requirements to specify the reason for the waste and accurately reflect this in the medication administration records. • Unit leadership will utilize the audit provided by pharmacy to inspect compliance and follow up with staff accordingly. Pharmacy audit tool includes undocumented waste and narcotic discrepancy.	

cc: Shane Strum, Interim Chief Executive Officer, MHS

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To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: February 11, 2025

From: Mario Salceda-Cruz, Chief Operating Officer, MPG MS
Esther Surujon, Chief Financial Officer, MPG ES

Subject: **Action Plan: COMPLIANCE AUDIT FOR UROLOGY EVALUATION AND MANAGEMENT AND PROCEDURES FOR MEMORIAL PHYSICIAN GROUP PROFESSIONAL CODING AND BILLING**

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend that MPG Business Office correct and rebill or refund accounts as appropriate.	Account refunded	03/31/2025
We recommend that the Administrative Director of Urology coordinate with the Auditor of Coding Compliance Education to conduct a reeducation session for the providers on documentation guidelines, requirements for telehealth, and to have the providers re-review the MPG Copy and Paste Policy	Auditor of Coding Compliance/Education will conduct a reeducation session for the Urology providers on documentation guidelines, requirements for telehealth, and copy and paste.	05/30/2025

cc: Shane Strum, Interim President and CEO, MHS

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To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: March 12, 2025

From: Mario Salceda-Cruz, Chief Operating Officer, MPG DS MS
Esther Surujon, Chief Financial Officer, MPG DocuSigned by: Esther Surujon 5B3194FFE1074E8...

Subject: **Action Plan: COMPLIANCE AUDIT OF ORTHOPEDIC SURGERY EVALUATION AND MANAGEMENT SERVICES FOR MEMORIAL PHYSICIAN GROUP PROFESSIONAL CODING AND BILLING**

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend that Memorial Physician Group (MPG) Business Office correct and rebill or refund accounts as appropriate.	MPG Business Office will correct and rebill or refund accounts as appropriate.	04/30/2025
We recommend that the MPG Business Office reeducate providers on medical record documentation, coding, and billing to support medical necessity and services billed.	Auditor of Coding Compliance/Education will conduct a reeducation session for the providers on documentation guidelines, coding, and billing to support medical necessity and service billed.	05/30/2025

cc: Shane Strum, Interim Chief Executive Officer, MHS

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To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: February 14, 2025

From: Felicia Turnley, Chief Executive Officer, MHP
Patrick Connor, Chief Financial Officer, MHP

Subject: **Action Plan: FOLLOW-UP COMPLIANCE AUDIT OF THE IMPORTANT MESSAGE FROM MEDICARE (IM) NOTICE AT MEMORIAL HOSPITAL PEMBROKE**

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend that the Patient Financial Services (PFS) management continue to provide ongoing reeducation to staff on Medicare requirements of providing the initial IM including the required timeframe, necessary required documentation and ensure that the IM is maintained in the patient's medical records.	Staff education to be completed during huddles and via e-mail communication for those unable to attend. Reviewed during annual performance review of competencies individually with staff assigned to visit patients in the EDs and on patient floors. Training session during Team Lead meeting on 04/14/25. Staff Meeting training scheduled for 04/21/25 and 04/25/25.	03/31/25 Annually 04/30/25
We recommend the PFS management continue to perform regular prospective reviews on Medicare and Medicare advantage inpatient accounts to ensure compliance with the completion of Medicare requirements.	PFS Managers will audit 50 IMM accounts for compliance monthly. Inconsistencies will be assessed and staff coached.	March 31,2025 and monthly thereafter Ongoing

We recommend that the Case Management (CM) management continue to provide ongoing reeducation to staff on Medicare requirements of providing the follow up IM including the required timeframe, necessary required documentation and ensure that the IM is maintained in the patient's medical records.	Education as routine topic during monthly staff meetings to confirm all staff members including new staff, are up to date with the regulations and requirements. First meeting 2/27/25	Monthly through 7/31/25 Added to agenda thereafter based on monthly audit findings
We recommend the CM management continue to perform regular prospective reviews on Medicare and Medicare advantage inpatient accounts to ensure compliance with the completion of Medicare requirements.	Audits to be conducted monthly on 50 accounts to assure compliance and improvement.	Ongoing

cc: Shane Strum, Interim Chief Executive Officer, MHS

MEMORIAL HEALTHCARE SYSTEM

COMPLIANCE AND AUDIT DEPARTMENT POLICY

Date: July 2000

Date Reviewed: August 2001; May 2002; May 2003; June 2004; May 2005; January 2007; September 2009; September 2011; August 2013; July 2021; July 2023; February 2025

Date Revised: May 2005; September 2011; February 2025

Title: **POLICY NO. 1-A: Charter**

Purpose: To establish the Compliance and Audit Department mission, access to records, and audit approach

Policies:

I. Mission

The Compliance and Audit Department's (Compliance and Audit) mission is to construct and maintain a Corporate Compliance Program to be followed by South Broward Hospital District employees and agents which is reasonably capable of reducing the prospect of criminal conduct. The Program will include: (1) The establishment and maintenance of compliance standards and procedures to be followed by employees and agents; (2) Assurance that substantial discretionary authority is not delegated to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in illegal activities; (3) Effective communication of the standards and procedures to all employees and agents; (4) Maintenance of monitoring and auditing systems to detect criminal conduct by employees and agents without fear of retribution; and (5) Steps to respond appropriately to detected offenses and to prevent further similar offenses.

Compliance and Audit's mission is also to provide the Board of Commissioners (Board), the Compliance and Audit Committee of the Board, the Chief Executive Officer, and the Administrators of the facilities of Memorial Healthcare System (MHS), with an independent, risk-based, and objective appraisal of the adequacy of internal controls and MHS operations.

Compliance and Audit will be an independent function reporting to the Audit and Compliance Committee and the Chief Executive Officer. The Compliance and Audit function enhances governance, risk management, and controls processes, and provides assurance, advice, insight, and foresight for the Board and Senior Management decision-making and

oversight, provides reputation and credibility with stakeholders, and serves public interest.

II. Access to Records, Information, and Reports

The Board authorizes Compliance and Audit be granted full and complete, unrestricted access to all MHS functions, records, data, physical properties, and personnel relevant and pertinent to carry out the compliance and audit functions. Compliance and Audit will be kept apprised of all significant changes to accounting, clinical, or management of information systems. Compliance and Audit will be kept apprised of all outside audit engagements, including those performed by governmental agencies. Resulting reports will be made available to Compliance and Audit.

Records and information given to Compliance and Audit will be handled in the same prudent manner as by those employees normally accountable for them as prescribed by the Institute of Internal Auditors' Code of Ethics (See Compliance and Audit Department Policy 1-C).

III. Authority Limited

The Board grants the Compliance and Audit function the authority to provide the Board and senior management with objective assurance. Compliance and Audit's authority is created and supported by its direct reporting to the Board, which allows for unrestricted access to the Board. Compliance and Audit has no direct responsibility or any authority over any of the activities or operations that they review. Except for the establishment and maintenance of the compliance standards and procedures, they will not develop or install procedures, prepare records, or engage in activities which would normally be reviewed by internal auditors. The Board authorizes Compliance and Audit to allocate resources, including personnel within or outside the organization, set the frequency, subjects and scope of audit work, audit techniques utilized, and issue communications to accomplish audit objectives. It is the role of management to establish and maintain the internal controls necessary to safeguard the assets of MHS. Recommendations on standards of control applicable to a specific activity may be included in a written report of audit findings which is provided to operations and financial management for review and implementation.

Independence, Organizational Position, and Reporting Relationships

The Chief Compliance and Internal Audit Officer will be positioned at a level in the organization that enables internal audit services and responsibilities to be performed without interference from management, thereby establishing the independence of the internal audit function. The Chief Compliance and Internal Audit Officer will report functionally to the Board and administratively on day-to-day operations to the President and Chief Executive Officer. This positioning provides the organizational authority and status to bring matters directly to senior management and escalate matters to the Board, when necessary, without interference and supports the auditors' ability to maintain objectivity.

The Chief Compliance and Internal Audit Officer will confirm to the Board, at least annually, the organizational independence of the Compliance and Audit function. If the governance structure does not support organizational independence, the Chief Compliance and Internal Audit Officer will document the characteristics of the governance structure limiting independence and any safeguards employed to achieve the principle of independence. The Chief Compliance and Internal Audit Officer will disclose to the Board any interference auditors encounter related to the scope, performance, or communication of Compliance and Audit work and its effectiveness.

Changes to the Charter

Circumstances may justify a follow-up discussion between the Chief Compliance and Internal Audit Officer, Board, and senior management on the Compliance and Audit charter. Such circumstances may include but are not limited to a significant acquisition or reorganization within the organization, changes in the Chief Compliance and Internal Audit Officer, Board, and/or senior management, changes to the organization's strategies, objectives, risk profile, or the environment in which the organization operates, or new laws or regulations that affect the scope of MHS compliance and internal audits.

Board Oversight

Board responsibilities are outlined in the Board Charter. To establish, maintain, and ensure that MHS's Compliance and Audit function has sufficient authority to fulfill its duties, the Board will discuss with the Chief Compliance and Internal Audit Officer and senior management other topics that should be included in the Compliance and Audit charter, approve the Compliance and Audit function's charter, periodically review the Compliance and Audit charter with the Chief Compliance and Internal Audit Officer to consider changes affecting the organization, approve the risk-based Compliance and Audit Work Plan, collaborate with senior management to determine the qualifications and competencies the organization expects in a Chief Compliance and Internal Audit Officer, authorize the appointment and removal of the Chief Compliance and Internal Audit Officer, approve the remuneration of the Chief Compliance and Internal Audit Officer, review the Chief Compliance and Internal Audit Officer's performance, and determine whether scope or resource limitations are inappropriate.

Chief Compliance and Internal Audit Officer Roles and Responsibilities

Ethics and Professionalism - The Chief Compliance and Internal Audit Officer will ensure that compliance and internal auditors conform with Audit Standards and the principles of Ethics and Professionalism that are integrity, objectivity, competency, due professional care, and confidentiality. Auditors must understand, respect, meet, and contribute to the legitimate and ethical expectations of the organization and be able

to recognize conduct that is contrary to those expectations. Auditors are to encourage and promote an ethics-based culture in the organization and report organizational behavior that is inconsistent with the ethical expectations, as described in the MHS Code of Conduct.

Objectivity

The Chief Compliance and Internal Audit Officer will ensure that the Compliance and Audit function remains free from all conditions that threaten the ability of compliance and internal auditors to carry out their responsibilities in an unbiased manner, including matters of engagement selection, scope, procedures, frequency, timing, and communication. If the Chief Compliance and Internal Audit Officer determines that objectivity may be impaired in fact or appearance, the details of the impairment will be disclosed to appropriate parties.

Compliance and internal auditors will maintain an unbiased mental attitude that allows them to perform engagements objectively. Auditors believe in their work product, do not compromise quality, and do not subordinate their judgment on audit matters to others, either in fact or appearance. Auditors will have no direct operational responsibility or authority over any of the activities they review.

Accordingly, compliance and internal auditors will not implement internal controls, develop procedures, install systems, or engage in other activities that may impair their judgment. Such activities include assessing specific operations for which they had responsibility within the previous year, performing operational duties, approving or initiating transactions external to the audit function, and directing the activities of any South Broward Hospital District or MHS employee that is not employed by the Compliance and Audit function. Compliance and Internal auditors will disclose impairments of independence or objectivity, in fact or appearance, to appropriate parties and at least annually, maintain objectivity in gathering, evaluating, and communicating information, fairly assess all available and relevant facts and circumstances and take necessary precautions to avoid conflicts of interest, bias, and undue influence.

IV. Audit Approach

Audits will be conducted according to an Annual Risk-Based Work Plan that considers the input of the Board and senior management approved by the Audit and Compliance Committee. Special audits may be conducted at the discretion of the Board, Chief Executive Officer, or the Chief Compliance and Internal Audit Officer. Reviews of and adjustments to the Work Plan, as necessary, in response to changes in the healthcare industry and MHS's business, risks, operations, programs, systems, and controls.

Audits will generally be preceded by an entrance conference with the department head and/or administrator with responsibility for the area being audited. Exit conferences will be held with the same individuals at the close of the audit, prior to the issuance of the report, to allow those

individuals an opportunity to respond to the audit findings. The administrator and chief financial officer with responsibility for the area being audited are expected to respond to the findings, with recommendations for corrective action, within 10 days of the exit conference.

Compliance and Audit will issue its report to the Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, General Counsel (if warranted) and the Administrator(s) and Chief Financial Officer(s) responsible for the area audited.

Six months following the issuance of the report, the department head and/or administrator with responsibility for the area audited will report to the Compliance and Audit department the status of the recommendations. Follow up on engagement findings to confirm the implementation and recommendations and action plan items were implemented and effective should be part of the report narrative. Follow up review results are communicated to the Board and senior management.

A quarterly summary of the Compliance and Audit reports will be presented by the Chief Compliance and Audit Officer to the Compliance and Audit Committee.

Managing the Compliance and Internal Audit Function

The Chief Compliance and Internal Audit Officer has the responsibility to ensure the Compliance and Audit function collectively possesses or obtains knowledge or skill and other competencies and qualifications needed to meet the requirements of auditing standards.

The Chief Compliance and Internal Audit Officer has the responsibility to identify and consider trends and emerging issues that could impact MHS and communicate them to Board and senior management. Emerging trends that foster successful auditing practices will be considered and established.

Relevant MHS policies and procedures will be adhered to unless conflicting with the Audit and Compliance charter. If a conflict should exist, resolution should be documented and communicated to the Board and senior management.

The Compliance and Audit function will coordinate activities with the work of other internal or external providers of assurance and advisory services. Reliance on the internal or external providers work will be considered. If coordination or reliance cannot be achieved, it will be communicated to senior management and if needed, to the Board.

Communication with the Board and Senior Management

The Chief Compliance and Internal Audit Officer will report regularly to the board and senior management regarding significant revisions to the Compliance and Audit Work Plan and budget, impairments to independence, significant risk exposures and control issues including fraud risks, and management’s responses to risk that is determined to be unacceptable or greater than MHS’s risk tolerance levels.

Approved by the Board members at the Audit and Compliance Committee meeting on [date].

Acknowledgments/Signatures

_____	_____
Chief Compliance and Internal Audit Officer	Date
_____	_____
Audit & Compliance Chair	Date
_____	_____
Chief Executive Officer [optional]	Date